HEARING ON VA AND INDIAN
HEALTH SERVICE COOPERATION

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THURSDAY, NOVEMBER 5, 2009

United States Senate,
Committee on Veterans Affairs,
Washington, D.C.

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

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

Also Present: Senator Murkowski.

OPENING STATEMENT OF CHAIRMAN AKAKA

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

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

Native American veterans have a rich and storied history of service to our nation, and like all veterans, they deserve the care and benefits that they have earned. Many Native American veterans served with distinction, but return home to a very difficult transition. Substance

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abuse, extreme poverty, and unemployment still plague parts of Indian Country. American Indian and Alaska Native veterans are nearly 50 percent more likely than other veterans to have a service-connected disability and twice as likely to be unemployed. And as we will hear from a witness from my home State, challenges also extend to other Native veterans, including the many Native Hawaiians who have and are serving our nation.

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

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

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

As I speak, Tribal leaders are gathering for a White House summit, as you know. Such summits remind us of the

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government-to-government relationship the U.S. has with Tribal Nations and their members. Therefore, for VA to effectively serve the many Native Americans who have shared in our mutual defense, it must also collaborate with the Federally-recognized Tribal governments whose citizens serve with pride and patriotism.

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

OPENING STATEMENT OF SENATOR TESTER

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

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

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

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

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

But beyond the question of dollars and cents, it is clear that neither agency has the unique needs of the Indian veterans front and center. As a result, we hear the horror stories of a veteran walking into an IHS facility, only to

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be told to go to a VA hospital hundreds of miles away, and of the veteran walking into a VA facility, only to be sent to an IHS facility. This so-called ping-ponging veterans is at odds with each agency's mission to care for the patient first.

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

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

One of the areas that seems to be working, where we have had decent results on, is the roll-out of the telehealth capabilities. As you know, Mr. Chairman, telehealth is particularly important in rural States, like many in my State. Many times, it is the only opportunity for folks in frontier areas to see a doctor or a mental health provider. Many of these telehealth opportunities are the product of funding approved by Congress in the past year for VA rural health programs. That is a good story for both

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the VA and the IHS, and we need to build on it. We have made good progress, but the work is not done.

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

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

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

Chairman Akaka. Thank you very much, Senator Tester.

Senator Murray, your opening statement.

OPENING STATEMENT OF SENATOR MURRAY

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

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

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

I do want to take a moment to say how proud I am of all the veterans in this room. All of you have sacrificed so much in service to our country. We owe it to you to honor the promises we have made to take care of you when you come home. And one of the most important ways to do this is by making sure that veterans have access to a system that treats you fairly.

Tribal veterans, in particular, have made tremendous sacrifices for our country. In fact, Native Americans serve in the Armed Forces at a higher rate per capita than any other ethnic group. And I also know that Tribal veterans face some of the toughest barriers to accessing the services they have earned. Many Tribal veterans don't live anywhere near VA services. They face communication barriers. And too often, Tribal veterans face issues with coordination

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between the Indian Health Service and the VA. So it is our job to do everything within our power to break down those barriers and help our Tribal veterans access the care they need. You fought for us. We need to fight for you now.

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

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

Chairman Akaka. Thank you, Senator Murray.

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

OPENING STATEMENT OF SENATOR BURR

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

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

Mr. Chairman, Native Americans have the highest record of military service per capita when compared to other ethnic groups. I believe this record of service to our nation and to the country is rooted in their culture and their

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traditions. Courage, duty, honor, sacrifice--these are values that make up our military men and women and make them second to none, and they are the values that run thick in the culture of so many from Indian Country.

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

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

In 2003, VA and Indian Health Service developed a Memorandum of Understanding outlining five mutual goals. One, improve access to quality care. Improve communications. Encourage the development of partnerships and sharing agreements. Ensure appropriate resources are

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available. And fifth, improve health promotion, disease, and preventative services. Today, I hope to learn where we are meeting these important goals, but more importantly, where we still need work.

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

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

Chairman Akaka. Thank you very much, Senator Burr.

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

OPENING STATEMENT OF SENATOR BEGICH

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

From a State that has a huge percentage of Alaska Native population, obviously, 120,000 Alaska Natives, but

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also a very unique problem in delivery of services to our veterans in rural parts of Alaska, which again is much different than the Lower 48, where in some cases you can drive to facilities, but in Alaska, you may not even be able to get to a facility until the weather is correct and you can fly or snow machine or, depending on the conditions of the area.

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

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

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veterans, especially in rural communities, and Alaska Native American Indians have unique situations.

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

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

Chairman Akaka. Thank you very much, Senator Begich.

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

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

Our third witness, I am pleased to introduce Andrew Joseph, a Councilman from the Confederated Tribes of

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Colville, who is testifying on behalf of the National Indian Health Board.

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

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STATEMENT OF CLAY PARK, DIRECTOR, NATIVE AMERICAN HAWAIIAN VETERANS PROJECT, PAPA OLA LOKAHI

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

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

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

Recently, we have established at each of our five Native Hawaiian Health Care Systems, which operate throughout the State, veterans "Aunties" and "Uncles"

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

Likewise, Papa Ola Lokahi has developed a relationship with the Indian Health Service over the past 15 years. This relationship has afforded the provision of primary care service for American Indians and Alaska Native residents in Hawaii. Presently, these services are provided through Ke Ola Mama, one of the largest Native Hawaiian Health Care Systems, and directed by Lisa Mao Ka'anoi, an Alaska Native of Native Hawaiian ancestry.

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

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Native Hawaiian Health Care Systems are considering adopting.

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

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

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

[The prepared statement of Mr. Park follows:]

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Chairman Akaka. Thank you very much, Mr. Park.
Mr. Howlett, we will receive your testimony.

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

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

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

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

Specifically, there has been a longstanding belief that health care for Native Americans was the responsibility of the Indian Health Service. While I agree that the IHS has principal responsibility as the Federal agency designated to provide care, I also know that as citizens of the States in which Indians live, they are entitled to the services provided to the citizens of that State. In addition, by

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having served our country in the Armed Services, veterans have earned the right to care provided by the Veterans Administration medical system.

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

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

We are aware of the existence of a Memorandum of Understanding between the Indian Health Service and the VA. We are also aware that it represents more symbolism than action. Without question, the full implementation of the existing MOU linked to specific Tribal recommendations would go a long way in providing a more comprehensive level of care to our veterans. Specifically, the agencies agreed to

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many things, including the sharing of information technology and an interagency work group to oversee proposed national initiatives.

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

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

Mr. Chairman, I could speak for hours about the specific needs of the 480 veterans living on my reservation. My purpose and goal today was to enlighten you from my perspective about the organization, structural, and resource

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issues that comprise the maze of health care for veterans on the Flat Head Indian Reservation. I truly believe that the level of care that is afforded must equal the services they have rendered. I also believe that we can find solutions if we stay focused on the task and spend less time trying to point fingers. We need to utilize the tools we have and the commitment all of us have in this room share.

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

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

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

[The prepared statement of Mr. Howlett follows:]

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

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

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STATEMENT OF ANDREW JOSEPH, COUNCILMAN, CONFEDERATED TRIBES OF COLVILLE, BOARD AND EXECUTIVE COMMITTEE MEMBER, NATIONAL INDIAN HEALTH BOARD

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

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

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

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veterans, the U.S. Government has made a commitment to provide health care in honor for their military service. Therefore, our Native veterans deserve quality health care.

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

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

Other issues include lack of communication that exists between VA and IHS regarding treatment. Some Native

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veterans who access health care through both VA and IHS must manage their own care by maintaining medical records, sharing the medical diagnosis and care between VA and IHS. Without these agencies directly talking with one another, there may be increased risks, such as side effects from counteracting medications.

We have provided some recommendations in our written testimony. I would like to raise a couple here. First, a key recommendation to address the health needs of Native veterans is the need for additional funding to provide care to Native veterans. Many times, IHS is the only facility in the area to provide care for Native veterans. Supplemental funding to IHS and Tribal facilities for services provided to Native veterans would help ensure all the care needed can be provided to Native veterans.

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

Another option is to bring VA health professionals specialized in behavior and mental health treatment to Tribal communities to treat Native veterans. Many of the IHS and Tribal facilities have behavior health departments,

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but deal with veterans returning home from combat requires specialized care and treatment.

In closing, thank you for this opportunity to provide these comments and I am happy to answer any questions the committee might have. I would like to thank each of you for serving our country, also. As a Tribal leader, I know you swore an oath to protect and care for all of our people, the same as Tribal leaders do, and your time is greatly appreciated. Thank you.

[The prepared statement of Mr. Joseph follows:]

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

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

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

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

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

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

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

Senator Tester. [Presiding.] Thank you, Mr. Chairman.

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

Senator Burr. I thank the Chair.

Mr. Park, if I understand you correctly, there are three outpatient clinics in Hawaii, and 14 Community Health

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Centers and five Native Hawaiian Health Care Systems. Is that pretty accurate?

Mr. Park. There are four CBOCs.

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

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

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

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

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

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

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

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

Mr. Park. Like Hawaii, we are nonexisting.

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

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

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and all these things are things that are going to have a reflection on the capacity to provide care.

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

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

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

Mr. Howlett. That would be--yes, yes, for sure. I agree.

Senator Burr. Thank you.

One last statement, Mr. Chairman, if I may. For all the challenges we have got between VA and Indian Health,

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

I thank you.

Senator Tester. Thank you, Senator Burr.

Yes, Mr. Joseph?

Mr. Joseph. I guess I would like to answer to that question, also. In this building, in the White House, or anyplace where law is written, it is just like our treaties. They are orders that the government is supposed to abide by. I take that very serious. I believe the VA should take this work that you do here very serious. You have the ability to make the law the way that you write it and once they are given orders in the military, when you are given orders, you have to abide by those orders and somebody needs to give them orders. But I think that you have the power here to make things happen. Thank you.

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Senator Tester. Thank you.

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

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

It will work because of the trust issue. The veterans, they don't trust government, and I will give you an example. I have just been to Hana to talk with the Vietnam veterans there and I tell them, this is an insurance policy. You

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paid the premiums. It is time for you to collect. And the only way you are going to do it is you need to put in your application, VHA and VBA applications.

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

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

Senator Tester. Thank you.

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

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

Senator Tester. Right.

Mr. Howlett. If we have the capacity to meet their needs, I would want to treat them. But, you know, in

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Montana, we have two options, Fort Harrison or Spokane, depending on where you live in the State. So the answer to your question is, if they are a veteran, we have had personal relationships, although we don't have formal agreements, with both VA centers. I have visited with them both personally. They welcome the veterans. They do the best they can. But there is no formal process in place. But I would want to think that we could treat within our capacity what their needs would be if they came to our particular clinic.

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

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

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everything that we could to get them connected to a VA center. But that is where it is at this point.

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

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

Mr. Howlett. Somehow, I anticipated that question. I think, initially, you would look at a national group that would be comprised of a cross-section of people. And then I think you would, of necessity, need to dissect that a little further to deal with issues like Alaska and distance and weather and other things. But I think, initially, you would take this work group, and it would take a lot of time and a lot of energy, believe me, but to really sit down and analyze the issues affecting health care for Native American veterans, and you are going to have a lot of crosswalk between health care in general, but it just--it is just confusing to a health administrator now. You know that a

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veteran is eligible, but you don't know what an agency is going to sponsor in terms of getting them to another place.

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

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

Senator Tester. Okay. Could you just very briefly tell me, the MOU has been referred to several times, between VA and Indian Health Service. There is really no lead agency, just work together and try to find ways you can make things better. Have you seen--that MOU, I think, went into effect, when, 1996? Six years--I am a millennium off, but about six years ago. Have you seen any difference?

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

Senator Tester. Thanks. Before I turn it over to Senator Murray for questioning, I want to welcome Senator

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Murkowski. She serves on the Indian Affairs Committee. We will get to your comments as soon as we get through the first line of questions.

Senator Murray?

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

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

Senator Murray. So it doesn't apply to--

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

Senator Murray. All right. Mr. Howlett?

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

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

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

Senator Murray. Okay, excellent.

Mr. Joseph?

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

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Second, I would say that the VA could learn from IHS. IHS scored the highest out of any HHS Department on their report card. With the limited funding that we have in IHS, I believe that the VA could learn from how IHS is run. So I think that would be my second thing.

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

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

Senator Murray. Okay. I appreciate that.

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

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

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

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

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

Senator Tester. Thank you, Senator Murray.

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Senator Begich?

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

I want to follow up, if I can, on a couple of things. Mr. Howlett, your idea in your commentary to Senator Tester regarding kind of--and I think it was your words--internal-external working group, or a process that could go down the road in setting up a better relationship in a sense, do you see that--and you talked about kind of a national model and breaking it down by regions--do you see that in the process of setting up that, we actually--because I read the MOU and it is a few pages. It is great one-liners and they sound great. If we could achieve all that, the world would be fantastic. But there are no goals. There are no measurable time lines. There is nothing that you can come back and say, how did you do it, when did you do it, and who did you serve and how many did you serve?

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

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

Senator Begich. So that is how you see that?

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

Senator Begich. As you develop that, do you think there is a role for that working group? Let us assume they set a plan, an action plan. Do you see a role for that working group after the fact, in other words, kind of a reviewer and insurer, or do you see that more of a Congressional role of this committee, for example, to ensure--

Mr. Howlett. I think, Senator, that the role of that would really be dependent upon the issues that arise from that, whether there are legislative barriers or there are policy barriers or whatever, because I think that,

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obviously, if it is legislative, there needs to be some input there. But I would--I would give it enough life to, in your best estimate, to complete the job. But I don't think there is a necessity for a committee in perpetuity.

Senator Begich. Good. Okay. Thank you.

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

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

Senator Begich. Right, but not the VA?

Mr. Howlett. Right.

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

And I have always had this idea, it seems so simple

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

Mr. Park. I think it is too simple.

[Laughter.]

Senator Begich. I thought so.

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

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

Mr. Park. Yes.

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

Mr. Howlett. I, too, think it makes too much sense. No, there are significant issues with Federal agencies

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paying their bills. In Indian Health Service, there are thousands of people whose personal lives have been ruined, their credit has been ruined because IHS hasn't paid their bills on time. I mean, these people have been turned over to collection and that is just--that is the way it is. I don't know about the VA. We have not worked with them. But that needs to be worked on.

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

Senator Tester. Thank you, Senator Begich.

Senator Murkowski, did you have a statement?

OPENING STATEMENT OF SENATOR MURKOWSKI

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

And it is interesting to hear the responses to Senator Begich's comment about is it just too simple, is it just too common sense. Well, I think the obligation that we owe to our veterans is to provide for that level of care that was promised to you, and unfortunately, I think we find more and more that with the systems that we have in place, we

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effectively disenfranchise our veterans from their earned benefits through the systems and through the silos that we have in place, and I am hopeful that with the leadership that we have here in this committee, what we are attempting to do on the Indian Affairs Committee, that we ought to be able to provide for this more seamless transition within the systems.

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

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

While I was the Vice Chairman of the Indian Affairs Committee, I conducted a field hearing on the difficulties that our Alaska Native veterans were encountering in accessing their veterans health benefits, and the focus at that time was on the Alaska National Guard's Third Battalion. They come from about 81 different communities

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scattered around the State of Alaska, and a sizeable number of these Guardsmen lived in the very small bush villages. They live in communities that are not connected by roads, by any connectors that we would imagine here.

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

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

And long before that deployment date, I called the VA in and I asked them. I said, let us work with the Alaska Native Tribal Health Consortium. Let us develop this

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unified plan for caring for our Native veterans when they return. We had an opportunity to discuss it with the Secretary of Veterans Affairs, Secretary Nicholson. We continued to bring the VA together with ANTHC during that year, and in spite of all these discussions, in spite of the Memorandum of Understanding between the VA and the Indian Health Service, there was very little progress that was made in formulating that unified plan during the year.

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

So you drill below the surface here and what I learned was that there is just a very wide distrust--and I think, Mr. Park, you mentioned that as I was coming in--a very wide distrust between the VA and the Native Health System. The VA expresses their concern that it would neither be able to control access to care nor the cost of the care delivered in the Native Health facility. The VA was concerned that the Native Health System was really asking the VA to subsidize Congress's inadequate funding of IHS. And for their part, the Native Health System argued that, hey, we are only

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funded at 50 percent of the level of need. They can't afford to subsidize the better-funded VA. So you have got this impasse going on here.

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

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

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argues that, well, we don't have the authority to dover these expenses.

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

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

In spite of what limited progress that is out there, I regret to say that we are as far from building this seamless

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relationship between the VA and the IHS in Alaska that I have long been working for and Senator Begich has, as well, and the gaps aren't just affecting our Alaska Native veterans of Iraq and Afghanistan. It goes back to our Vietnam-era veterans that are living in rural Alaska.

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

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

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

We will call up the second panel, and while the second panel is coming up, I will introduce them. It is Mr. James Floyd, Network Director for the VA Heartland Network, VISN 15, for the Veterans Health Administration. He will testify on VHA's IHS for Native American veterans. He will be accompanied by Mr. Buck Richardson, Minority Veterans Program Coordinator for the Rocky Mountain Health Network

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and the Montana Health Care System, as well as Dr. James Shore, psychiatrist and Native Domain Lead, VA Salt Lake City Health Care System.

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

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

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

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

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

With me on this panel this morning, to my right, who needs no introduction to you, is Buck Richardson, who is the Minority Veterans Program Coordinator for the Rocky Mountain Health Network, based out of Helena, Montana. To his right is Dr. Jay Shore. Jay is the psychiatrist and Native Domain Leader from the VA Salt Lake City Health Care System.

VA remains committed to working with the Department of

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

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

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

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

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

Improving communication and partnerships are essential components of our collaborative efforts and we continue to nurture our relationships both nationally and locally. Our goals include improved access, communications, partnerships, sharing agreements, resources, and health promotion and disease prevention. We have found already incremental expansion of initiatives such as the Tribal Veterans

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Representative Program and expanded use of telehealth. We are also collaborating to offer more Welcome Home events for returning OIF/OEF veterans, to expand access to care and develop approaches that address the unique physical, spiritual, economic, and demographic needs of these veterans.

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

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

The VA and the Indian Health Service need to continue to work together to ensure within current legal authority that veterans who are eligible for health care from both the VA and the Indian Health Service receive all needed care. The VA and the Indian Health Service continue to discuss changing existing policies and processes in regard to

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payment for veterans' health care. A resource sharing provision was included in the MOU that I referred to earlier to encourage the development of responsible sharing services to meet the needs of patients and communities.

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

[The prepared statement of Mr. Floyd follows:]

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Senator Tester. Thank you for your testimony, Mr. Floyd.

Mr. Grinnell, if you would proceed with your testimony.

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

Mr. Grinnell. Mr. Chairman and members of the committee, good morning. I am Randy Grinnell. I am the Deputy Director for Indian Health Service. Today, I am accompanied by Dr. Terri Cullen. She is the Chief Information Officer and a family practice physician, and we are pleased to have the opportunity to testify on the collaboration of the IHS and the Veterans Health Administration.

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

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35 different States, and in many cases, they are the only source of health care in many remote and poverty-stricken areas of this country.

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

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

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

I did want to mention that our system, we currently estimate that there are about 45,000 veterans that are registered within our system, and that includes both the IHS-operated facilities as well as the Tribally-operated facilities. In some cases, these veterans also live in urban locations and may not have access to these facilities

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that are out on the reservations and within Indian Country and they have to rely on limited urban health programs as well as any local facilities that may be available for their care.

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

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

As mentioned earlier in some of the testimony, the Alaska area has partnered since 1995 via the Alaska Federal Health Care Partnership that includes not only the IHS and the Alaska Native Corporation, but the VA, Army, Air Force, and Coast Guard partners. They have numerous initiatives,

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including teleradiology as well as telehealth monitoring and telebehavioral health, as well. Some of their past projects have also included the Alaska Tribal Health System Wide Area Network.

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

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

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

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

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to continue.

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

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

[The prepared statement of Mr. Grinnell follows:]

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Senator Tester. And I thank you for that. Thank you for your testimony, and we will start the first round of questions with Senator Burr.

Senator Burr. Thank you, Mr. Chairman.

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

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

Senator Burr. I appreciate that, and let me suggest to you that it was unacceptable when it happened and I find it somewhat unbelievable that we still have systemic problems.

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I realize you have only been there a short period of time--

Mr. Floyd. Twelve months.

Senator Burr. --but I hope you will take this as a warning shot that this will be not the last time this committee looks at those systemic problems in that facility specifically and across the network.

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

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

Mr. Floyd. I might begin answering that question. First of all, about the MOU, it was purposeful vague so that we can work with individual areas, Indian communities, urban areas, and all so that we can address unique circumstances of each local community, Tribe, nonprofit organization that exists that has Native American veterans. And we have made strides in that.

If I could give you an example, when I was the Director of the VA Salt Lake City Health Care System, we worked with the Billings Area Indian Health Service and did a comparison

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of databases between the VA and the Indian Health Service to identify patients within the Indian Health Service System who were veterans who weren't enrolled within the VA. We used that and then used that as a method of outreach for patients in Wyoming, Montana, Idaho, and Utah. That helped us increase the enrollments of these individuals into the VA Health Care System. That is one example.

Senator Burr. Communication--how do you measure improvements since 2003?

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

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

Mr. Floyd. I am not sure how many existed in 2003. I can speak for the ones that at the present time exist in at least 15 of the 21 Veterans Integrated Service Networks within the VA with varying levels of agreements in place, whether that is for telehealth, traditional services, direct

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primary care, the installation of the Electronic Health Record from the VA into Indian Health Service or Tribal facilities. Those are examples of where we use specific agreements to follow up from the MOU to improve mechanisms for care.

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

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

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

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information is available.

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

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

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

The Memorandum of Understanding was meant to cover all the Native American geographical area. I think we have a tendency to focus on certain successes, certain outreaches, certain partnerships. But I hope you got the gist I did from the first panel, that this is not the overriding theme of the VA, to live up to all the standards in that agreement. I am not sure that there is an overriding commitment on the part of VA to make sure that there is incredible access to quality health care within Indian Country. I am not sure that there is a real focus within

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the VA to make sure that the communications is open to the degree that in all areas, they know exactly what is available to them. And I could sort of go down the list.

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

Mr. Floyd. Well, within the Electronic Health Records System of the VA, as a veteran enrolls in the VA Health Care System, there is a question asked of their racial designation. It is a voluntary request on their part. Those who identify Native American or Alaskan Native as their primary racial group is in our database. Yes, sir, we have that information.

Senator Burr. If they are enrolled in the VA?

Mr. Floyd. Yes, sir.

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

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

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

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

I thank all our witnesses. I thank the Chair.

Senator Tester. And I thank you, Senator Burr.

I am going to follow up on Senator Burr's questions here real quickly, on the measurement aspect. I am going to paraphrase what you said, but you basically merged medical records between the VA and IHS and found which Native Americans were out there that were veterans that weren't

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being served by the VA. Is that fairly accurate?

Mr. Floyd. Yes, sir.

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

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

Senator Tester. And how many folks did you have?

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

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

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

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

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

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

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

Mr. Floyd. Specifically with the Indian Health Service, no, I am not aware of any contracts with them.

Senator Tester. Why is that?

Mr. Floyd. Because it seems to be more appropriate for us to co-manage the patients, although--

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

Mr. Floyd. Yes, sir.

Senator Tester. So why is there a difference? I am

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just curious, because as one of the people testified in the first panel, a lot of the areas that the Native Americans live in are pretty darn remote.

Mr. Floyd. Yes, sir.

Senator Tester. And one of the things that we have talked about on this committee is when you are in remote areas, it makes more sense to deal with the veteran there than ship him a few hundred miles, or in Alaska's case, a lot further than that, to a CBOC or a hospital.

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

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

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

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

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yourself?

Mr. Floyd. Umm--

Senator Tester. No talking across the aisle.

[Laughter.]

Senator Tester. No bell curve, right.

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

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

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

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

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

Mr. Grinnell, what grade would you give us?

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

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

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

Senator Tester. Right.

Mr. Grinnell. In many cases, the agreement and the relationship is between the VA and the Tribes that now manage those programs, an example like the Alaska. All the Alaskan programs are now under 100 percent management of the Tribes up there. I believe that the opportunities that we have before us is to bring the partnership to--to bring the Tribes and the Alaskan Natives into that partnership in a more open and equal manner, and I think that that will help us move ahead.

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

Senator Tester. Okay. Thank you very much.

Senator Begich?

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

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

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way.

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

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

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

Senator Begich. Right.

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Mr. Floyd. --but a lot of patients do say, well, it is Indian Health Service. They can note Indian Health Service on there--

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

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

Senator Begich. Can you be more--I mean, can you?

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

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

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

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

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

Mr. Floyd. Between the--if I could answer that--

Senator Begich. Between both of you, yes.

Mr. Floyd. Yes. We do share our database of the projects that we are either working on individually or jointly. Those are identified, and the objective, the status of the actions, and who is responsible as the lead on

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those types of issues. And then we discuss those on conference calls.

Senator Begich. So you have some document that you keep track of this?

Mr. Floyd. Yes, sir, we do.

Senator Begich. Is that something you can share with the committee?

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

Senator Begich. Both of you? I don't know who is the right person. I am asking kind of--mine is a dual eligible question, so--

Mr. Grinnell. Yes. It is maintained through this National Committee that--

Senator Begich. Okay. So you can provide that to us to give us a sense?

In implementing that, is one of the pieces of the puzzle funding on a regular--it doesn't matter if it is VA or Indian Health Service, but on both situations, are any of the implementations of those just a funding issue versus a desire or a combination? Does that make sense, the question? In other words, do you get to an item and say, we want to do it, but there is just no money for it? And just to make sure you know, my second question will be, if the answer is yes to that, then I would say, are you asking for

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that, and is it OMB and their magical black box that kind of strips at the pieces and then you end up having to take what you get? How is that for putting you on the spot? I wanted to warn you of the second part of the question.

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

Senator Begich. Quickly--I know my time is over--

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

The other part is within Health Information Technology. We are seeing some increases in our budget there that will be targeted to move us into more of these telemedicine

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partnerships that we have with the VHA to expand our services to those veterans in those remote locations.

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

Mr. Grinnell. I would have to--

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

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

Senator Begich. Okay. No problem. Thank you.

Senator Tester. Thank you, Senator Begich.

A couple more questions, and the first one is for Mr. Richardson. Buck, you are the guy who actually executes the goals of the MOU on the ground. You go out to reservations. You deal with the veterans, the IHS, and Indian Tribal Health. How do you and other folks in the VA know what the challenges are out there and how do you share your ideas among your counterparts? How do you let them know what you are doing outside your region to influence folks?

Mr. Richardson. We do a combination of things, Senator. It is either through conference calls, letters that--or not letters, excuse me, reports I do through the VISN Director or actually takeing other VA employees out and then Dr. Shore and I do a report that we do that is monthly

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that shows what we are actually doing at each one of the reservations, that shows the activity that we are doing and how many veterans we are seeing through the different clinics. And then I have got a website for the TVRs that shows what is going on with each reservation and what is going on for the TVR, or the Tribal Veterans Representative Program so that they can see what is going on in each one of the reservations.

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

Senator Tester. Thank you.

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

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

Mr. Grinnell. Yes.

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

Mr. Floyd. Well, my own experience, if I can answer

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that--

Senator Tester. Sure.

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

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

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

Senator Tester. Okay.

Mr. Richardson. And once they find that veteran, a lot of times, there is a language barrier and they have to go through the language issue through the family of that veteran. And then once they get over that problem of the language and they get the veteran found, whichever reservation it might be, then they will get the veteran back

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in touch with me and then I will get the veteran in touch with the appropriate employee so that they can get them back into whatever facility they might need to go to.

Senator Tester. How about you, Mr. Grinnell?

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

Senator Tester. Sure.

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

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

Senator Tester. Let me restate what you just said. You are telling me that health care professionals in Indian

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Health Service can access those medical records in the VA?

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

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

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

Senator Tester. All right. Thank you.

Senator Begich, did you have any other questions?

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

Dr. Cullen. Appropriate credentials and security, yes.

Senator Begich. Security. If I can ask you a question, how many of your facilities have that, in

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percentage of total?

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

Senator Begich. What about the percentage? What would that--very small?

Dr. Cullen. Very small percentage.

Senator Begich. And is it successful?

Dr. Cullen. Yes.

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

Mr. Grinnell. Resources.

Senator Begich. Is that the issue? Have you requested that in the 2010 or 2011--

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

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

Mr. Grinnell. This--

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

[Laughter.]

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Senator Begich. Just in all fairness.

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

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

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

Mr. Grinnell. Yes, that is correct.

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

[Laughter.]

Senator Begich. It kind of kept moving down. Dr.

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Cullen moved it quickly from--

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

Senator Begich. That is fair.

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

Senator Begich. I would appreciate that.

Mr. Floyd. --question of the authority.

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

Mr. Chairman, thank you very much.

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

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

This panel we had here, and you are all great folks, I sense much less attention on what is going on on the ground. All I would say is that the question asked by grading where

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you were at, I mean, you are right, Mr. Floyd. We can always do better. But I think we need to really, really work at doing better. These are really tough issues, and sometimes it just comes down to who is paying the bill. But more than that, I think it comes down to working together and finding out ways how we can service, in this case, Native American veterans in a way that they deserve.

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

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

This meeting is adjourned.

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

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