National Indian
Health Board

Testimony of the National Indian Health Board
Joint Hearing on Legislative Presentations of Veterans Service Organizations
United States House of Representatives & United States Senate Veterans Affairs Committees
March 18, 2021

Chairman Tester, Chairman Takano, Ranking Member Moran, Ranking Member Bost, and Members of the respective Committees, thank you for holding this critical hearing to receive the legislative presentations of Veterans Service Organizations (VSOs). On behalf of the National Indian Health Board (NIHB) and the 574 federally-recognized sovereign American Indian and Alaska Native (AI/AN) Tribal Nations we serve, NIHB submits this testimony for the record.

NIHB thanks both Committees for their leadership in passing several significant bills that impact the delivery, access and coordination of healthcare for AI/AN veterans who receive care from both the Indian Health Service (IHS) and Veterans Administration (VA) including: the **Native Americans PACT Act**, the **Veterans Affairs Tribal Advisory Committee Act**, and the **PRC for Native Veterans Act.** Bringing greater parity between the VA and IHS will expand access to care for Native Veterans and encourage greater care coordination between the two federal health agencies. NIHB strongly urges the swift implementation of these new laws.

Background: Federal Obligations to AI/AN Veterans

The United States federal government has a dual obligation to AI/AN Veterans – one obligation specific to their political status as citizens of sovereign Tribal Nations, and one obligation specific to their courageous service in our Armed Forces. By current estimates, there are over 140,000 Native Veterans, with AI/ANs enlisting to serve at nearly five times the national average, and at higher rates per capita than any other ethnicity.[1] Yet despite the bravery, sacrifice, and steadfast commitment to protecting the sovereignty of Tribal Nations and the entire United States, Native Veterans continue to experience among the worst health outcomes, and among the greatest challenges in receiving quality health services, among all Americans. These enduring challenges have left Native Veterans at significantly higher risk of COVID-19 due to disparities.

In 1955, Congress established the Indian Health Service (IHS) in partial fulfillment of its constitutional obligations for health services to all AI/ANs. The IHS is charged

[1] Veterans Administration. 2017. American Indian and Alaska Native Veterans. https://www.va.gov/vetdata/docs/SpecialReports/AIAN.pdf

with a similar mission as the VHA as it relates to administering quality health services, with the exception of the following differences: (1) the federal government has Treaty and Trust obligations to provide health care for all American Indians and Alaska Natives; (2) IHS is severely and chronically underfunded in comparison to the VHA, with per capita medical expenditures within IHS at $3,779 in Fiscal Year (FY) 2018 compared to $9,574 in VHA per capita medical spending that same year[2]; and (3) unlike IHS, the VHA has been protected from government shutdowns and continuing resolutions (CRs) because Congress enacted advance appropriations for the VHA a decade ago.[3] Moreover, **while the VHA service population is only three times the size of the Indian health system, its discretionary appropriations are *approximately thirteen times* higher than for IHS.**

Similarly, Congress has not provided comparable emergency funding to IHS compared to VHA in response to the COVID-19 pandemic. For instance, the Coronavirus Aid, Relief, and Economic Security Act **(CARES) Act invested $15.85 billion into medical care at the VHA, including $3.1 billion specifically for health information technology (HIT) and telemedicine; but only $1.032 billion for IHS, of which only $65 million was allocated for HIT support.**

Health Outcomes for AI/AN Veterans

Destructive federal Indian policies and unresponsive human service systems have left Native Veterans and their communities with unresolved historical and intergenerational trauma. From 2001 to 2015, suicide rates among Native Veterans increased by 62% (50 in 2001 to 128 in 2015).[4] In FY 2014, the Office of Health Equity within VHA reported significantly higher rates of mental health disorders among Native Veterans compared to non-Hispanic White Veterans, including in rates of PTSD (20.5% vs. 11.6%), depression symptoms (18.7% vs. 15.2%), and major depressive disorder (7.9% vs. 5.8%).[5] Native Veterans are 1.9 times more likely to be uninsured than non-Hispanic White Veterans, and are significantly more likely to delay accessing care due to lack of timely appointments and transportation issues.[6] Among all Veterans, Native Veterans are more likely to have a disability,

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[2] The full FY 2022 IHS Tribal Budget Formulation Workgroup Recommendations are available at https://www.nihb.org/docs/05042020/FINAL_FY22%20IHS%20Budget%20Book.pdf

[3] 3 See 38 U.S.C. 117; P.L. 111-81

[4] VA, Veteran Suicide by Race/Ethnicity: Assessments Among All Veterans and Veterans Receiving VHA Health Services, 2001-2014 (Aug. 2017) (citing CDC statistics).

[5] Lauren Korshak, MS, RCEP, Office of Health Equity and Donna L. Washington, MD, MPH, Health Equity-QUERI National Partnered Evaluation Center, and Stephanie Birdwell, M.S.W., Office of Tribal Government Relations

[6] Johnson, P. J., Carlson, K. F., & Hearst, M. O. (2010). Healthcare disparities for American Indian veterans in the United States: a population-based study. Medical care, 48(6), 563–569. doi:10.1097/MLR.0b013e3181d5f9e1

service-connected or otherwise.[7] Native Veterans are exponentially more likely to be homeless, with some studies showing that 26% of low-income Native Veterans experienced homelessness at some point compared to 13% of all low-income Veterans.[8] There exists a paucity of Native Veteran specific health, housing, and economic resources and programs that are accessible and culturally appropriate. It is essential that the VHA work with IHS and Tribes to create more resources specifically for Native Veterans.

According to IHS, AI/ANs born today have a life expectancy that is on average 5.5 years less than the national average.[9] In states like South Dakota, however, life expectancy for AI/ANs is as much as two decades lower than for Whites. Health outcomes among AI/ANs have either remained stagnant or become prevalent as AI/AN communities continue to encounter higher rates of poverty, lower rates of healthcare coverage, and less socioeconomic mobility than the general population. According to the Centers for Disease Control and Prevention, in 2016, AI/ANs had the second highest age-adjusted mortality rate of any demographic nationwide at 800.3 deaths per 100,000 people.

In addition, AI/ANs have the highest uninsured rates (25.4%); higher rates of infant mortality (1.6 times the rate for Whites); higher rates of diabetes (7.3 times the rate for Whites); and significantly higher rates of suicide deaths (50% higher). AI/ANs also have the highest Hepatitis C mortality rates nationwide (10.8 per 100,000); and higher rates of chronic liver disease and cirrhosis deaths (2.3 times that of Whites). Further, while overall cancer rates for Whites declined from 1990 to 2009, they rose significantly for AI/ANs. For instance, from 1999 to 2015 AI/ANs encountered a 519 percent increase in drug overdose deaths – the highest rate increase of any demographic nationwide.[10] All of these health determinants of health and poor health status could be dramatically improved with adequate investment into the health, public health and health delivery systems operating in Indian Country.

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[7] U.S. Department of Veterans Affairs. (2015a). American Indian and Alaska Native Veterans: 2013 American Community Survey. Retrieved from https://www.va.gov/vetdata/docs/SpecialReports/AIANReport2015.pdf

[8] 8 US Department of Housing and Urban Development, US Department of Veterans Affairs, National Center on Homelessness Among Veterans. Veteran Homelessness: A Supplemental Report to the 2010 Annual Homeless Assessment Report to Congress. Washington, D.C.2011:56

[9] Indian Health Service. 2018. Indian Health Disparities. Retrieved from https://www.ihs.gov/newsroom/includes/themes/responsive2017/display_objects/documents/factsheets/Disparities.pdf

[10] Mack KA, Jones CM, Ballesteros MF. Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas — United States. MMWR Surveill Summ 2017;66(No. SS-19):1–12. DOI: http://dx.doi.org/10.15585/mmwr.ss6619a1

The VA's Veteran Outreach Toolkit lists AI/ANs as an "at-risk" population, citing this troubling suicide rate. Additionally, AI/ANs grapple with complex behavioral health issues at higher rates than any other population—for children of AI/AN veterans, this is compounded by the return of a parent who may suffer from post-traumatic stress disorder (PTSD). Outreach events for AI/AN communities should be a VA priority to increase wellness, decrease stigma, and prevent suicide. It is essential that the VHA continue to engage with Tribal leaders, through consultation, to assist in carrying out these activities.

Lack of VA Data on COVID-19 Cases among AI/AN Veterans

As of March 12, 2021, the VA has confirmed 237,680 cumulative COVID-19 cases and 10,993 known deaths. An interactive map on the VA website illustrates COVID-19 clusters across 140 VA facilities nationwide, with the largest cluster of cases concentrated in the Northeast stretching from Washington D.C. to Boston. Nevertheless, there are multiple positive case reports from many VA facilities in close proximity to Tribal lands and reservations, including in Arizona, Montana, Utah, eastern Washington State, South Dakota, Wyoming, and Oklahoma.

Like most healthcare systems, the VHA has transitioned to virtual care delivery via telehealth, reporting a 1,821% increase in telehealth visits since March 6, 2021 with an average of 214,998 weekly telehealth visits.[11] Yet **VHA also has yet to release any demographic-based breakdowns of use of telehealth-based care delivery, thereby yielding zero insight into any population-specific disparities in access to virtual health services**. However, COVID-19 data reporting from IHS and state health departments demonstrates that AI/ANs are, yet again, being disproportionately impacted by this public health crisis.

Substandard Care for AI/AN Veterans Before and During COVID-19 Pandemic

In a 2018 VHA Survey of Veteran Enrollees' Health and Use of Health Care, the VHA reported having 217,580 patients who self-identified as AI/AN – representing 2.5% of the agency's enrolled patient population.[12] Yet across the board, AI/AN Veterans report higher rates of issues around quality of care and accessibility that have undermined trust in the VHA system and left AI/AN Veterans significantly more vulnerable to adverse health outcomes, including for COVID-19. For instance,

[11] U.S. Department of Veterans Affairs. COVID-19 Pandemic Response Weekly Report. https://www.va.gov/health/docs/VA_COVID_Response.pdf

[12] Veterans Health Administration. 2018 Survey of Veteran Enrollees' Health and Use of Health Care. https://www.va.gov/HEALTHPOLICYPLANNING/SOE2018/2018EnrolleeDataFindingsReport_9January2019Final508Complia nt.pdf

the 2018 survey found that only 66.9% of AI/AN Veterans reported that it was easy to schedule medical appointments in a reasonable time, compared to 78.7% of White Veterans. The same report found that only 67.2% of AI/AN Veterans reported easy access to the local VA or VA-approved facility (compared to 82.7% of White Veterans); and only 65.7% of AI/AN Veterans reported short wait times after arriving for an appointment (compared to 80.6% of White Veterans). Even more alarmingly, **only 79% of AI/AN Veterans reported receiving respect from VHA employees, and only 78.2% reported that VHA employees accepted them for who they are – percentages lower than any other ethnicity.**

AI/AN Veterans also reported the least satisfaction with three out of four indicators related to their healthcare decision-making process – reporting the least satisfaction with how healthcare problems were explained to them (72.4% compared to 84% among White Veterans); their personal level of participation in decisions about their healthcare (65.7% compared to 81.8% among White Veterans); and with explanations of their options for care (65.2 percent compared to 80.5% among White Veterans). **A whopping 45.2% of AI/AN Veterans reported prior dissatisfaction with the level of VA care received – nearly double the rate for White Veterans.**

These experiences of substandard care at VHA facilities have not miraculously disappear under the current COVID-19 crisis. In fact, it is much more likely that the negative experiences reported by AI/AN Veterans are contributing to even greater challenges in receiving sufficient, patient-centered care from VHA facilities during the COVID-19 pandemic. Moreover, while race-specific data on Veteran use of telehealth services during COVID-19 is unavailable, it is, unfortunately, safe to assume that the same experiences of inferior and inadequate care persist. These issues are likely exacerbated by pervasive gaps in broadband access in Indian Country. In a 2019 Federal Communications Commission (FCC) report, **only 46.6% of housing units on Tribal lands were reported to have a fixed terrestrial provider of 25/3 Mbps broadband service – a roughly 27 point gap compared to homes on non-Tribal lands.**[13] In addition, roughly 3% of people living on Tribal lands lack mobile LTE coverage, compared to only 0.2% of the total U.S. population.[14] These sobering statistics indicate that AI/AN Veterans are, once again, experiencing higher healthcare accessibility challenges than the general Veteran population as the COVID-19 pandemic continues.

[13] Federal Communications Commission. 2019. Report on Broadband Deployment in Indian Country, Pursuant to the Repack Airwaves Yielding Better Access for Users of Modern Services Act of 2018. https://docs.fcc.gov/public/attachments/DOC357269A1.pdf
[14] U.S. Department of the Interior. 2020. Expanding Broadband in Indian Country. https://www.indianaffairs.gov/sites/bia.gov/files/assets/asia/ieed/pdf/Expanding%20Broadband%20in%20Indian%20Country%20Primer%20Final%203.17.20.pdf

COVID-19: Lack of Adequate VA and IHS Care Coordination

AI/AN Veterans are entitled to healthcare services from both the Veterans Health Administration (VHA) and the IHS. In Fiscal Year (FY) 2017, IHS reported that 48,169 active IHS users self-identified as Veterans.[15] According to the VA, more than 2,800 AI/AN Veterans are served at IHS facilities.[16] In instances where an AI/AN Veteran is eligible for a particular health care service from both the VA and IHS, the VA is the primary payer. Under section 2901(b) of the Patient Protection and Affordable Care Act (ACA), health programs operated by the IHS, Tribes and Tribal organizations, and urban Indian organizations (collectively referred to as the "I/T/U" system) are payers of last resort regardless of whether or not a specific agreement for reimbursement is in place.

Section 407(a)(2) of the Indian Health Care Improvement Act (IHCIA) reaffirms the goals of the 2003 Memorandum of Understanding (MOU) between the VHA and IHS established to improve care coordination for Native Veterans. In 2010, the VHA and IHS modernized their 2003 MOU to further improve care coordination for Native Veterans by bolstering health facility and provider resource sharing; strengthening interoperability of electronic health records (EHRs); engaging in joint credentialing and staff training to help Native Veterans better navigate IHS and VHA eligibility requirements; simplifying referral processes; and increasing coordination of specialty services such as for mental and behavioral health.

Of the twelve strategic goals of the 2010 MOU, four are directly or exclusively related to health information technology (HIT). Goal 2 is centered on improving care coordination, including through the establishment of standardized EHR mechanisms; Goal 3 is focused on improving care through the development and sharing of HIT to improve interoperability and joint development of applications and technologies; Goal 4 is specific to the development of implementation of new care technologies including and especially telehealth, tele-psychiatry, and tele-pharmacy; and Goal 6 revolves around improving availability of services through development of payment and reimbursement mechanisms, including as they relate to sharing and development of HIT. Yet in a 2019 Government Accountability Office (GAO) report on the VA-IHS MOU, **66% of VA, IHS and Tribal facilities surveyed in the report indicated significant challenges in accessing each other's HIT systems, citing lack of EHR interoperability. In fact, the same report found that none of**

[15] Government Accountability Office. GAO-19-291. Retrieved from https://www.gao.gov/assets/700/697736.pdf

[16] VA/IHS listening session held on May 15, 2019

the fifteen performance measures created under the VA-IHS MOU have established targets to measure progress.

Since implementation of the 2010 MOU, the VHA has reported entering into 114 signed agreements with Tribal Health Programs (THPs), along with 77 implementation agreements to strengthen care coordination. While a single national reimbursement agreement exists between federally-operated IHS facilities and the VHA, THPs continue to exercise their sovereignty by entering into individual agreements with the VHA. From 2014 to 2018, those reimbursement agreements with THPs alone increased by 113%.

<u>EHR Interoperability and HIT Modernization</u>

The Resource and Patient Management System (RPMS) – which is the primary health IT system used across the Indian health system – was developed in close partnership with the VHA and has become partially dependent on the VHA health IT system, known as the Veterans Information Systems and Technology Architecture (VistA). The RPMS is an early adoption of VistA for outpatient use, and the legacy system was designed with the decision to keep the same underlying code infrastructure as VistA. IHS began developing different clinical applications for their outpatient services, and the VHA adopted code from RPMS to provide this functionality for VistA. RPMS eventually began to use additional VistA code as the need for inpatient functionality increased. This type of enhancement and support for both the IHS and VHA was made possible because VistA's software components were designed as an Open Source solution. The RPMS suite is able to run on mid-range personal computer hardware platforms, while applications can operate individually or as an integrated suite with some availability to interface with commercial-off-the-shelf (COTS) software products.

Currently, the RPMS manages clinical, financial, and administrative information throughout the I/T/U, although, it is deployed at various levels across the service delivery types. However, in recent years, many Tribes and even several Urban Indian Health Programs (UIHPs) have elected to purchase their own COTS systems that provide a wider suite of services than RPMS, have stronger interoperability capabilities, and are significantly more navigable and modern systems to use. As a result, there exists a growing patchwork of EHR platforms across the Indian health system. When the VA announced its decision to replace VistA with a COTS system in 2017 (Cerner), concentrated efforts to re-evaluate the Indian Health IT system accelerated, and arose significant concerns as to how VHA and I/T/U EHR interoperability would continue. In 2018, IHS launched a Health IT Modernization Project to evaluate the current I/T/U health IT framework, and to, through Tribal

consultation, key informant interviews, and national surveys, develop a series of next steps and recommendations towards modernizing health IT in Indian Country.

Difficulties in achieving IT interoperability among VA, IHS, and THP facilities pose significant problems for Native Veterans' care coordination. Unfortunately, the VHA and IHS have yet to identify a systemic solution towards increasing EHR interoperability between I/T/U and VHA hospitals, clinics, and health stations. A resulting scenario includes situations where a THP provider – having treated a Veteran and referred them to the VHA for specialty care – would not receive the Veteran's follow-up records as quickly as if they had streamlined access to each other's systems.

Now that the VHA is transitioning to the Cerner system, it has worsened concerns around care coordination and sharing of EHRs between I/T/U and VHA systems. The fact is, Native Veterans are suffering today from the lack of health IT interoperability. **It is shameful that Native Veterans are put in a position where they have to find their own solutions to streamline EHR sharing, most shockingly exemplified by anecdotes of AI/AN Veterans hand carrying their health records between their IHS and VHA provider.**

Congress must ensure that the Indian health system is fully integrated across the development and implementation of the VHA's transition to Cerner; however, thus far it has failed to do so. By the most current estimates, the transition to Cerner will take up to 10 years to fully implement, with a current price tag of roughly $16 billion. None of the existing estimates include calculations of how much it will cost to include IHS in this transition; however, through the Tribal Budget Formulation Workgroup, Tribal Nations put forth a requirement of a $3 billion investment into HIT infrastructure in Indian Country. Ensuring EHR interoperability between I/T/U and VHA health systems will be impossible if Congress fails to establish parity in appropriations for VHA and IHS health IT modernization.

Conclusion

The federal government has a dual responsibility to AI/AN Veterans that continues to be ignored. As the only national Tribal organization dedicated exclusively to advocating for the fulfillment of the federal trust responsibility for health, NIHB is committed to ensuring the highest health status and outcomes for Native Veterans. We applaud the House VA Committee and Senate VA Committee for holding this important joint hearing, and stand ready to work with Congress in a bipartisan manner to enact legislation that strengthens the government-to-government

relationship, improves access to care for AI/AN Veterans, and raises health outcomes.