National Indian Health Board

TESTIMONY OF NATIONAL INDIAN HEALTH BOARD – WILLIAM SMITH
HEARING ON VA'S USE OF TELEHEALTH DURING THE COVID-19 PANDEMIC
COMMITTEE ON VETERANS' AFFAIRS JOINT SUBCOMMITTEE HEARING
TUESDAY JUNE 23, 2020

Chair Lee, Ranking Member Banks, and Members of the Subcommittee on Technology Modernization; and Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee on Health: 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, thank you for the opportunity to submit testimony in response to the joint subcommittee hearing on June 23, 2020 regarding the U.S. Department of Veterans Affairs use of Telehealth during the COVID-19 Pandemic Response. I submit this written testimony for the record.

Policy Recommendations

NIHB urges the House VA Committee to implement the following policy recommendations to improve healthcare quality and accessibility for AI/AN Veterans.

1. **Pass the bipartisan H.R. 4908 – Native American PACT Act**
   - The federal government's Treaty obligations for healthcare for all AI/ANs encompasses every federal agency, including the Veterans Health Administration (VHA). While AI/ANs are not charged for healthcare services received from IHS or through the Medicaid program, AI/AN Veterans are charged copays by the VHA- a practice that is inappropriate and requires reform. As such, it is imperative that Congress enact legislation that requires the VHA to similarly exempt AI/AN Veterans from copays and deductibles in the VA system in recognition of federal obligations for healthcare that exist in perpetuity.
     - Importantly, copay costs should not be shifted to IHS or Tribes. The VHA must absorb these costs on behalf of AI/AN Veterans in recognition of their Trust and Treaty obligations to AI/AN Peoples.
2. **Ensure parity in legislation and funding between the VHA and IHS, especially for health information technology (HIT) modernization and Telehealth infrastructure**
   - Previously enacted legislation, including the VA MISSION Act, have largely failed to include provisions that meaningfully further the goal of establishing parity in HIT modernization efforts between IHS and VHA facilities. Similarly, there continues to be a vast and inequitable gulf between congressional HIT appropriations for VHA and IHS, with VHA appropriations over thirteen times higher than IHS in FY 2020.
     - Without dedicated and equitable funding into HIT and telehealth infrastructure development across both VA and IHS, quality, continuity and accessibility of care for thousands of AI/AN Veterans will remain deficient and health outcomes will remain poorer.
3. **Pass the bipartisan H.R. 2791 – Department of Veterans Affairs Tribal Advisory Committee Act of 2019**
   - Tribal Nations and NIHB have also strongly advocated for the seating of a Tribal Advisory Committee (TAC) within the Office of the Secretary at the VA.
   - Establishing a Veteran TAC is essential for strengthening the government-to-government relationship between Tribes and the VA, and towards improving VA accountability to AI/AN Veteran health needs.

- Through the seating of a TAC, top VA officials would have the ability to hear directly from Tribal leaders about the unique health priorities and challenges that impact Native Veterans, including around telehealth. In addition, the TAC would create the opportunity to co-develop policy with the VA and that would help prevent the development of new rules or policies that would adversely affect the care for Native Veterans

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 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**.

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

As of June 19, 2020, the VA has confirmed 1,880 active COVID-19 cases and 1,498 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. **To date, however, the VA**

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

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

has yet to release breakdowns of COVID-19 case rates by race or ethnicity, yielding zero insight into population-specific disparities in COVID-19 health outcomes. Like most healthcare systems, the VHA has transitioned to virtual care delivery via telehealth, reporting a 1,065% increase in telehealth visits since March 1, 2020 with an average of 127,498 weekly telehealth visits.[4] 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.

COVID-19 Impact on AI/AN Population

As of June 17, 2020, the Indian Health Service (IHS) reported 16,199 positive cases of COVID-19, with the overwhelming majority of positive cases reported out of the Phoenix and Navajo IHS Areas. However, IHS numbers are highly likely to be underrepresented because case reporting by Tribal health programs, which constitute roughly two-thirds of the Indian health system, is voluntary. According to data analysis by APM Research Lab, **AI/Ns are experiencing the second highest aggregated COVID-19 death rate at 36 deaths per 100,000**.[5] The Centers for Disease Control and Prevention (CDC) reported on June 6, 2020 that **age-adjusted COVID-19 hospitalization rates among AI/ANs are higher than any other ethnicity, at 194 per 100,000**.[6] Reporting by state health departments has further highlighted disparities among AI/ANs.

- In New Mexico, AI/ANs represent roughly 8% of the population, yet account for over 53% percent of all COVID-19 cases.[7]
- As of this writing, the Oyate Health Center in South Dakota has conducted 544 COVID-19 tests, with 114 confirmed positive case results (20.9%). Of those 114 cases, 13 were reported between June 10 and June 16.[8]
- In Wyoming, AI/ANs account for over 30% of all COVID-19 cases statewide despite representing only 2.9% of the state population.[9]
- Similarly in Montana, where AI/ANs constitute about 6.6% of the state population, over 13% of confirmed COVID-19 cases are among AI/ANs.[10]
- In Oregon as of June 17, 2020 AI/ANs are experiencing the second highest case rates by race at 26.3 cases per 10,000 compared to 7.1 per 10,000 for Whites.[11]

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

[5] APM Research Lab. The Color of Coronavirus: COVID-19 Deaths by Race and Ethnicity in the U.S. https://www.apmresearchlab.org/covid/deaths-by-race

[6] Centers for Disease Control and Prevention. COVID-19 Data Visualization. https://www.cdc.gov/coronavirus/2019-ncov/covid-data/data-visualization.htm

[7] New Mexico Department of Health. COVID-19 in New Mexico. https://cvprovider.nmhealth.org/public-dashboard.html

[8] Great Plains Tribal Chairman's Health Board. CEO Update: Oyate Health Center To Host Mass Testing, New Website Launches. https://gptchb.org/news/ceo-update-oyate-health-center-to-host-mass-testing-new-website-launches/

[9] Wyoming Department of Health. COVID-19 Map and Statistics. https://health.wyo.gov/publichealth/infectious-disease-epidemiology-unit/disease/novel-coronavirus/covid-19-map-and-statistics/

[10] Montana Department of Public Health and Human Services. https://dphhs.mt.gov/publichealth/cdepi/diseases/coronavirusmt/demographics

[11] Oregon Health Authority. COVID=19 Weekly Report (Published June 17, 2020) https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/DISEASESAZ/Emerging%20Respitory%20Infections/COVID-19-Weekly-Report-2020-06-17-FINAL.pdf

Most poignantly, in a new data visualization of COVID-19 case rates per 100,000 by Tribal Nation created by the American Indian Studies Center at the University of California Los Angeles, **it was found that if Tribes were states, the top five infection rates nationwide would all be Tribal Nations**.[12]

The COVID-19 pandemic has further exposed the vast deficiencies in health care access, quality, and availability that exists across the Indian health system. Prior to COVID-19, the Indian health system was beset by an average 25% clinician vacancy rate[13], and a hospital system that remains over four times older than the national hospital system.[14] Limited intensive care unit (ICU) capacity to address a surge of COVID cases across many IHS and Tribal facilities has strained limited Purchased/Referred Care (PRC) dollars, creating further challenges that are contributing to rationing of critical health care services. Overall, per capita spending within IHS ($3,779) is at only 40% of national health spending ($9,409), making IHS the most chronically underfunded federal health care entity nationwide and thus severely ill-equipped to respond to COVID-19.

For example, while CDC has noted that hand-washing is the number one way of protecting against a COVID-19 infection, water and sanitation infrastructure in Indian Country is significantly underdeveloped. Approximately 6% of AI/AN households lack access to running water, compared to less than half of one percent of White households nationwide.[15] In Alaska, the Department of Environmental Conservation reports that over 3,300 rural Alaskan homes across 30 predominately Alaskan Native Villages lack running water, forcing use of "honey buckets" that are disposed in environmentally hazardous sewage lagoons.

Because of the sordid history of mineral mining on Navajo lands, groundwater on or near the Navajo reservation has been shown to have dangerously high levels of arsenic and uranium. As a result, roughly 30% of Navajo homes lack access to a municipal water supply, making the cost of water for Navajo households *roughly 71 times higher* than the cost of water in urban areas with municipal water access.[16] In fact, in a new peer-reviewed study of 287 Tribal reservations and homelands, COVID-19 cases were found to be 10.83 times more likely in homes without indoor plumbing.[17]

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

[12] University of California Los Angeles. American Indian Studies Center. Coronavirus in Indian Country: Latest Case Counts. Retrieved from https://www.aisc.ucla.edu/progression_charts.aspx
[13] Government Accountability Office (GAO-18-580). https://www.gao.gov/products/GAO-18-580
[14] Indian Health Service. 2016. IHS and Tribal Health Care Facilities' Needs Assessment Report to Congress. https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/RepCong_2016/IHSRTC_on_FacilitiesNeedsAssessmentReport.pdf
[15] US Water Alliance. 2019. Closing the Water Access Gap in the United States. Retrieved from http://uswateralliance.org/sites/uswateralliance.org/files/Closing%20the%20Water%20Access%20Gap%20in%20the%20United%20States_DIGITAL.pdf
[16] Ingram, J. C., Jones, L., Credo, J., & Rock, T. (2020). Uranium and arsenic unregulated water issues on Navajo lands. *Journal of vacuum science & technology. A, Vacuum, surfaces, and films : an official journal of the American Vacuum Society*, *38*(3), 031003. https://doi.org/10.1116/1.5142283
[17] Rodriguez-Lonebear, Desi PhD; Barceló, Nicolás E. MD; Akee, Randall PhD; Carroll, Stephanie Russo DrPH, MPH American Indian Reservations and COVID-19, Journal of Public Health Management and Practice: July/August 2020 - Volume 26 - Issue 4 - p 371-377 doi: 10.1097/PHH.0000000000001206

having 217,580 patients who self-identified as AI/AN – representing 2.5% of the agency's enrolled patient population.[18] 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, 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**.[19] 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.[20] 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.

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-

[18] Veterans Health Administration. 2018 Survey of Veteran Enrollees' Health and Use of Health Care. https://www.va.gov/HEALTHPOLICYPLANNING/SOE2018/2018EnrolleeDataFindingsReport_9January2019Final508Compliant.pdf

[19] 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/DOC-357269A1.pdf

[20] U.S. Department of the Interior. 2020. Expanding Broadband in Indian Country. https://www.indianaffairs.gov/sites/bia.gov/files/assets/as-ia/ieed/pdf/Expanding%20Broadband%20in%20Indian%20Country%20Primer%20Final%203.17.20.pdf

identified as Veterans.[21] According to the VA, more than 2,800 AI/AN Veterans are served at IHS facilities.[22] 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 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%. **Unfortunately, the VHA has largely failed during the COVID-19 pandemic to act on these existing partnerships and MOUs with IHS and Tribal programs to deliver resources, improve care coordination, and increase access to telehealth based delivery systems. According to the VHA COVID website, Navajo Nation is the only recipient of technical and personnel assistance, receiving a handful of respiratory therapists and nurses. The VHA also reported delivering 100 masks to AI/AN Veterans on the Cheyenne and Standing Rock lands. That is it. There is no further information on VHA efforts to act on its MOUs with IHS and Tribal Nations**.

[21] Government Accountability Office. GAO-19-291. Retrieved from https://www.gao.gov/assets/700/697736.pdf
[22] VA/IHS listening session held on May 15, 2019

NIHB has identified additional COVID-specific care coordination challenges based on conversations with AI/AN Veterans and Tribal leaders. These are listed below.

- VA has not committed any additional funding towards outreach to AI/AN Veterans to prevent gaps in access to care as VHA facilities curtail services or shutdown in response to the pandemic
- VA has failed to commit resources to assist AI/AN Veterans with rescheduling cancelled appointments
- VA's Native American Direct Loans for housing have purportedly been put on hold during the pandemic, creating even further disparities in care access for homeless AI/AN Veterans
- For AI/AN Veterans that have been able to utilize telehealth, many have anecdotally reported frequent connection issues including frequent dropped calls especially in areas with poor broadband access. In areas with many fluent Native language speakers, access to care is further encumbered by lack of culturally and linguistically appropriate virtual care.

EHR Interoperability and HIT Modernization

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.

Tribes and NIHB were pleased to see that the FY 2020 President's Budget included a request for a new $20 million line item in the IHS budget to assist with health IT modernization, and that this request was included in the House-passed FY 2020 Interior Appropriations package. But in comparison, the FY 2020 House Military Construction Appropriations bill budgeted $1.6 billion to assist VHA in its transition. 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 Subcommittee for Health and Subcommittee for Technology Modernization for holding this important hearing, and stand ready to work with Congress in a bipartisan manner to enact legislation that strengthens the government-government relationship, improves access to care for AI/AN Veterans, and raises health outcomes.