NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

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Submitted via email: tribalgovernmentconsultation@va.gov

June 10, 2019

The Honorable Robert Wilkie
Secretary
U.S. Department of Veterans Affairs
VACO/OTGR
810 Vermont Avenue, NW
Suite 915a
Washington, DC 20420
ATTN: Clay Ward

RE: VA MISSION Act Strategic Plan - Native American Veteran Healthcare Needs

Dear Secretary Wilkie:

On behalf of the Northwest Portland Area Indian Health Board (NPAIHB), I submit the following comments on the healthcare needs of Native American veterans for the Department of Veterans Affairs (VA) Maintaining Internal Systems and Strengthening Integrated Outside Networks of 2019 (MISSION Act) Strategic Plan, in response to the VA Dear Tribal Leader Letter (DTLL), dated April 16, 2019.

Established in 1972, the NPAIHB is a non-profit, Tribal organization under the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638, representing the 43 federally-recognized Indian Tribes in Idaho, Oregon, and Washington on healthcare issues. In the Portland Area, 75% of the total IHS funding is compacted or contracted and includes 6 federally operated service units, 16 Title I Tribes, 26 Title V Tribes, 3 urban facilities, and 3 treatment centers. NPAIHB operates a variety of important health programs on behalf of our member tribes, including the Northwest Tribal Epidemiology Center,[1] and works closely with the IHS Portland Area Office. Our mission is to eliminate health disparities and improve the quality of life of American Indians and Alaska Natives by supporting Northwest Tribes in their delivery of culturally appropriate, high quality healthcare.

[1] A "tribal organization" is recognized under the Indian Self-Determination Education Assistance Act (P.L. 93-638; 25 U.S.C. § 450b(1)) as follows: "[T]he recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities."

Thank you for the opportunity to provide recommendations to address the healthcare needs of American Indian/Alaska Native (AI/AN) veterans within the VA MISSION Act Strategic Plan.

BACKGROUND

AI/AN veterans have played a vital role in the United States military for over two hundred years in all of the Nation's wars since the Revolutionary War. In fact, AI/AN veterans have served in several wars before they were even recognized as American citizens. AI/AN veterans have distinctive cultural values that drive them to serve their country. AI/ANs serve in the U.S. Armed Forces at higher rates per capita, are younger as a cohort and have a higher concentration of female servicemembers compared to all other servicemembers, yet they are underrepresented among veterans who access the services and benefits they have earned. The U.S. Census Bureau's 2018 American Community Survey (ACS) identified 6,795,785 veterans as AI/AN.[2] In Fiscal Year (FY) 2017, the United States Census Bureau counted for 11,028 AI/AN veterans in the Northwest out of 146,596 AI/AN veterans nationally (not including two or more races). In FY 2017, there were 1,356 AI/AN veterans in Idaho, 2,740 AI/AN veterans in Oregon, and AI/AN veterans 5,937 AI/AN veterans in Washington.[3]

There are also no Indian Health Service (IHS) or tribal hospitals in the Portland Area. When hospital care and specialized services are not available at these sites, health services are purchased from public and private providers through the IHS-funded Purchased and Referred Care (PRC) program. PRC funds are very limited and get exhausted often before the fiscal year is over. For this reason, Portland Area tribes are PRC dependent. The PRC program is one of the most important health programs for tribes and tribal clinics in the Portland Area as it allows AI/ANs to access critical specialty care services.

Tribal Consultation

The United States has consistently acknowledged the government-to-government relationship with tribes and its special trust responsibility to provide healthcare services to AI/ANs. This unique responsibility and relationship with AI/ANs and tribal governments is the direct result of treaties between the United States and Indian tribes, and has been reaffirmed by judicial decisions, executive orders, memoranda, and Acts of Congress. The issues impacting our AI/AN veterans must be elevated as a priority for the VA.

In 2011, the VA established a tribal consultation policy in order to "enhance the relationship of cooperation, coordination, open communication, good will; to work in good faith to amicably and fairly resolve issues/differences; and to continue to pursue mutually agreeable objectives successful."[4] To comply with this order, it is essential that policy and technical decisions are made with comprehensive knowledge from tribes to the VA of the impact on access to VA benefits and healthcare for AI/AN veterans. Tribal consultation is an evolving process and must include an

[2] American Indian and Alaska Native Veterans: 2018 U.S. Census Bureau, October 2018.
[3] United States Census Bureau American Fact Finder, 2017 American Community Survey.
[4] Department of Veterans Affairs Tribal Consultation Policy (2011).

ongoing strategy between the VA and tribal nations. There is much more work to be done to align the policies, programs, and systems for billing for VA services in order to ensure that AI/AN veterans have access to culturally competent benefits they are entitled to receive. Section 106(b) of the VA Maintaining Internal System and Strengthening Integrated Outside Networks (MISSION) Act includes a requirement for consultation with tribal governments.[5] NPAIHB urges the VA to conduct tribal consultation throughout the development and implementation of the MISSION Act Strategic Plan to comprehensively address AI/AN veteran healthcare needs and to ensure that tribal recommendations are comprehensively included.

MISSION Act

On June 6, 2018, President Donald Trump signed the VA MISSION Act legislation. Congress passed the VA Mission Act in large part to implement a new community care system for veterans (replacing the Veterans' Choice Program), extend the VA network of facilities, and coordinate care with the network of local providers. The purpose of the MISSION Act is to make dramatic improvements and enhance healthcare options for veterans outside of VA facilities. The MISSION Act improves VA infrastructure with expanded authorities, such as to provide telehealth services across state borders. The program also authorizes the VA to cover urgent care within 72 hours of such care being provided as long as the veteran seeking care is enrolled in VA healthcare and has received VA care within the last 24 months.

The MISSION Act will not impact the tribal reimbursement agreements, and language is included in the statute seeking to preserve existing agreements. The VA reimbursement agreements have provided a positive impact on the availability of healthcare for veterans in tribal communities, and the need for those agreements must continue into the future. The VA has increased the number of tribal reimbursement agreements and thus AI/AN veterans served between 2014 and 2018. The number of tribal reimbursement agreements during the period rose from 53 to 113 and an additional 42 are pending. However, only 19 out of the 43 federally-recognized tribes in the Northwest currently have reimbursement agreements with the VA.

Tribes and tribal organizations are still seeing issues with respect to veterans' specific health needs in their communities. The network of community care providers being established by the VA in the tribal community could have potential impacts on the availability of care for AI/AN veterans and could affect the tribal programs themselves. NPAIHB requests clarification from VA on coordination of specialty care among tribal providers, the VA facilities, and the VA's new network of providers being established under the MISSION Act. Additionally, we request that VA conduct regional tribal consultation through the Veterans Integrated Service Network (VISN) 20 and outreach with its tribal partners beyond asking for comments from tribes on these four limited questions.

[5] Section 106. Strategy Regarding The Department of Veterans Affairs High-Performing Integrated Health Care Networks, VA MISSION ACT, Public Law No.115-182.

1. **What are the most important healthcare needs of Veterans in your area now and in the future?**

Factors, such as, residing in remote rural communities, poverty, mental health conditions, historical mistrust and a limited number of culturally competent healthcare providers create barriers to care that lead to AI/AN veterans experiencing greater health disparities compared to other veterans. In addition, regulatory barriers further exacerbate AI/ANs ability to access care. Restrictions on specialty care, assessment of co-pays, duplicative processes, overly-burdensome administrative requirements and lack of coordination of care delay access to care and have caused irreparable harm to veterans.

Access to Care

Lack of access to care at VA hospitals is a main need of every veteran. Veterans have to wait months before getting an appointment and hours after checking in for less than quality care. NPAIHB urges the VA to include the need to increase the number of AI/AN veterans who access VA programs, and the need to increase benefits and services to better serve our warriors who have given so much to our Nation.

Referrals

Lack of ability for a veteran to be referred to an outside provider without being sent back to the VA for authorization, each and every time, compounded by the referral process that can take months. Veterans are forced to maneuver through a complex healthcare system and an elaborate administrative process usually requiring multiple referrals in order to address their healthcare needs. For tribes it is a barrier to constantly refer patients back and forth to the VA because it is time consuming and, ultimately delays services. The current referral process is overly-burdensome and is counterproductive to providing timely and efficient access to care for AI/AN veterans.

Culturally-Based Approaches

Barriers to treating AI/AN veterans include distance, poverty, mental health symptoms, historical mistrust, limited number of AI/AN providers at the VA, and the sole focus on evidence-based practices. The VA should provide increased support and inclusion within the continuum of care for innovative culturally-based approaches to treatment and care. The VA has recognized the value of sweats to Native service members, and since the 1990s, has allowed sweats to be conducted as several VA medical centers across the country. Traditional health practices in the Northwest at VA facilities has consistently proved to be of significant importance to recover from the trauma of combat and transition to civilian life. For example, the Native American Veterans Healing Center at the Spokane VA Medical Center have been described as life-saving by a U.S. Army veteran from Spokane, who was diagnosed with Post Traumatic Stress Disorder (PTSD) and who underwent standard psychotherapy and medication treatment- which he said did more harm than good.[6]

[6] Cecily Hilleary. VOA News. Veterans with PTSD Find Relief in Native American Rituals, March 22, 2018.

Purchased and Referred Care (PRC) Reimbursement

Veterans often require additional services that are not available at IHS or tribal healthcare facilities. In many instances eligible veterans are also eligible for PRC services. The PRC program authorizes IHS and tribal healthcare facilities to purchase services from a network of private providers. IHS and tribal healthcare facilities are the payors of last resort[7], which require that all other sources of obtaining health services must be exhausted prior to receiving care through the PRC program. These services may include primary or specialty care that is not available at an IHS and/or tribal healthcare facility. Many tribes utilize provider networks to ensure veteran's healthcare needs are being met.

The VA, however, does not reimburse IHS or tribal healthcare facilities for specialty care but instead insists that the veteran return to the VA health system for a VA referral for care. While some services may be directly available and provided under the current reimbursement agreements and reimbursed by the VA; in most cases, specialty care is not reimbursed by the VA and IHS and tribal healthcare facilities are purchasing this care with limited PRC funding. We request that reimbursement agreements allow for reimbursement of specialty care.

The current management of care is inefficient, a waste of resources and fails to prioritize the healthcare needs of AI/AN veterans. Further, non-reimbursement of specialty care services does not align with the VA's mission and creates additional barriers for AI/AN veterans in need of care. Rather than creating additional obstacles, we need to ensure and improve access to all types of care for AI/AN veterans.

Care Coordination

Continuity of care is a colossal need within the VA's healthcare system. The lack of ability for VA healthcare records to be exchanged with IHS/tribal and community providers makes care management inefficient for veterans receiving care from numerous providers. It is difficult for IHS/tribal healthcare providers to access VA or another health information system's information when necessary.

Mental Health Treatment

The VA is responsible for treating a large population of veterans diagnosed with mental health conditions and the number of veterans who are in need of treatment has increased. The VA does not currently provide timely access to mental health care including access to long-term treatment for more serious mental health conditions and war-related post-deployment mental health challenges. NPAIHB recommends the need for VA to provide timely access for veterans seeking primary mental healthcare and specialized readjustment services, emphasizing early intervention and routine screen for all post-deployed veterans.

NPAIHB urges Congress and the VA to ensure ample resources are available for mental health programs, including peer specialist services and not only evidence-based treatments but also tribal-based practices. Mental health treatment for all veterans, regardless of disability eligibility must be

[7] 25 U.S.C. § 1623. Special rules relating to Indians; and 42 CFR § 136.61 Payor of last resort.

a priority. Tribal veterans, no matter the eligibility rating should be eligible to receive trauma-related services.

On March 5, 2019, President Trump issued an Executive Order on a National Roadmap to Empower Veterans and End Suicide.[8] The purpose of the VA Task Force to develop a strategy to bring providers together to address the consistently high veteran suicide rate. The federal government is seeking partners from state, local, territorial, and tribal governments as well as private and non-profit entities. We need to have tribes involved with this task force, because they will be providing funding through states and local grants. Tribes should not be forced to go through the states in order to receive funding for preventing veteran suicide.

2. **If you were to redesign the VA healthcare system, what are the five most important changes, if any, you would like to suggest? This could include patient care, customer service, and billing and payment to name a few.**

Access to Care

Veterans should be able to be referred out from VA care after which the provider has been referred to should decide to refer them elsewhere, the veteran should not be forced to physically return to the VA for authorization. AI/AN veteran eligibility must be a priority by improving partnerships and addressing the needs of IHS/tribal healthcare providers. There must be improvements in outreach and partnership with tribal clinics on how to identify veterans eligible for VA services. When you have an AI/AN veteran in a rural/tribal community they want to visit a healthcare facility where they will receive quality culturally responsive care and where they will not have to spend time and money. The VA system can be a barrier to this process. Further, NPAIHB recommends that VA prioritize patient care by illness or injury, including dental for all veterans.

Referrals

NPAIHB recommends the need for VA to partner with tribal healthcare facilities and streamline policies and guidance on how to refer patients to improve the continuum of care for AI/AN veterans. Facilities have reported conflicting information about the process for referring AI/AN veterans from IHS or tribal facilities to VA. There is a need for the VA to develop a policy or guidance for the VA, IHS, and tribes to share a common understanding of the options available for referrals and how to make a referral for a veteran to receive specialty care. NPAIHB recommends the need for improvements in identification of AI/AN veterans, and make them eligible and trustful of the VA to receive culturally competent and comprehensive healthcare services.

Reimbursement for Purchased Referred Care (PRC)

NPAIHB urges the VA to reimburse IHS and Tribes for purchased and referred care (PRC). Native veterans often require additional services that are not available at IHS or by THPs. Many tribes utilize provider networks to ensure veteran's healthcare needs are being met.

[8] Executive Order on a National Roadmap to Empower Veterans and End Suicide, March 5, 2019.

The PRC program authorizes IHS or THPs to purchase services from a network of private providers. These services may include primary or specialty care that is not available at an IHS and/or THP. This is already authorized in 25 U.S. Code § 1645 and it has not been fully implemented. Reimbursement for specialty care through PRC is essential to ensure that native veterans receive the best care possible. We need to ensure and improve access to all types of quality care for AI/AN veterans, including PRC in the national and tribal MOU and allowing for reimbursement for these referrals is essential.

Care Coordination

The VA MISSION Act is designed to expand veterans access to healthcare through a new integrated community care program and the VA will remain the primary provider of care and be responsible for managing the networks and coordinating care. VA must complete market area assessments and develop strategic plans to provide care to enrolled veterans in each market. NPAIHB recommends emphasis in the MISSION Act Strategic Plan on continuity of care and metrics to ensure highest quality of culturally responsive care for all veterans.

The VA and Department of Defense (DOD) must improve care coordination for service members transitioning from the military to VA. Our veterans need better transitions into civilian life for soldiers leaving the service. Peer-to-peer support services for our veterans are important because of the rapport involved with having served in the military. For example, the Heroes Café, run by Verdant Health Commission in Lynwood, WA, has been successful for veterans to stop by, meet other veterans, and possibly get recommendations or assistance in applying for VA services. The VA must ensure coordination of mental health services and specialized services for the aftermath of wartime trauma and military sexual assault. The VA must ensure that veterans have access to medications from providers near their home. Further, the VA needs to support providers who offer care to our veterans by providing a streamlined process for IHS/tribal clinics to become in-network providers without an administrative burden.

IHS/tribes and the VA must all be able to share AI/AN veteran healthcare information on a health information exchange (HIE). With the VA transition from Vista to the Cerner Electronic Health Record (EHR) system, we are unsure of potential barriers to exchanging patient health information with the new Cerner system. Spokane and Seattle have been identified as pilot sites for the 2020 phase-in, yet tribes have not been nationally or regionally consulted or involved in discussions between IHS and VA. Tribes in the Northwest utilize the Resource Patient Management System (RPMS) as well as various off-the shelf EHR systems. NPAIHB requests a consultation in the Portland Area for the Cerner transition and efforts to improve the continuum of care for patients through the exchange of health information.

Mental Health Treatment

The VA must develop a number of targeted initiatives, programs, and services along with IHS/tribes to prevent veteran suicide. NPAIHB recommends the inclusion of mental health treatment for all veterans regardless of the rating of disability as a priority healthcare need connected to trauma. We also urge the VA and Administration to include Native veteran mental healthcare issues on the President's Veteran Wellness, Empowerment, and Suicide Prevention Task Force and partner with tribes to prevent veteran suicide.

NPAIHB urges that the VA and VA clinics partner with IHS/tribes to improve mental healthcare for veterans for their spiritual and mental health in addition to physical health. The VA must ensure inclusion of traditional healing practices to ensure holistic care of AI/AN veterans. These services must be included in the continuum of care for AI/AN veterans and should be utilized as an innovative veteran healthcare model. The VA must recognize AI/AN veterans' contributions to the U.S. armed forces with the understanding that warriors cannot be healed physically until they are also healed spiritually. Care at tribal facilities is based on tradition, prevention and holistic care for the entire person. Tribes build their healthcare programs differently by treating our patients with traditional practices and community-based support at the center of care. For example, ceremonial sweat lodges in the Northwest attached to VA facilities have provided veterans of all backgrounds with a community-based meditative healing experience for veterans looking to improve relationships, cope with nightmares, cut back on prescription medications and destructive habits.

3. **What are the top three to five recommendations you would make to help VA improve how it provides care to Native American Veterans who use VA healthcare?**

   a) Improve AI/AN veteran eligibility for VA services by improving partnerships and addressing needs of tribal healthcare providers. There needs to be improvements in how the VA identifies veteran eligibility for services, make them eligible and trustful of the VA to receive culturally competent and comprehensive healthcare services.

   b) The VA must partner with IHS/tribal healthcare facilities and streamline policies and guidance on how to refer patients to improve the continuum of care for AI/AN veterans. Facilities have reported conflicting information about the process for referring AI/AN veterans from IHS or tribal facilities to VA. There is a need for the VA to develop a policy or guidance for the VA and IHS/tribes to share a common understanding of the options available for referrals and how to go about making a referral for a veteran to receive specialty care.

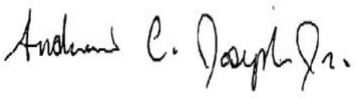
   c) NPAIHB urges the VA to reimburse IHS and tribal health facilities for purchased and referred care (PRC). AI/AN veterans often require additional services that are not available at IHS or tribal health facilities.

   d) The VA and VA clinics must partner with tribes to improve mental healthcare and encourage culturally responsive care for veterans for their spiritual and mental health in addition to physical health. For example, inclusion of traditional healing practices such as sweat lodges. VA must provide timely access for wartime veterans seeking primary mental health care and specialized readjustment services, emphasizing early intervention and routine screening for all post-deployed veterans as a critical building block to an effective suicide prevention effort.

CONCLUSION

We appreciate the Department of Veterans Affairs' commitment to the important goals of improving the lives of our Native veterans. NPAIHB and Northwest tribes look forward to working with the VA to ensure that our recommendations and priorities are taken into account of the MISSION Act Strategic Plan. If you have questions or would like more information about our recommendations discussed above, please contact Sarah Sullivan, Health Policy Analyst (503) 228-4185 or by email to ssullivan@npaihb.org.

Sincerely,



Andy C. Joseph, Jr.
NPAIHB Chairperson
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Cc: Stephanie Birdwell, Director, VA Office of Tribal Government Relations
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