Table of Contents

U.S. DEPARTMENT OF VETERANS AFFAIRS ADVISORY COMMITTEE ON TRIBAL AND INDIAN AFFAIRS MEETING #5

February 27–29, 2024

The U.S. Department of Veterans Affairs (VA) Advisory Committee on Tribal and Indian Affairs (the committee) convened for its fifth meeting on February 27–29, 2024. The meeting occurred in person at Choctaw Nation headquarters in Durant, OK. In accordance with the provisions of Public Law 92-463, the meeting sessions were open for the public to attend. This document summarizes the presentations and discussions that took place during the 3-day meeting.

Committee Members in Attendance

The table below lists the committee members and indicates which days each member attended.

Member		Day 1	Day 2	Day 3
Chairwoman Sonya M. Tetnowski		✓	✓	✓
Ricky Alex		✓	✓	✓
Adam Archuleta				
Jack Austin, Jr.		✓		✓
Bobbie Baldwin		✓	✓	✓
Dean Dauphinais		✓	✓	✓
Reyn Kaupiko				
Nickolaus Lewis				
Kevin Meeks		✓	✓	✓
Chauncey Parker		✓	✓	✓
DeLisa Ramon		✓	✓	✓
Ivan Sam		✓	✓	✓
William Smith		✓	✓	✓
Frank Star Comes Out				
Eugene "Geno" Talas		✓	✓	✓

Table 1. Committee Member Attendance

Day 1

Tuesday, February 27, 2024

Opening

Peter Vicaire, the committee's designated federal officer (DFO), called the meeting to order.

The Choctaw Nation Color Guard then posted the colors. Next, Jesse Pacheco offered an opening prayer, followed by an opening song from Scott Wesley.

Choctaw Nation Assistant Chief Jack Austin, Jr., welcomed the meeting participants on behalf of the Choctaw Nation.

Next, Mr. Vicaire conducted roll call. He announced that a quorum was present.

Welcoming Remarks

Zaneta Adams, VA Deputy Assistant Secretary for Intergovernmental Affairs, greeted the participants and provided brief opening remarks. She expressed appreciation for the recommendations the committee has put forward thus far and eagerness to hear more input from them about how VA can foster better relationships with tribal nations and Native American Veterans. Deputy Assistant Secretary Adams highlighted several VA programs and actions specifically designed to serve Native American Veterans, including copayment exemptions and the Native American Direct Loan (NADL) Program. She asked the committee to consider how VA offices or programs that do not have a specific tribal focus can better serve Native American Veterans. Currently, VA is engaging in strategic planning regarding how to best work with tribes, as well as examining ways to improve communication with tribes, increase telehealth options, and bolster housing assistance for Native American Veterans.

Sony M. Tetnowski, Chairwoman of the VA Advisory Committee on Tribal and Indian Affairs, greeted the participants and thanked the Choctaw Nation for hosting the meeting.

VA Advisory Committee Management

Jeffrey Moragne, Director for the VA Advisory Committee Management Office, delivered a presentation regarding the management of this committee as a federal advisory committee (FAC).

The VA Advisory Committee on Tribal and Indian Affairs was formed under the Federal Advisory Committee Act (FACA). This legislation, which was signed into law in October 1972, promotes transparency and accountability in the operation of FACs.

FACA applies to this committee whenever it convenes as a full committee or when a subcommittee of the parent committee convenes. FACA requirements include a committee to have:

- A signed and filed charter
- The presence of a DFO at all committee and subcommittee meetings
- Meetings that are open to the public, with the agenda announced within the Federal Register 15 days prior and with the opportunity for the public to provide comments during the meeting
- Balanced committee membership
- Records that are consistently maintained and available for public review

There are three types of meetings in which an FAC may engage:

- Open
- Closed
- Partially closed

Only committee members and the DFO would participate in closed meetings. A meeting may be closed in the event of certain circumstances, such as the discussion of classified information or proprietary data or the sharing of personal testimony by constituents. The VA Office of General Counsel (OGC) must concur on the meeting's closure in advance. For a closed meeting, the closure and accompanying justification must be noted within the agenda.

For any committee meeting to occur, a quorum (50% of the committee's membership plus one additional member) must be present, a DFO must be in attendance, and there must be an approved agenda publicized at least 15 days prior. When a quorum is present, the committee may decide on recommendations. If a quorum is not present, the members in attendance must proceed as an ad hoc subcommittee, with the meeting being a working meeting during which decisions regarding recommendations cannot be made.

There are two instances in which an FAC may meet privately, without opening the meeting to the public.

- When two or more committee members meet to engage in preparatory work, such as gathering or analyzing data, conducting research, or drafting documents
- When two or more committee members convene to discuss administrative matters of the committee, such as agenda development or travel arrangements

During private meetings, committee members are not permitted to discuss recommendations, as such discussions must occur publicly.

If asked to testify in front of Congress, committee members are permitted to do so in a personal capacity. However, they are prohibited from doing so on behalf of VA or the committee.

Director Moragne listed the following best practices for VA federal advisory committees.

- Plan 18 months of committee meetings in advance during the next meeting or administrative call.
- Become familiar with the committee charter and the VA Committee Members Handbook and review these documents regularly.
- Formally establish subcommittees in accordance with VA guidance to conduct research and help draft recommendations.
- Allocate meeting time to discuss how individual presentations tie into the committee's recommendations.
- Use subcommittees to engage and collaborate with other FACs.
- Employ the SMART goal template, ensuring that recommendations are specific, measurable, achievable, relevant, and time-bound.
- Use VA Library Services to gather data and information.
- Recommend subject matter experts who can present to the committee.
- Conduct annual field visits in conjunction with committee meetings that occur in the field, in addition to annual meetings in Washington, DC.
- Ask the DFO for guidance regarding any FACA-related questions.

OTGR Updates

VA Office of Tribal Government Relations (OTGR) Acting Director Clay Ward greeted the attendees and then presented updates on behalf of OTGR. He began by providing background on the committee's establishment and summarizing its activities to date.

The committee was established to provide advice and guidance to the U.S. Secretary of Veterans Affairs on all issues pertaining to Native American Veterans. The committee charter was filed on April 23, 2021. In October 2021, VA appointed 15 inaugural members to the committee. Approximately half of these

members had shorter terms to enable staggered committee member terms moving forward. VA recently brought in six new committee members to replace the members whose terms expired. Previously, Acting Director Ward served as the committee's original DFO. Mr. Vicaire later took over as the DFO.

The newly added committee members include:

- **Ricky Alex,** Division Director, Mississippi Band of Choctaw Indians Veterans Service
- **Bobbie Baldwin,** Executive Director, Navajo Nation Veterans Administration
- **Dean Dauphinais,** Owner/Operator, Native Eco Solutions All Star Vets
- **DeLisa Ramon,** Legislative Council Representative, Tohono O'odham Nation
- **Ivan Sam,** Native American Cultural Ambassador, Veterans Art Project
- **Frank Star Comes Out,** President, Oglala Sioux Tribe

The committee has convened twice per year since its inception, meeting once per year in Washington, DC, and once per year in a location hosted by a tribe or VA regional office. The first committee meeting occurred in January 2022, and it took place virtually due to the ongoing COVID-19 pandemic. The second meeting, which followed a hybrid format, took place in Albuquerque, NM, in August 2022. In November 2022, the committee met in Washington, DC, and they convened for a fourth meeting in Oregon during April 2023. The present meeting marks the committee's fifth meeting.

To date, the committee has presented 13 recommendations to VA leadership. Secretary of Veterans Affairs Denis McDonough reviewed and approved all 13 recommendations. During this meeting, VA personnel will update the committee on progress made toward fulfilling these recommendations.

Following these remarks from Acting Director Ward, the committee members introduced themselves.

Welcoming Remarks from the Local VA Health Care System

Rolanda Webb, Associate Director for the Eastern Oklahoma VA Health Care System, provided brief opening remarks. She shared that the system operates a 61-bed hospital in Muskogee, OK, and five outpatient clinics throughout the eastern portion of the state. Currently, they are partnering with the Cherokee Nation to open a clinic on Cherokee lands. The facility will open in April 2024 and begin seeing patients in May 2024. In addition, the system will open a 58-bed hospital in downtown Tulsa, OK, in January 2026, in partnership with Oklahoma State University.

VA Office of Tribal Health Updates

Dr. Christie Prairie Chicken, Director for the VA Office of Tribal Health (OTH), thanked the participants for attending and the Choctaw Nation for hosting the meeting. She then introduced Kyle Iron Lightning as the new outreach coordinator for OTH. Next, she provided updates from OTH regarding the copayment exemption, cultural awareness training, and traditional healing approaches.

Copayment Exemption Implementation

VA recently implemented a copayment exemption for Native American Veterans. They are working to enroll as many Native American Veterans as possible in this benefit. As of February 17, 2024, VA had approved 4,820 applications for enrollment in the exemption. At this point in time, there were six additional applications on hold, and an additional 706 had been denied. As of February 5, 2024, VA had exempted or reimbursed 159,206 copayments under this new benefit, which collectively totaled $2,834,973.60 in exempted and reimbursed copayments.

Currently, OTH national outreach managers are preparing to meet with tribes and individual Veterans to encourage enrollment in the copayment exemption benefit. OTH welcomes the committee's input on additional avenues for encouraging Veterans to enroll in the benefit.

Application submissions for this benefit began in April 2023 and peaked in July 2023, with 1,312 submissions that month. VA plans to conduct an outreach campaign in April 2024 that commemorates the 1-year anniversary of this benefit's implementation. VA is tracking data on the states of residence among Veterans who have applied for copayment exemption, and they will use this data to continue strategizing outreach. Of the Veterans who are enrolled, the highest number live in Oklahoma, followed by California and then Arizona.

Geno Talas asked what will change within the billing system once a Veteran enrolls in the copayment exemption benefit. Dr. Prairie Chicken responded that for a Veteran enrolled in the benefit, there is a code added to the billing system that automatically cancels any billing for copayment that would have occurred prior to this benefit being available.

A committee member inquired about the reasons for the denial of 706 applications for copayment exemption and whether VA is tracking data on reasons for denial. Dr. Prairie Chicken confirmed that VA tracks this data. She said that the most common reasons for denial include incomplete or unreadable application information, as well as applicant affiliation with Canadian First Nations. At present, this benefit is only available for Veterans affiliated with federally or state-recognized tribes within the United States.

Chief Bill Smith remarked that because most Alaska Natives are shareholders of Alaska Native Corporations, they may not realize that they are, in fact, citizens of federally recognized tribes. Further, the rolls for the Alaska Native Corporations closed in 1971, meaning that anyone born after this year is classified as a descendant, rather than a shareholder.

Chief Smith also asked about the number of cases for which VA has requested a corrected credit report for Native American Veterans who were sent to collections due to unpaid copayments. Dr. Prairie Chicken said that no one has yet contacted her to report this issue. She asked the committee to have anyone who raises this issue contact her office.

Cultural Awareness Training

OTH is strengthening cultural awareness training for VA personnel via several avenues, as follows.

- Every VA medical center employs VA Minority Veteran Program coordinators. These coordinators provide cultural training to VA staff who work with Native American Veterans.
- Clinical contact center employees receive culturally aware nurse training that focuses on how personnel can better connect with Native American Veterans.
- VA, the Indian Health Service (IHS), and the Substance Abuse and Mental Health Services Administration (SAMHSA) have partnered to facilitate an upcoming 2.5-day strategic planning event in August 2024. In partnership with tribes and tribal organizations, the agencies plan to pilot a new model under which they will develop culturally centered approaches for suicide prevention among Veterans, their families, and active-duty service members.

Traditional Healing

To promote the incorporation of traditional healing practices, such as sweat lodges and talking circles, into federal programs and services, the White House Council on Native American Affairs will hold a 3-day, multi-agency traditional medicine summit later in 2024 (date to be determined). The event will highlight successful models of integrated health care, including traditional healing practices in prevention, intervention, and treatment. The summit will also feature information on the preservation of Indigenous knowledge through increased access to and application of traditional ways of healing.

Dr. Prairie Chicken acknowledged that while sharing information about local traditional healing practices is often considered taboo, providing this information is essential for establishing basic diagnostic and billing codes, which are in turn essential for including traditional healing in VA's benefits.

New Congressional Charter: National American Indian Veterans

Robert Dunsmore, Tribal Veterans Service Officer (TVSO), Cheyenne River Sioux Tribe, provided a brief overview of the newly chartered National American Indian Veterans (NAIV) organization.

In December 2023, Congress granted a charter for the NAIV as part of the passage of the National Defense Authorization Act for Fiscal Year (FY) 2024.

The NAIV serves the needs and interests of Native American Veterans, and now that it is chartered, Native Americans will not need to pay membership dues to other chartered organizations. This development will strengthen the voices of Native American Veterans. The NAIV charter will be officially organized in April 2024.

Chauncey Parker noted that in combination with other programs, such as the TVSO program, this new charter will present additional opportunities for Native American Veterans to raise awareness of their needs and challenges.

VHA-IHS MOU Operational Plan Update

Dr. Peter Kaboli, Executive Director, VA Office of Rural Health (ORH), provided an update on the Veterans Health Administration (VHA)-IHS memorandum of understanding (MOU) operational plan. To start, he provided a brief overview of ORH.

The strategic goals and associated objectives of ORH are as follows.

- Promote federal and community care solutions for rural Veterans.
    - Unite relationships within VA and the federal government to exchange rural-centered information.
    - Collaborate with non-governmental organizations that support rural Veterans' health and well-being.
    - Expand ORH's partnership and programming reach.
- Reduce rural health care workforce disparities.
    - Expand understanding of the current health care workforce.
    - Support rural implications of the MISSION Act.

- Enrich rural Veteran health research and innovation.
    - Increase rural Veteran health research.
    - Innovate new models of care for Veterans who live in rural communities.
    - Build recognition of VA's rural research, innovations, and outcomes.

ORH outlines four broad categories of rural health challenges, as follows.

- Workforce
- Geography
- Digital divide
- Social determinants of health

Among the 18.2 million Veterans in the United States, approximately 8.3 million (46%) are enrolled in VA benefits. This proportion of enrolled Veterans is higher among rural Veterans, with approximately 61% of those who live in rural areas being enrolled with VA. As this data reflects, rural Veterans rely disproportionately on VA given their limited options for health care.

As of the end of FY 2023, approximately 45% of Native American Veterans across the United States were enrolled in VA benefits.

Dr. Kaboli went on to share updates regarding the VHA-IHS MOU and operational plan, as follows.

The purpose of the VHA-IHS MOU, which was first passed in 2003 and subsequently revised in 2010 and 2020, is to do the following.

- Establish a framework for coordination and partnership to leverage and share resources in support of each agency's mutual goals.
- Set forth an agreement between two federal agencies committed to collaboration, tribal consultation, and urban confer consistent with policies, statutes, regulations, and executive orders.
- Ensure that both agencies achieve greater accountability and success in service to Native American Veterans and serve more effectively as stewards of public resources.

The mutual goals of the MOU are as follows.

- **Access:** Increase access to and improve the quality of health care and services through performance monitoring.
- **Patients:** Facilitate enrollment and seamless navigation across health care systems through improved care coordination and expansion of training programs.
- **Information technology:** Facilitate the integration of electronic medical records and health information technology by monitoring the development and interoperability of VA, IHS, tribal, and urban Indian health organization systems.
- **Resource sharing:** Share technology, providers, training, human resources, services, facilities, communication, and reimbursement through collaboration among services and providers, new reimbursement options, expanded telehealth, and collective learning options.

The operational plan, which is about 15 pages long, discusses specific mechanisms and examples for working together to attain the above-listed mutual goals.

As outlined within the operational plan, VA and IHS will do the following in support of attaining the mutual goals.

- Use metrics to monitor the achievement of objectives by various programs, such as the Rural Native Veteran Health Care Navigator Program and the Highly Rural Transportation Grant Program.
- Evaluate options to expand reimbursable services, including the expansion of the current VHA-IHS reimbursement agreement to include direct health care services.
- Develop and expand resources and learning options.

VA and IHS decided to reorganize the VHA-IHS MOU Workgroup structure that was initially proposed through the operational plan. Originally, the workgroup was conceptualized as an executive committee with six sub-workgroups (patient care, information technology, access, data and metrics, learning and development, and external communications), plus ad hoc sub-workgroups as needed. Under the new structure, the sub-workgroups were consolidated into four teams. The learning and development and external communications groups were combined into a single team entitled Veteran Outreach and Engagement. The patient care and access groups were combined into a team that will focus on access. Similarly, a new data and information technology team comprises the previous data and metrics and information technology groups. Finally, the agencies added a fourth team centered around resource sharing.

Successes under the VHA-IHS MOU since its inception include the following.

- VA has reimbursed $154 million to IHS and tribal health providers for care administered to more than 16,000 Native American Veterans.
- Approximately 8.6 million mail-out pharmacy prescriptions have been processed for VHA-IHS patients.
- In FY 2023, the Highly Rural Transportation Grant Program served 58 tribal communities in Alaska, California, Montana, New Mexico, North Dakota, Oregon, South Dakota, and Washington.
- VA Video Connect has improved mental health care access for rural Native American Veterans.
- 114 Veterans have received housing placements through the tribal U.S. Department of Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH) Program.
- The agencies have engaged in numerous tribal consultations and urban confer sessions, as well as participating in 43 training sessions with tribes.

The next steps for the VHA-IHS MOU operational plan are as follows.

- Each fiscal year, VA and IHS will jointly review, revise, and update the operational plan.
- The agencies will continue to gather feedback on the operational plan each year. Upcoming feedback sessions for this year include a virtual tribal consultation/urban confer session on March 21, 2024, and a joint in-person tribal consultation/urban confer event on April 15, 2024, in conjunction with the Tribal Self-Governance Conference in Chandler, AZ.
- Oversight and execution of the operational plan will transition from ORH to OTH.

Deputy Assistant Secretary Adams noted that VA is partnering with the U.S. Department of Defense (DoD) so that Veterans may seek care from DoD facilities. As of March 5, 2024, eligible Veterans who were exposed to toxins during their military service, as outlined in Section 103 of the PACT Act, can

enroll directly into VA health care without applying. This opportunity will provide another channel for Veterans to access health care.

Chairwoman Tetnowski asked about the meeting frequency of the VHA-IHS MOU Workgroup's executive committee. Dr. Kaboli responded that the executive committee convenes approximately every 2 months. Their next meeting is scheduled for March 5, 2024.

Behavioral Health/Suicide Prevention

Cicely Burrows-McElwain, Director, Technical Assistance Resource Center, Community-Based Interventions for Suicide Prevention, VA Office of Mental Health and Suicide Prevention (OMHSP), began this presentation by briefly discussing planned outreach efforts to gather tribal input on a new suicide prevention model.

Most of VA's suicide prevention work occurs in partnership with SAMHSA. OMHSP has begun to embrace a public health approach to prevention that emphasizes community-based efforts to promote the mental health of Veterans and their families. OMHSP has focused on engaging all 50 states and the five U.S. territories but recognizes the need to engage tribes, as well. For this reason, they plan to contact tribes to discuss how to improve prevention efforts, beginning with a series of six listening sessions. They also plan to hold a meeting at the end of August 2024 during which they will create an outline for a new prevention model based on tribal input. They will invite this committee and the SAMHSA tribal advisory committee to participate in the meeting.

Dr. John McCarthy, Director, Data and Surveillance, Suicide Prevention, OMHSP, then presented data from the two most recent National Veteran Suicide Prevention Annual Reports and information on how this data is collected, as previously requested by the committee. He also provided an update on the committee recommendation that pertains to suicide prevention, VA's response to the recommendation, subsequent findings, and next steps.

VA studies on suicide among VHA patients show that suicide risks vary by race, and the rural/urban distribution of VHA patients also varies by race. According to the 2022 National Veteran Suicide Prevention Annual Report, among Veterans who use VHA, suicide rates are elevated for those who live in rural areas compared to those in urban areas. Differences in suicide risk among VHA patients according to their rurality status may be due in part to demographic differences. Between 2016 and 2020, the suicide rate among Native American Veterans in rural areas was 14.6% lower compared to those in urban areas. The data shows a similar trend for Black Veterans, but for all other racial groups, suicide rates were higher in rural areas during this timeframe.

VA recently issued the 2023 National Veteran Suicide Prevention Annual Report. This report includes data from 2001 to 2021. Per this report, age- and sex-adjusted suicide rates are higher among Veterans compared to non-Veteran adults in the United States. Among Veterans, suicide rates are elevated within those who seek VHA care. This statistic is likely due to VHA patients having increased suicide risk factors, including greater severity of illness, compared to those who do not seek VHA care. In 2021, the highest Veteran suicide rate was among Native American Veterans, with 46.3 per 100,000 Native American Veterans dying by suicide. This rate marks a 51.8% increase in the unadjusted suicide rate among Native American Veterans from 2020 to 2021. Due to the small size of this population, the rate often varies widely from year to year. Within the general U.S. adult population, the unadjusted suicide rates are also

highest among Native Americans. Among recent Veteran VHA users, suicide rates were elevated for residents of rural areas, compared with those who lived in urban areas.

Recommendation 3A from the committee called for VA to provide information on its efforts to collect data regarding (1) Veteran suicides that occur on tribal lands and (2) American Indian and Alaska Native Veteran suicides that occur in urban areas. The recommendation noted that how VA defines rural versus urban areas is unclear. It asked that VA begin collecting the requested data by October 2023 and publish an initial report by October 2024, subsequently publishing the results annually in October.

VA's response to this recommendation is concurrence in principle. They support the goals of this recommendation and request the opportunity to discuss avenues for enhancing available data sources to broaden accurate reporting on suicides among Native American Veterans. However, there are some challenges to doing so.

In response to the committee's question about how VA determines rural status, Dr. McCarthy shared that rural versus urban status is determined based on comparing the Veteran's zip code of residence to the U.S. Department of Agriculture's Rural Urban Commuting Area Codes.

Pertaining to the request for data on Native American Veteran suicides that occur in urban areas, Dr. McCarthy said that VA annual reporting on Veteran suicide rates by race includes information specific to Native American Veterans. Ongoing work to enhance VA suicide reporting includes reviews regarding available data sources, which enables enhancements to this annual report. It is also worth noting that while from 2005 to 2017, suicide rates where elevated among rural Native American VHA users, from 2018 to 2021 the rates were elevated among urban Native American Veterans.

Dr. McCarthy noted a key challenge in response to the request for data on suicides that occur on tribal lands. Veteran suicide deaths are identified through joint VA/DoD searches of the Centers for Disease Control and Prevention National Death Index (NDI), which compiles death certificate data from each state. The NDI does not provide additional specificity regarding the location of death beyond the state where it occurred. VA needs the committee's assistance in determining how to identify Veteran suicides that occur on tribal lands. One possible approach is to take into account the Veteran's zip code of residence. VA has also contacted the IHS Office of Public Health Support for assistance with this issue. VA could also seek input from the Bureau of Indian Affairs to explore geographic files regarding the land areas of federally recognized tribes and determine whether zip code population centroids fall within those tribal lands.

In response to the recommended timeline for gathering data and issuing an initial report, Dr. McCarthy said that OTGR and OTH will provide an action plan by the end of the second quarter of FY 2024 that outlines how they will move forward with addressing the recommendation.

Chief Smith urged the removal of the four-walls requirement for the reimbursement of prevention services. This way, traditional healing practices such as sweat lodges would become reimbursable. He added that many homeless Veterans do not use homeless shelters because they have mental health or substance use conditions.

Ivan Sam noted that elders and traditional healers used to honor warriors and help them heal from war-time trauma by performing a ceremony with the warriors before they returned home. Without such practices, the trauma that service members often witness typically returns home with them, following

them to their homes and families. It is important to continue using holistic approaches to return balance to Veterans' lives and promote their mental wellness. Mr. Sam thanked VA for providing the requested data and follow-up information.

Jack Austin, Jr., echoed the critical importance of removing the four-walls requirement. He shared that many Veterans will not come to a brick-and-mortar facility but would instead allow a mental health care provider to come to their home and, for example, sit with them on the front porch.

Mr. Talas thanked VA for providing the requested data and follow-up information. He added that all tribes have their own approaches to cultural healing. He asked if data on deaths by suicide among active-duty service members aligns with suicide rates for Veterans.

Director Burrows-McElwain said that DoD tracks this data for active-duty service members and offered to connect the committee with DoD to discuss this issue. Dr. McCarthy said that in general, the data reflects that suicide rates increase after separation from the military.

Mr. Talas asked if the 2023 National Veteran Suicide Prevention Annual Report contains data that is broken down by era of service. Dr. McCarthy responded that there is a breakdown by age but not by service era. He acknowledged the need for VA to further explore this data.

Chairwoman Tetnowski asked if VA worked with any tribal or urban Indian epidemiology centers to gather the data presented. She suggested that if VA has not done so already, they should partner with these organizations, who can help capture some of this key data on Native American Veterans. Dr. McCarthy said that they did not work with tribal epidemiology centers as part of this process. He asked the committee to send him an email with more information about these organizations.

Chairwoman Tetnowski thanked VA for the progress they have made thus far on the committee's recommendation.

Pilot Program on Graduate Medical Education and Residency

Dr. Kanta Velamuri, Acting Director, Medical and Dental Education Section, VHA Office of Academic Affiliations, presented information about the MISSION Act Section 403 Pilot Program on Graduate Medical Education and Residency (PPGMER).

Resident medical education starts after graduation from medical school and can last from 3 to 7 years, with sub-specialty training requiring an additional 1 to 3 years.

Graduate medical education (GME) training programs are administered by the sponsoring institution. The Accreditation Council for Graduate Medical Education (ACGME) accredits GME training programs and sets the requirements for institutional and program accreditation. Most GME funding comes from federal sources, including Medicare, Medicaid, VA, DoD, and the Health Resources and Services Administration.

For GME that takes place in VA medical facilities, the VA facilities establish affiliation agreements with ACGME and the sponsoring institutions, provide faculty supervision and learning environments, and reimburse the sponsoring institutions for resident rotations at VA. The VHA Office of Academic Affiliations provides oversight of health profession trainee education at VA medical centers.

Under the current VA funding mechanism for GME, the local VA facility reimburses the GME sponsor, which hires and pays the residents who rotate to the VA facility. The Office of Academic Affiliations provides funding to reimburse the VA facility.

Section 403 of the MISSION Act of 2018 authorizes VA to establish a pilot program to place 100 or more resident physicians at covered facilities and to reimburse the associated costs. This initiative ends on August 7, 2031.

Currently, VA is at the request for proposals (RFP) stage of the pilot program. As part of the rule making process for PPGMER, VA engaged in tribal consultation on the proposed rule and issued a Dear Tribal Leader Letter during the public comment period. The final rule was publicized on November 13, 2023.

The final rule defines covered facilities as those operated by a tribe, a tribal organization, IHS, or DoD. Selection criteria for covered facilities include the following.

- There is a need for providers in areas surrounding the facility.
- The Secretary of Veterans Affairs has designated the local community served by the facility as being underserved.
- The facility operates in a health professional shortage area.
- The facility's location is rural or remote.

Among covered facilities, the PPGMER will prioritize applications from facilities that are:

- Operated by IHS
- Operated by a tribe or tribal organization
- Located in communities designated as underserved by the Secretary of Veterans Affairs

The PPGMER final rule created two new authorities, which are (1) reimbursement for a resident's time spent delivering care to non-Veterans in non-VA facilities and (2) reimbursement of start-up costs for new residency programs at non-VA facilities. In line with these two new authorities, VA will roll out two new RFPs for PPGMER pilot models A and B.

Pilot model A will deal with resident rotations at non-VA facilities. Under Model A, the covered facility and sponsored institution will collaborate to jointly apply for the RFP. The GME sponsor will hire and pay the residents who rotate to the covered facility, and VA will reimburse the GME sponsor for the salaries and benefits of these residents.

Under Pilot model B, the covered facility will sponsor a new GME program, and VA will reimburse the facility/sponsor for new program start-up costs as well as the salaries and benefits of the residents. To constitute a new residency program, the new GME program must have initial ACGME accreditation or continued ACGME accreditation without outcomes, and the program must have not yet graduated an inaugural class.

Some of the start-up costs that are eligible for reimbursement under model B include curriculum development, faculty recruitment and retention, accreditation fees, faculty salary, and resident education expenses.

For model A, the RFP will be issued in the summer of 2024, with applications due in the fall of 2024. VA will make award decisions in December 2024. Resident rotations will begin in July 2025. If fewer than

100 resident positions are filled, VA will do a second RFP for model A. This potential second RFP would be issued in July 2025.

For model B, stakeholder communications and planning will take place throughout 2024. In July 2025, VA will publish an RFP for model B.

Reporting requirements for the PPGMER will mandate the awardees to report the following data.

- Number of Veterans receiving care from residents
- Number of resident positions at each covered facility
- Number of clinical appointments for Veterans
- Medical specialties pursued by residents
- Resident time
- Program costs
- Number of residents hired by VA

Mr. Talas asked at what point the graduate students are contacted about participation in the program.

Dr. Velamuri responded that the facility where the students will complete their residencies and the GME sponsor would contact the residents. Having residents complete their GME at IHS, tribal, and rural or remote facilities is intended to create a pathway for the residents to work at these facilities once their training is complete.

Chairwoman Tetnowski noted that since few tribes have their own residency programs, this pilot program will offer a great opportunity for residents to become familiar with tribal communities and increase their cultural competency.

Day 2

Wednesday, February 28, 2024

Opening

Chairwoman Tetnowski called the meeting to order. Mr. Vicaire conducted roll call. A quorum was present.

Native American Direct Loan

Heather Sborz, Chief of Loan Policy, provided an overview of the Native American Direct Loan Program.

The VA Loan Guaranty Service has a team of Native American loan coordinators to administer the NADL Program. They recently created an assistant director position to oversee NADL. This new position has been filled by Jason Latona. Assistant Director Latona greeted the meeting participants, and then Ms. Sborz continued her presentation.

The NADL Program is a home loan program established in 1992. Through the NADL Program, VA provides direct loans for the purchase, construction, or improvement of homes for eligible Native American Veterans (or Veterans married to Native American non-Veterans) who live on trust lands. Veterans can also refinance existing Native American Direct Loans through the NADL Program.

Typically, private lenders will not issue home loans on trust lands because tribes are sovereign nations and because on trust lands, state laws do not govern real estate transactions and obtaining a security interest is difficult. The NADL Program helps fill the gaps in home loan options on trust lands. It is intended to mirror the no-down-payment loan guaranty benefit that would otherwise be available to eligible Veterans through a third-party lender.

For a Veteran to be eligible for the NADL Program, they must have sufficient entitlement through length and character of service. In addition, their tribe must have an MOU with VA, the home must be located on trust or allotted land, and the Veteran or their spouse must be a citizen of the tribe.

To date, 112 MOUs are in place between VA and federally recognized tribes regarding the NADL Program. The most recent MOU was signed in October 2023 by VA and the Confederated Tribes of Siletz Indians.

Veterans who close their NADLs on or after March 13, 2023, will automatically receive an interest rate of 2.5% for the duration of the loan. Veterans who currently have a NADL with an interest rate of 3.5% or higher can refinance to take advantage of the 2.5% rate. This interest rate is effective for 24 months and is slated to expire in 2025; however, VA is seeking to extend this interest rate for longer if possible. VA is tracking data to determine whether and how the affordability of this low interest rate impacts use of the program.

To date, there are 530 active loans in the NADL portfolio. The program has emphasized outreach as well as tracking and following up on applications. Unsuccessful applications are usually due to incomplete information or unsatisfactory credit. Often, the team coaches these applicants to help them become qualified for a loan. From the beginning of FY 2022 to present, the program has held 121 outreach events, received 257 NADL applications, and closed on 83 loans.

Native American Veterans may use either NADL or VA-guaranteed loans. Both loan options typically require no down payment, and both programs offer exemption from the funding fee if a Veteran receives a service-connected disability compensation. Key differences between the two programs include the following.

- For NADL, VA processes the loan, while for a VA-guaranteed loan, the VA-approved lender processes the loan.
- VA sets the NADL interest rate but negotiates this rate with the lender for VA-guaranteed loans.
- Closing costs are always low for NADL but vary for VA-guaranteed loans, as they are negotiated with the lender.
- VA originates loans through NADL, while the lender originates VA-guaranteed loans.

Practices to promote the future success of the NADL Program include:

- Improved communication and opportunities for tribes and Veterans to provide feedback
- Partnerships with other VA entities
- Continued expansion of outreach
- Program use in Alaska
- Ongoing review of and updates to NADL guidance

VA has been providing technical support for the NADL Improvement Act, which proposes to improve the NADL Program by providing additional flexibility through removing the MOU requirement, providing an avenue for Veterans with non-NADL loans to refinance through the NADL Program, allowing for a cash-out refinance product for Veterans to use to improve their homes, and establishing a Native community development financial institution re-lending program for trust lands. VA is on record as fully supporting the bill, subject to program appropriations.

Previously, the committee recommended that VA subsidize the cost of construction or the loan itself. However, VA does not have discretionary authorization for the resources required to carry out the feasibility study needed for such funding. VA will continue to work with the committee on this recommendation and any others that may arise.

Chief Smith raised the issue of how land is held in Alaska. Tribes in Alaska have corporation land rather than trust land. The requirement that Veterans live on "trust land" has been an ongoing barrier to the program's use in Alaska. Chief Smith acknowledged that VA is working to resolve this issue but noted that he would like to know more about any hurdles they are encountering in the process. He added that there is some trust land in Alaska, but this land is tied to individuals rather than to a tribe.

Ms. Sborz confirmed that VA is working to determine how to resolve this challenge. She said she would like to meet with Chief Smith to further discuss the issue.

A committee member asked if Veterans can purchase modular homes through NADL, and Ms. Sborz confirmed that they can.

The committee member also asked for examples of allowable home improvements under NADL. Ms. Sborz responded that any improvements to protect or enhance the livability of the home are allowable. Such improvements could range from roof repairs to adding a room to the home.

Dean Dauphinais inquired about the most common hurdles that VA encounters when trying to establish MOUs with tribes for the NADL Program.

Ms. Sborz said that the process is usually much faster for tribes that have established lease agreements that meet VA requirements and a sufficient lending or foreclosure housing ordinance in place. When tribes do not have these ordinances in place, the MOU process takes longer.

Mr. Dauphinais asked if a Native American Veteran can use NADL if they live on the lands of a different tribe from the tribe with which they are enrolled. Ms. Sborz said she will look into this issue and follow up with a response.

Mr. Dauphinais asked if there is home ownership readiness training available for Veterans. Ms. Sborz responded that currently, the NADL team provides informal education that focuses primarily on borrower preparedness. VA is working to add homeowner education programs.

Chairwoman Tetnowski asked if VA encounters any hesitance from tribes to negotiate an MOU due to concerns about waiving sovereign immunity. Ms. Sborz indicated that she will run this question past the legal team and follow up with a response.

Veronica Duncan, Tribal Government Relations Specialist, VA OTGR, said she will send Chairwoman Tetnowski's email address to Ms. Sborz so that Ms. Sborz can obtain this question in writing.

DeLisa Ramon shared that the Tohono O'odham Nation is currently working through the NADL MOU process and is developing a foreclosure ordinance. The tribe's housing authority handles all housing on Tohono O'odham lands. She asked what happens in the case of a default when a Veteran's tribe has the NADL MOU and all required ordinances in place—does VA or the tribe determine who owns the property next?

Ms. Sborz said she will find out more about this issue and follow up with the committee. There is a mechanism within the NADL MOUs for dispositioning property that goes into default.

Homelessness Programs

Anne Dunn, Deputy Director, Health Care for Homeless Veterans Program, VHA Homeless Programs Office, presented an overview of homeless Veteran stand down events.

VA is working to ensure a "no wrong door" approach, meaning that VA services meet Veterans where they are, rather than the other way around.

The Health Care for Homeless Veterans Program employs outreach workers, peer support specialists, and nurses. This program supports stand down events, operates HUD-VASH and a transitional housing program, and staffs each VA medical center with employment specialists who assist Veterans in finding jobs. In addition, they oversee the Veterans Justice Program, through which justice specialists visit jails and prisons to engage with Veterans and reentry specialists aid incarcerated Veterans in reintegrating with society after incarceration. Recently, the program also began a legal specialist program. Finally, they administer the Supportive Services for Veteran Families Grant, under which grantees provide services to Veterans at risk of experiencing homelessness.

Stand downs are events designed to support Veterans who are homeless or at risk of homelessness. These events are named after a term used in times of war when bringing the front-line troops out of the battlefield and providing a time for them to safely rest. These events offer brief respite and opportunities for Veterans to connect with VA and community providers. VA does not run these events directly but does partner with communities to help plan and organize them.

Stand down events serve as effective outreach platforms through which VA staff connect with Veterans experiencing homelessness and present them with a wide range of services and housing supports. Typically, these events last from 1 to 3 days. Services offered may include food, shelter, clothing, health screenings, dental services, legal services, and VA benefits counseling. Additionally, these events provide a forum for VA to refer Veterans to other services offered by community-based providers, such as permanent housing and medical care.

VA typically provides specific purpose funding to VA medical centers participating in stand down events to help support their operations costs. Funding guidance for stand down events is typically issued to VA medical centers each spring. Currently, VA is modifying this guidance to include instructions for VA medical centers to reach out to tribal and urban Indian organization partners.

During FY 2023, there were 240 stand down events across the United States, 15 of which took place on tribal lands. Collectively, these events served 44,603 Veterans.

The Health Care for Homeless Veterans Program has set a goal of working with OTGR and OTH to build cultural components into stand down events and ensure overall cultural appropriateness of the events.

Veterans who are homeless or at risk of homelessness can contact the National Call Center for Homeless Veterans at any time to be connected with local resources who can help meet their needs.

Mr. Dauphinais asked if the VHA Homeless Programs Office has data regarding homelessness among Native American Veterans. Deputy Director Dunn responded that they have some high-level data on this demographic and have been working with OTH to analyze data gathered from stand down events to gain a clearer understanding of homelessness among Native American Veterans. Gathering data from these events has been difficult since they are run by local organizations. VA cannot require the host organizations to share this data but intends to encourage them to do so. HUD does a point-in-time count each year, but the data is self-reported with no verification of Veterans status, so the resulting data is an estimate.

Mr. Dauphinais asked what types of organizations can host a stand down event. Deputy Director Dunn said that any local entity can run the event, such as a tribal government, a tribal organization, or a nonprofit organization. VA can put any interested entities in touch with their nearby VA facility for assistance with the event.

Mr. Talas asked who receives the specific purpose funding that VA provides for stand down events. Deputy Director Dunn responded that this funding goes to the local VA facility, which in turn uses it to support the stand down. Some restrictions apply; for example, the purchase of food is not permitted. VA no longer requires the facility to provide an after-action report regarding the event.

Deputy Director Dunn indicated that she will send Ms. Duncan a list of upcoming stand down events and a contact list of homeless network coordinators. Ms. Duncan can then share this information with the committee.

Choctaw Nation Warrior Wellness Project

Captain Courtney Trent, Director, Choctaw Nation Warrior Wellness, presented an overview of Choctaw Nation Warrior Wellness, which is the tribe's VA Staff Sergeant Fox Grant project.

The project started about 1.5 years ago. Choctaw Nation was one of 80 grantees who received this VA funding.

Suicide rates are high in Indian Country, and suicide is the thirteenth leading cause of death for Veterans overall. Among Veterans ages 45 and younger, it is the second leading cause.

Choctaw Nation Warrior Wellness employs a counselor and two peer recovery support specialists. All personnel are Veterans themselves. The program also employs therapy dogs. Program personnel travel throughout the county with the goal of addressing Veterans' trauma in a culturally appropriate way.

The program encourages Veterans to spend time in nature and to engage with other Veterans. It offers educational experiences, peer support groups, and case management. Experiential education opportunities include equine-assisted therapy, hiking groups, and guided fishing tours. Choctaw Nation Warrior Wellness also engages in advocacy and hosts Veterans' retreats. They also hold an annual conference for women Veterans, which will take place on March 12 this year in Durant, OK. Finally, they offer an app called Qactual that enables peer-to-peer support. The app makes it easy for a Veteran to request help from their support system, and it also has a daily mental health screening feature.

The program has a strong relationship with VA, often receiving referrals from VA and referring Veterans to VA.

Mr. Talas asked if IHS supports this program in any way, and Capt. Trent confirmed that they have received some support from IHS. She added that the grant is currently open for applications.

Mr. Parker noted that being able to approach Native American Veterans so that they feel comfortable discussing this difficult topic is an ongoing challenge. Capt. Trent agreed and noted that training and peer involvement help tremendously in building this trust.

Chairwoman Tetnowski expressed interest in learning more about how Choctaw Nation Warrior Wellness trained the project personnel. The program may have valuable insights that other tribes can use even without obtaining the grant.

A committee member asked if Qactual is only intended for use by the Choctaw Nation. Capt. Trent responded that the app is available for any tribe interested in purchasing it. The app developer provides data analytics and training on how to use the app. She said she will send the contact information for the app developer to Ms. Duncan, who can share these details with the committee.

Tribal Representation Expansion Project

Shekeba Morrad, Staff Attorney, VA OGC, shared a presentation about the Tribal Representation Expansion Project (T.REP). She began by providing some background information on VA recognition and accreditation.

Before an individual can prepare, present, or prosecute a claim before VA, they must first be recognized by VA. Typically, this recognition takes the form of accreditation. Individuals can be accredited as a representative of a VA-recognized organization, an attorney, or an agent. Alternatively, a non-accredited individual may be specially authorized to represent a particular claim or set of claims.

For an organization to be recognized as a Veterans Service Organization (VSO), there are specific requirements for each type of organization (national, state, tribal, regional, or local), as well as general requirements that apply to all organization types. Currently, there are 21 VSOs. Two tribes are recognized VSOs: the Navajo Nation and Gila River Indian Community. Two additional tribes have requested recognition as VSOs. National Native American organizations—not just individual tribal governments—are also eligible to become recognized. When an entity applies for VSO recognition, they must provide supporting documentation.

The primary difference between VSO representatives and accredited individuals is that VSOs cannot charge fees, while attorneys and agents can.

OGC leads T.REP with support from OTGR. Through T.REP, VA aims to ensure that Native American Veterans have the option to receive qualified, competent representation for their VA claims. Sometimes, finding representation is difficult for Native American Veterans due to challenges such as residing in remote areas. T.REP aims to provide trained, culturally competent representation for these Veterans.

OGC strives to work closely with tribes that wish to become recognized VSOs. The pathway for tribes to become recognized VSOs is to establish an MOU with VA.

Veterans and their families can search for accredited VSOs or individuals on the VA website.

The committee previously recommended that VA create a checklist and brief training package for the Veterans Benefits Management System (VBMS). In response, VA developed an infographic that illustrates the onboarding steps for those who are accredited for claims representation to access VBMS and track claims as they go. There are also videos and other resources available for VSOs to learn more about using VBMS.

Tribes can collaborate with VA via several avenues to ensure that their citizens have access to competent representation for their VA benefit claims. Interested tribes are encouraged to contact OGC to learn more about VA accreditation.

Chief Smith noted that many more tribes and Native American individuals need to obtain recognition or special authorization under T.REP. He asked about the possibility of removing the MOU requirement to simplify and streamline the recognition process.

Ms. Morrad said that OGC would be happy to create a step-by-step guide on how to seek recognition under T.REP. She said they will also look at possible avenues for enhancing the efficiency of T.REP, including potential removal of the MOU requirement.

Chairwoman Tetnowski thanked OGC for following up on the committee's recommendation.

ITU Reimbursement Agreement Program Updates

Donna Greene, Director, Network Support, VHA Office of Integrated Veteran Care, provided updates regarding IHS/tribal health program/urban Indian organization (ITU) reimbursement agreements.

Since 2012, VA has collaborated with ITUs to reimburse health care services provided to eligible Native American Veterans. Many of the existing reimbursement agreements with tribes and urban Indian organizations have been in place for more than a decade and thus need updating. To ensure the success of these ongoing partnerships, VA is implementing revised reimbursement agreements that promote high-quality health care, increase access to services, and strengthen resource-sharing.

Key updates to the revised agreements will include:

- Addition of purchased/referred care (PRC) and contracted travel as reimbursable expenses for eligible Native American Veterans
- Expanded scope that includes telehealth and additional direct care services
- Extension of the timely filing limits
- Removal of the agreement's end date

Reimbursements to IHS facilities are governed by an overarching VHA-IHS reimbursement agreement, and a new version of this agreement was signed on December 6, 2023. Currently, VA is collaborating with IHS to finalize the corresponding IHS Claims Processing Guide and to fully execute the agreement.

Key updates to the VHA-IHS reimbursement agreement include:

- Inclusion of additional direct care services, including telehealth
- Addition of PRC and contracted travel as reimbursable expenses, which can be billed retroactively dating back to January 5, 2021
- Removal of the requirement for IHS to follow VA's pharmacy formulary

- Modification of the pharmacy rates to billed charges
- Removal of VA quality oversight requirements
- Removal of the agreement end date

In February, VA sent tribal leaders a proposed new VA-tribal health program agreement for tribes in the lower 48 states. The 30-day comment period for this draft agreement is currently open. VA will use feedback from the open comment period to finalize the new agreement.

Key updates to this agreement include:

- Inclusion of additional direct care services, including telehealth
- Addition of PRC and contracted travel as reimbursable expenses, which can be billed retroactively dating back to January 5, 2021
- Revision of the language regarding dispute resolution, with the aim of respecting tribal sovereignty by engaging neutral mediators as a first step in the resolution process
- Elimination of the VA quality oversight requirements
- Removal of the agreement's end date.

An updated VHA-tribal health program reimbursement agreement is in process for tribes in Alaska. The agreement is in the final stages of review and will be finalized within the next few months, at which point it will be shared with tribal leaders in Alaska for tribal consultation. The draft agreement features the same scope expansions listed for tribes in the lower 48, including additional direct care services and reimbursement for PRC and contracted travel. Further key updates to this agreement include:

- Combination of the previously separate Part A and Part B agreements into a single agreement with three sections
- Clarification about which terms apply to each eligibility group (Native American or non-Native Veterans)
- Updates regarding compliance with the MISSION Act in providing care to non-Native Veterans
- Updates for consistency with MISSION Act requirements, such as the exclusion of ineligible providers, standards for provider qualifications, and additional quality standards

An updated agreement is also in process for urban Indian organizations. Currently, the agreement is under review and will be completed in the coming months, at which point it will be disseminated for tribal consultation. Significant updates to this agreement include the addition of more direct care services, adjustment of the VA quality oversight requirements, and removal of the agreement's end date. Presently, VA has reimbursement agreements in place with six urban Indian organizations.

The committee previously made several recommendations pertaining to including traditional healing practices in reimbursement agreements. Director Greene reviewed VA's responses to each recommendation, as follows.

Recommendation 3B-1 urges VA to champion the use of traditional healing in supporting the wellness of Native American Veterans. In their response, VA notes that they could adopt traditional healing at rates developed by the Center for Medicare and Medicaid Services (CMS) to pay for or reimburse these services.

Recommendation 3B-2 asks VHA to coordinate with the committee to create a timeline that outlines steps and processes for the inclusion of cultural healing practices in reimbursement agreements. VA's response indicates that VHA would welcome the committee's assistance in this process, and the Chaplain Service remains available to partner with tribes to expand the number of contracts that involve traditional healing.

Recommendation 3B-4 requests that VHA work with the committee on designing a program that would add traditional healers to the VA Chaplain Service. VA's response notes that the Chaplain Service is happy to collaborate with traditional healers to assist them in becoming VA chaplains.

Chief Smith noted that under the new VHA-IHS reimbursement agreement, Veterans who visit IHS instead of VA will not be dropped from VA coverage, whereas previously, a Veteran who did not visit VA regularly could lose VA coverage even if they visited IHS regularly. He expressed surprise that non-Native Veterans who visit an ITU facility will still be required to use the VA formulary. He further noted that PRC travel costs are a priority issue for many tribes right now, and VA provides 33% less for this type of expense than what is allowable per the Internal Revenue Service.

Mr. Talas asked what costs are covered under reimbursement for contracted travel expenses. Kara Hawthorne, Program Manager, VA Office of Integrated Veteran Care, responded that IHS has defined allowable contracted travel expenses as any travel cost for which they have a purchase order. She noted that PRC and contracted travel are mentioned as two separate items, as VA wanted to ensure that the agreement includes travel that may not be considered PRC through the IHS PRC program.

Bobbie Baldwin noted that the Navajo Nation has several 638 contract facilities and asked if there is a possibility for VA clinics inside tribal health provider or IHS clinics to become eligible for the reimbursement program.

Director Greene responded that a clinic located within another clinic does not currently fall under the reimbursement program. These facilities are managed through local sharing agreements between the tribal clinic and the local VA medical center.

Chairwoman Tetnowski thanked VA for working on the committee's recommendations.

Claims Events in Indian Country

Julian Wright, Senior Program Analyst for Outreach, VA Outreach, Transition and Economic Development Department, delivered a presentation regarding VA claims events in Indian Country.

The Transition and Economic Development Department engages in outreach, supports service members who are leaving the military during this transition, and offers economic development support, such as financial literacy education.

The mission of VA's outreach to tribal Veterans is to ensure that all Native American Veterans, service members, and surviving spouses are aware of VA services and benefits and how to access them. This outreach includes consulting with tribes to develop partnerships that enhance access to services and benefits for Veterans. Some of VA Outreach Office's goals include the following.

- Build trust with Native American Veterans.
- Address barriers to access that Native American Veterans in rural areas commonly encounter.

- Ensure that VA staff have a basic understanding of tribal cultures.

OTGR and the Veterans Benefits Administration (VBA) are working together to conduct outreach to tribal communities with the goal of helping Veterans and surviving spouses to access VA benefits and services. Since the passage of the PACT Act in 2022, they have held more than 100 tribal claims events across more than 30 states. They have reached more than 5,000 Veterans and surviving spouses through these events. To put on claims events, they collaborate with various partners, including VSOs, IHS, VHA, tribal Veterans representatives, the NADL Program, VBA regional offices, and the Medical Disability Examination Office (MDEO).

MDEO supports outreach efforts by finding contracted vendors to provide compensation and pension exams at claims clinics. Vendor support is strictly voluntary. Regional VBA offices schedule these exams so that Veterans can receive them on the spot during claims events. Mobile medical units often help provide these exams at claims events, especially in rural areas.

Chief Smith noted that Veterans can file disability claims at claims clinics. However, Veterans often do not know whether they have a qualifying disability. He asked if VA staff at claims events are able to advise Veterans on whether to file disability claims.

Mr. Wright responded that VA personnel try to engage Veterans in conversations about this issue to help them deduce what qualifying disabilities may be present, as well as what toxins or environmental hazards the Veteran may have been exposed to based on their era and location of service.

Chief Smith noted the need to ask the right questions and build trust with Veterans, as many Veterans may say they are doing well when they actually need help. He thanked VA for putting on these claims clinics.

Mr. Talas pointed to a need for improved follow-up from VBA personnel after claims events. He reported receiving inquiries from Veterans asking about the status of their claims after claims events. Mr. Wright encouraged the committee members to contact him directly with any questions about the status of Veterans' claims.

VA Office of Connected Care

Dr. Leonie Heyworth, Deputy Director for Clinical Services, VA Office of Connected Care, provided updates on behalf of Connected Care.

Connected Care aims to use connected technologies to enhance the accessibility, capacity, quality, and experience of VA care for Veterans, their families, and their caregivers. The office manages MyHealtheVet, My VA Health, the VA mobile app, and VA's telehealth efforts.

Their priorities for virtual care include the following.

- Bringing care to Veterans in the places of their choosing
- Matching clinical supply and demand
- Providing the right care at the right time

VA first implemented telehealth technologies in 2003. Telehealth services began with monitors being placed in patients' homes. Some of these are still in place. Later, VA transitioned to primarily clinic-

based telehealth. In 2017, legislation was passed that enables VA telehealth services to occur anywhere, including across state lines from where the provider is located.

Telehealth modalities include synchronous services, asynchronous services, and remote patient monitoring that occurs within the patient's home.

Virtual care has grown significantly since FY 2017, with massive increases in Veterans' use of this modality during the COVID-19 pandemic. During FY 2023, approximately 2.4 million Veterans received health care through telehealth modalities, with approximately 11.6 million episodes of care taking place this way.

A FY 2023 survey found that Veterans prefer video telehealth over in-person care or telehealth via the phone. VA has commissioned a special study on Native American Veterans' preferences around telehealth specifically. They anticipate having findings to share approximately a year from now.

VA has organized regional and national hubs that can provide telehealth services. These hubs have a wide range of clinical specialties.

To learn more about how to use technology to receive health care services, Veterans can visit virtual health resource centers (VHRCs). Currently, there are 32 VHRCs, and VA is working to expand this resource to more areas.

My HealtheVet, which is VA's online patient portal, offers secure messaging, prescription refills, and VA health records. It has been in operation since 2003. This portal will soon move to VA.gov.

The Digital Divide Consult is a program that connects Veterans who do not have Internet access or a video-capable device by providing the connectivity or technology needed to receive telehealth services. If, during an appointment with a health care provider, the Veteran and their provider agree that the Veteran would benefit from virtual health care options, a social worker then determines if the Veteran qualifies for the loaned tablet program and/or other supports. Since this program's inception, approximately 149,000 such consults have occurred, and VA has subsequently loaned more than 115,000 internet-connected tablets to Veterans. Through the loaned tablet program, VA can also provide peripheral devices, like a thermometer, which connect to the tablet for Veterans to use at the request of their providers during telehealth visits.

VA's provision of connected devices for Veterans has improved mental health care access and continuity, as demonstrated by such metrics as increased psychotherapy and medication management visits, while concurrently decreasing suicide-related and emergency room visits.

Accessing Telehealth through Local Area Stations (ATLAS) is a telehealth grant program designed to help Veterans without internet connectivity at home to participate in telehealth visits. This program partners with local facilities to provide secure, comfortable places equipped with Broadband where Veterans can connect to their telehealth appointments.

Further expansion of ATLAS is anticipated through establishment of a telehealth grant program under Section 701 of the John Scott Hannon Mental Health Improvement Act. This legislation will enable organizations interested in establishing an ATLAS site to receive grant funding to do so. VA is preparing to implement the regulations that would operationalize the telehealth grant program. They anticipate publishing the final rule for this program in FY 2025 and awarding grants in FY 2026.

Connected Care envisions continuing to help Veterans access care through a variety of virtual care apps. To do so effectively, they must first provide better connectivity options for Veterans. Dr. Heyworth described several VA telehealth apps, as follows.

- VA Health Chat is a mobile app that Veterans can use for immediate non-emergency communication with their care team. This app is live in 16 Veterans Integrated Service Networks and is specifically designed for Veterans who live in rural areas, have mobility issues or challenges accessing VA facilities, and face limited connectivity.
- My VA Images is another telehealth app for Veterans. It enables patients to submit photos or video clips to their providers for review, upon the provider's request.
- Annie App sends automated text messages to Veterans based on their clinical health subscriptions. It also receives and stores text messages from Veterans. Users can subscribe to more than 170 enabled protocols, such as blood pressure, medication reminders, and weight management.
- PTSD Coach is one of the most-used apps among Veterans. It supports the self-management of post-traumatic stress disorder.

Section 151 of the Cleland-Dole Act requires VA to develop a detailed plan illustrating how VA is working with other federal agencies to enhance connectivity in rural, highly rural, and medically underserved areas to better reach all Veterans.

Mr. Sam noted that complications with telehealth are a long-standing challenge for many rural Veterans. He asked if there are other programs to assist Veterans in terms of increasing access to care and providing technical support for telehealth services.

Dr. Heyworth said that VA has a national helpdesk Veterans can call for assistance with telehealth technologies. However, this is only useful if they have sufficient connectivity to begin with. ATLAS locations may be the best solution, as they have broadband connectivity as well as personnel on site who can help Veterans with the technology.

A committee member asked if the telehealth platforms offer closed captioning. Dr. Heyworth responded that Connected Care is working with the VA Office of Information Technology to include closed captioning in numerous languages. This feature will be launched soon.

Chairwoman Tetnowski asked if a tribal clinic can become an ATLAS site, and if so, whether the tribe's MOU with VA would need to account for this.

Dr. Heyworth confirmed that tribal facilities can become ATLAS sites. VA has guidance in place for how to establish ATLAS locations as the program transitions from a donation-based program to a grant program. This guidance does encourage setting up an MOU.

Mr. Sam suggested elaborating within a future presentation on how IHS and tribal programs can participate in the ATLAS program. Dr. Heyworth said she would like the committee's advice on how to ensure tribal communities are aware of the program.

Day 3

Thursday, February 29, 2024

Opening

Chairwoman Tetnowski welcomed attendees to the third and final day of the meeting and thanked the participants for their input so far.

Next, Mr. Vicaire conducted roll call. Chairwoman Tetnowski announced that a quorum was present.

VA then showed two videos. The first was a greeting from Secretary of Veterans Affairs Denis McDonough, and the second featured comments from Secretary McDonough and IHS Director Roselyn Tso about the joint efforts of VA and IHS to increase access to health care for Native American Veterans.

Chief Smith remarked that the second video provides a powerful example of how federal agencies can work together effectively.

Mr. Talas asked OTGR to send the second video to the committee members so that they can relay it to Veterans, as it would be impactful for Veterans to hear about this collaboration. Mr. Dauphinais seconded this request.

Ms. Duncan indicated that she would send the video to the committee members.

Committee Administrative Meeting: Team Building

Facilitator Shade Dill (Choctaw Nation) led the committee through several team-building exercises so that they could learn more about each other and build connections and trust.

Public Comment Session

Mr. Vicaire noted that OTGR received one written public comment from the Navajo Nation. OTGR forwarded the comments to the committee members. Those written comments are included in this report as an appendix.

Several meeting participants then provided oral comments, as follows.

Jerry Levi, Jr., Director for the Cheyenne and Arapaho Tribes Office of Veteran Affairs, provided public comments in person. He said 278 Veterans are registered with his office. The office communicates with the tribe's Veterans frequently, including sending a regular newsletter. The office launched a bus service to help transport Veterans to and from IHS and VA appointments. Rural Native American Veterans are often reluctant to travel to urban areas for care, but there are many Native American Veterans living in or near urban areas who would benefit from culturally appropriate care. He pointed to a need for an urban center that is specifically designed for Native American Veterans.

Larue Guoladdle, Director, Kiowa Tribe Veteran's Office, also provided in-person comments during the meeting. She echoed what the first commentor said about rural Veterans' avoidance of urban clinics, noting the need to instead bring these services to the Veterans. She also said that computer literacy support would be helpful, as many Veterans expect her program to help them navigate technology. She raised a question about whether Veterans who apply for the copayment exemption receive confirmation that their application was submitted.

Terra Branson-Thomas, Muscogee (Creek) Nation Senior Policy Advisor, provided the final public comment. She noted that pharmaceuticals for Veterans incur a significant cost for tribes and urged VA to notify the committee when issues like this are evolving so that the committee can provide input. She applauded VA for the new VA-IHS MOU and reimbursement agreement, which establish a strong template for tribes to use in their agreements with VA.

Committee Administrative Meeting: Follow-Up and Action Items

OTGR Update on Committee Recommendations

Acting Director Ward and Director Moragne provided several key updates regarding some of the committee's previous recommendations, as follows.

- **VA's tribal consultation policy:** Acting Director Ward shared that VA revised the policy and engaged in tribal consultation in 2021 regarding the revisions. Currently, VA is finalizing the policy, with final comments due by March 11, 2024. OTGR anticipates extending this deadline by 30 days.
- **VA's urban confer policy:** Acting Director Ward said he will set up a meeting with Chairwoman Tetnowski to begin exploring this issue.
- **Joint advisory committee meetings:** Director Moragne said that per guidance from OGC, convening with other FACs to discuss issues or recommendations would essentially constitute the convening of a new FAC that does not have its own authorization. He suggested that the committee instead have its subcommittees meet with the subcommittees of other FACs. Only one DFO would need to be present for such meetings.

Subcommittees

Chairwoman Tetnowski noted that the committee currently has three subcommittees, as follows.

- Benefits and Cemetery Subcommittee, chaired by Mr. Dauphinais
- Administrative Subcommittee, chaired by Kevin Meeks
- Health Subcommittee, chaired by Chairwoman Tetnowski

Chairwoman Tetnowski then briefly reviewed the requirements that FAC subcommittees must follow. For all subcommittee meetings, the DFO must be present, and meeting minutes must be developed. Typically, the DFO prepares the meeting minutes for the subcommittee's review. Committee members can serve on more than one subcommittee, but each subcommittee must comprise no more than seven of the parent committee members.

Mr. Vicaire suggested reexamining the leadership and membership of each subcommittee, as members were initially assigned arbitrarily.

Chairwoman Tetnowski asked if any other committee members would like to be considered to serve as the chair for a subcommittee.

Mr. Talas motioned to approve the current committee chairs. The motion passed without objection.

Next, the committee discussed the subcommittee membership. They decided upon the following groupings.

Subcommittee	Members
Benefits and Cemetery	• Dean Dauphinais (Subcommittee Chair) • Ricky Alex • Bobbie Baldwin • Chauncey Parker • DeLisa Ramon • Ivan Sam • Frank Star Comes Out
Administrative	• Kevin Meeks (Subcommittee Chair) • Jack Austin, Jr. • Bobbie Baldwin • Dean Dauphinais • Chauncey Parker • Sonya Tetnowski
Health	• Sonya Tetnowski (Subcommittee Chair) • Adam Archuleta • Reyn Kaupiko • Nickolaus Lewis • DeLisa Ramon • Bill Smith • Geno Talas

Table 2. Subcommittee chairs and members

The following members were not present at the meeting and were thus assigned to their respective subcommittee(s) rather than volunteering:

- Ricky Alex
- Adam Archuleta
- Reyn Kaupiko
- Nickolaus Lewis
- Frank Star Comes Out

Chairwoman Tetnowski said that the subcommittee chairs will communicate with the other subcommittee members soon to schedule meetings.

Mr. Dauphinais suggested creating a subcommittee that focuses on developing recommendations for how VA can better conduct outreach to Veterans. He noted that this issue is not currently accounted for through the present subcommittees and suggested formation of a fourth subcommittee to ensure that outreach is prioritized. Chairwoman Tetnowski asked the committee if there is desire to form a fourth subcommittee or whether this topic can be addressed through the Administrative Subcommittee.

Chief Smith, Mr. Parker, and Mr. Talas pointed out that outreach is an important topic that connects to the focus areas of all three current subcommittees. Chief Smith said outreach should be addressed by the full parent committee.

The committee's consensus was to have the Administrative Subcommittee take on this priority for now. This can change later, as needed.

Ms. Duncan indicated that she will send a list of the subcommittee assignments to the committee members.

Mr. Vicaire said that he will serve as the DFO for the Benefits and Cemetery Subcommittee, while Mary Culley will support the Health Subcommittee and Ms. Duncan the Administrative Subcommittee.

Director Moragne suggested that the committee convene ad hoc subcommittees in various field locations three times per year in place of a full committee meeting in the field once per year. The full committee meetings could occur virtually once per year instead. That way, the committee can conduct site visits in all areas within a shorter timeframe. The ad hoc subcommittee approach does not cost VA any additional money.

Chairwoman Tetnowski asked the subcommittee chairs to add the issue raised by Director Moragne to the initial subcommittee meeting agendas for consideration and discussion. Director Moragne said he will write up this suggestion and share it with Mr. Vicaire, who will in turn send it to the committee.

Mr. Meeks asked if the committee needs to develop an annual budget, and Director Moragne responded that the DFOs are responsible for the budget; they will tell the committee how many field meetings to budget for during any given year.

Additional Discussion

Chairwoman Tetnowski opened the floor for committee members to raise any final comments.

Chief Smith said that the IHS Director called him and indicated that she would like to re-open the VHA-IHS reimbursement agreement to focus on reimbursement for traditional healing. He suggested that the committee discuss this issue. Acting Director Ward said he will share this information with VA leadership and report back to the committee on what he learns.

Mr. Meeks said that VA recently issued an updated drug formulary without engaging tribes. While this issue may not rise to the level of requiring tribal consultation, communication to tribes about the upcoming changes would have been tremendously helpful so that tribes could have prepared for the change. These updates have increased the cost of certain drugs for many tribes and for IHS. He emphasized the need for tribes to be made aware of such decisions. He also shared that there is restricted land—not trust land—in Oklahoma. Much of this land is held in the tribe's name, rather than in the name of the individual. Most federal legislation pairs these two terms (trust land and restricted land) together, but the NADL authorizing legislation does not. He suggested that the committee consider asking VA to change each mention of "trust land" in this legislation to "trust lands and restricted lands."

Mr. Dauphinais noted that the South Dakota Native Home Ownership Coalition has originated a proposed amendment to the NADL Program. He offered to put Mr. Meeks in touch with this organization so that he can share this proposed language change for possible inclusion in the draft amendment before it advances further.

Closing

The Choctaw Nation Color Guard retired the colors.

Mr. Sam provided a closing prayer.

Chairwoman Tetnowski thanked the participants and adjourned the meeting.

Appendix: Written Public Comment

Submitted via email to: peter.vicaire@va.gov

February 21, 2024

Peter Vicaire
U.S. Department of Veteran Affairs
810 Vermont Ave, NW Washington,
DC 20420

Re: Navajo Nation Comments Regarding the Advisory Committee on Tribal and Indian Affairs Meeting

Dear Peter Vicaire:

On behalf of the Navajo Nation ("**Nation**"), thank you for the opportunity to provide written comments in response to the Federal Register notice regarding the upcoming U.S. Department of Veterans Affairs ("**VA**") Advisory Committee on Tribal and Indian Affairs meeting. We will be represented in person at the meeting by Navajo Nation Veterans Administration ("**NNVA**") Director Bobbie Ann Baldwin.

The Nation is the largest American Indian tribe in the United States encompassing over 27,000 square miles and spanning into portions of three states – Arizona, New Mexico, and Utah. Currently, the Nation has over 400,000 enrolled members, half of whom reside on reservation land. In 1868, the United States entered a treaty with the Navajo Nation promising health care, education, agricultural assistance, and to improve the well-being of the Navajo people in perpetuity.

As such, the United States is legally and morally bound with a treaty responsibility and a sacred trust obligation to support the Nation in securing and improving the quality of life for our citizens. It is with these treaty obligations in mind that we seek to engage the VA and provide feedback to strengthen our nation–to–nation relationship.

Below you will find our responses to several topics that will be discussed in the upcoming meeting from February 27-29, 2024, in Durant, OK.

Navajo Nation Topics of Concern

Healthcare for Navajo Women Veterans – Our Navajo women veterans have disproportionately negative health outcomes due to the lack of care available to them. One solution to this would be implementing mobile medical units ("**MMUs**") on the Navajo Nation. These MMUs would provide life-saving preventative care, such as breast cancer screenings.

Carl T. Hayden Program – Please consider restarting the Carl T. Hayden Traditional Healing program and providing support from VHA and IHS to help get this important program started again. Many of our veterans benefitted from this program. Under the program our veterans were able to go through a cleansing ceremony after their time in service or war. One of the greatest stories of Native servicemen comes from one of our Navajo Code Talkers, the late Alfred K. Newman, who shared that the Navajo service members built a sweat lodge on one of the Japanese islands. Many of the men would use the sweat lodge as a place to replenish, rejuvenate and cleanse their bodies.

Share Medical Records – Please consider creating a program to support the sharing of medical records with different agencies such as VHA, IHS, and tribal health programs. This is one of the main reasons why many of our Native veterans do not visit Veteran healthcare facilities. If the sharing of records were supported, many of our Native veterans would be able to easily establish their records at both facilities allowing them to get better health care. This is also another reason why the numbers for VA Healthcare facilities are down, an effect we have seen at the Gallup Community Based Outpatient Clinic ("**CBOC**").

Funding for Accredited Veteran Service Officers ("VSOs") – Native Veteran Service Officers would better understand issues of cultural significance and our language. NNVA has several federally accredited VSOs to assist our veterans in applying for benefits. This, however, comes at a great cost to the Nation. We request funding from the Department of Veterans Affairs to assist us in carrying out our mission of serving our *Diné* veterans.

Improve Suicide Prevention and Increase Access to Mental Health Services – Suicide is increasingly becoming an issue with many of our veterans. There are many contributing factors to this issue, but services need to be made available to veterans in remote areas of the reservation. Many of our veterans are suffering in silence and would benefit from suicide prevention support.

Assistance and Funding for Veteran Benefit Outreach Center - The Navajo Nation Veterans Administration is proposing the construction of a regional Veterans Administration Center / Veterans Benefits Administration Center, a one-of-a-kind community-based outreach center of sorts, that is available to all veterans but focuses services on Native American veterans. The purpose of this facility is to provide much needed services in a geographical area that is underserved by the Department of Veterans Affairs. This facility would serve as a hub for a variety of services that include non-emergency / non-urgent care services typically found outside of a VAMC, such as physical or occupational therapy, mental health services, vocational training and education, temporary / transitional housing, and transportation services, as well as serving as an administrative facility for Navajo Nation, state, and federal VA staff to administer program services.

The Navajo Nation has already chosen and withdrawn land as a location for this facility. It is situated on New Mexico's Highway 264, less than two miles from the Arizona state line, and adjacent to the Navajo Nation capital in Window Rock, Arizona. It is located adjacent to the

future Navajo Code Talkers Museum site. This site has easy access to public roads with heavy traffic, as well as existing power, water, and sewer lines. It has been determined through surveys that the site is appropriate for the construction of a project of this magnitude. This facility is also consistent with the master plan for this area's development, which will boost the Navajo Nation's economic development efforts.

Veteran Representative at the IHS and THP Healthcare Facilities – Many of our veterans are not being properly registered as “veterans” at these facilities because they are not specifically being asked their veteran status. Several of our veterans have expressed that they are not getting the care they are entitled to as veterans. If they are registered and recognized as veterans, the services and reimbursements would improve as well as the services to all patients at these healthcare facilities.

Conclusion

In closing, the Navajo Nation looks forward to meeting with the VA Advisory Committee on Tribal and Indian Affairs. We also look forward to collaborating with the Veterans Health Administration to improve access and healthcare outcomes and having continued meaningful tribal consultations for American Indian/Alaska Natives. We hope the comments are seriously considered to improve access and the delivery of quality health care to our Navajo veterans who have proudly served this great nation. We appreciate this opportunity and look forward to supporting strong collaboration between our federal partners.

Should you or your staff have any questions, please do not hesitate to contact Justin C. Ahasteen, Executive Director of the Navajo Nation's Washington Office at (202) 682-7390 or by email at jahasteen@nnwo.org. *Ahéhee’* (thank yo