

Department of Health & Human Services, Centers for Medicare & Medicaid Services

LTSS Research: LTSS for Native Veterans

Annotated Literature Review

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Glossary

Activities of daily living	Basic activities a person must perform during a normal day to remain independent. These include daily actions such as, getting in and out of bed, dressing, bathing, eating, walking, and using the bathroom.
Adult day health care	A non-residential facility-based program that veterans can attend during the day who need skilled nursing and assistance with activities of daily living. Adult day health care for veterans may be provided at VA medical centers, State Veterans homes, or community organizations.
Assisted living facility	Residential facilities for veterans that need some assistance with activities of daily living and medical care, but do not require care in a nursing home.
Home-based primary care	Primary care provided in the home to elderly, frail, or chronically ill veterans who are homebound and would otherwise have to receive care in an institution
Long-term care	Services that help people with personal or health care needs and activities of daily living over an extended period. Long term care (LTC) is an older term, which has generally been replaced with Long Term Services and Supports (LTSS).
Long-term services and supports (LTSS)	A set of health, personal care, and social services delivered over an extended period to persons unable to perform their activities of daily living independently. These may be provided in a variety of settings or in the person's own home.
Respite care	Temporary relief of duties for caregivers provided either in the home or in an out-of-home setting, like an adult day care center or skilled nursing facility for overnight stays.

Executive Summary

American Indians and Alaska Natives (AI/ANs) have a long and proud history of military participation. In fact, AI/ANs have a high rate of service and the highest rate of women serving compared to all other service members (U.S. Department of Veterans Affairs (VA), 2012). For example, over 22% of all 45- to 54-year-old AI/ANs are veterans, compared to 15% among all other races in the same age group (VA, 2012). Due to physical injuries and mental trauma sustained during combat, veterans in the United States have high levels of disabilities. The long-term health needs of Native veterans are particularly complex due to a combination of geographic and demographic factors.

The complexities that Native veterans face lead to a high need for long-term services and supports (LTSS) among elderly and disabled veterans in Indian Country. LTSS are a set of health care, personal care, and social services delivered over an extended period to persons unable to perform their activities of daily living independently. LTSS may be provided in a variety of settings or in the person's own home.¹ LTSS includes home- and community-based services, which are care programs delivered in the home or community, and facility-based settings where care is provided in an institutional setting outside of a home.²

Examples of LTSS that Native veterans and their families might utilize include³:

- Nursing homes (including VA nursing homes, tribal nursing homes, and state veterans homes);
- Assisted living facilities;
- Adult day health care;
- Home-based primary care;
- Support for caregivers, including respite care; and
- Case management services.

Need for LTSS Among Native Veterans

The need for LTSS among Native veterans is affected by the general age distribution, income trends, disability status, and rate of post-traumatic stress disorder throughout the Native veteran community.

¹ Centers for Medicare & Medicaid Services (CMS). (2016). LTSS Overview. Retrieved November 1, 2016, from <https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/ltss-overview.html>

²CMS. (2015). Long-Term Services and Supports Fact Sheet for Tribal Leaders. Retrieved November 1, 2016, from https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/pdf/LTSS_Models_Fact_Sheet_072015.pdf

³ VA. (2015). Geriatrics and Extended Care. Retrieved November 15, 2016, from https://www.va.gov/GERIATRICS/Long_Term_Services_and_Supports_Overview.asp

Age Distribution, Income Trends, and Disability Status

When compared to veterans of the general population, Native veterans tend to be younger (VA, 2015a). Data from the 2013 American Community Survey finds that the median age for Native veterans is 57, compared to 63 among the general population (VA, 2015a). While the Native veteran population is currently younger than that of other veteran populations, the elderly Native veteran population is expected to increase (Holiday, Bell, Klein, & Wells, 2006). Overall, the elderly AI/AN population is one of the fastest growing groups of elderly minorities in the United States.⁴

Alongside age distribution, one study examined income trends among Native veterans (Holiday et al., 2006). The authors found that Native veterans over 65 have lower incomes than younger Native veterans and veterans of all races (Holiday et al., 2006). For example, 20.7% of Native veterans over 65 have an annual family income of \$10,000-\$19,999, compared to 12% among Native veterans under 65 and 10.4% among veterans of all races (Holiday et al., 2006). Lower incomes for elderly Native veterans impedes their access to LTSS and health care in general (Holiday et al., 2006).

Another major disparity among Native veterans is disability. Native veterans are more likely to have a disability, service-connected or otherwise, than veterans of all races (VA, 2011, and VA, 2015a). Further, AI/ANs have the highest rate of disability of any ethnic group in the United States.⁵ According to the National Council on Disability, 22% of AI/ANs have a disability compared to 20% among the general population.⁵ The combination of a rapidly aging population and high rate of disability have led to an increased need for LTSS in Indian Country, specifically among Native veterans.

Post-traumatic Stress Disorder

Post-traumatic Stress Disorder (PTSD) is, “a mental health problem that some people develop after experiencing or witnessing a life-threatening event, like combat, a natural disaster, a car accident or sexual assault”.⁶ Native veterans may have higher rates of PTSD than white veterans (Brooks et al., 2013). PTSD resulting from combat situations is compounded by a high rate of PTSD among the AI/AN general population.⁷

The contributing factors to PTSD among the general AI/AN population are complex and include historical trauma and high rates of interpersonal violence.⁷ Although PTSD does not always result in a loss of

⁴ Ortman, J., Velkoff, V., & Hogan, H. (2014). An Aging Nation: The older population in the United States, population estimates and projections. *Current Population Reports*, 25-1140. Retrieved November 15, 2016, from the U.S. Census Bureau website: <https://www.census.gov/prod/2014pubs/p25-1140.pdf>

⁵ National Council on Disability. (2003). Understanding Disabilities in American Indian and Alaska Native Communities: Toolkit Guide. Retrieved November 10, 2016 from http://www.ncd.gov/rawmedia_repository/53edc4ab_c8c7_4786_8f04_35a40855075c.pdf

⁶ VA. (2016). PTSD: National Center for PTSD. Retrieved November 15, 2016 from <http://www.ptsd.va.gov/public/PTSD-overview/basics/what-is-ptsd.asp>

⁷ National Institutes of Health. (2014). Posttraumatic Stress Disorder and Symptoms among American Indians and Alaska Natives: A Review of the Literature. Retrieved November 21, 2016, from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3875613/pdf/nihms-523524.pdf>

ability to live independently and perform activities of daily living, PTSD can severely impact an individual's ability to function, particularly in elderly individuals. A 2010 study funded by the U.S. Department of Defense found that male veterans ages 55 years and older with a PTSD diagnosis were more than twice as likely to develop dementia than male veterans of the same age group without a PTSD diagnosis.⁸ Based on this data and the increasing elderly population, the LTSS needs related to dementia are likely to increase among Native veterans.

Barriers to LTSS among Native Veterans

Native veterans experience several barriers to LTSS. These barriers result from Native veterans' poor access to care and complications from accessing care through Indian Health Service (IHS) and VA.

Poor Access to Care

Several studies report that Native veterans are more likely to lack health insurance than other groups of veterans (Holiday et al., 2006; Johnson, Carlson, & Hearst, 2010; VA, 2012; and VA, 2015a). In addition, Native veterans are more likely to delay care than White veterans due to their inability to obtain timely appointments and lack of transportation to health care facilities (Johnson et al., 2010). Native veterans are also more likely to live in highly rural areas than non-Native veterans (Kaufman et al., 2013). Within these rural areas, Native veterans have to travel significant distances to receive any health care services, including LTSS, yet they lack reliable transportation options (Kaufman et al., 2016).

Native Veterans' Use of IHS and VA

Several studies report that Native veterans are more likely to use Indian Health Service (IHS) than VA for their health care needs (Johnson et al., 2010; Kramer et al., 2009b; Reifel, Bayhille, Harada, & Villa, 2009). Native veterans appear to utilize IHS more frequently than VA due to a number of practical, geographical, and cultural reasons. While many of IHS' facilities and programs are underfunded, IHS employs culturally specific care. This cultural awareness and sensitivity makes IHS a more attractive option than VA for Native veterans (Reifel et al., 2009). Native veterans may also distrust or become frustrated with VA, adding to their preference for IHS (Kaufman et al., 2016). Further, Native veterans living in rural communities have limited or no access to VA Medical Centers (Kramer, Creekmur, Cote, & Saliba, 2016). These barriers to VA care are problematic, as VA is better equipped to provide LTSS to Native veterans than IHS (IHS, 2011, and Johnson et al., 2010). Despite a preference for IHS, Native veterans do utilize VA. One study found Native veterans more likely to report use of VA health care services than veterans of all other races (Holiday et al., 2006).

Overall, the literature conveys a lack of coordination between IHS and VA to provide quality care, including LTSS, to Native veterans. Although there are Native veterans who use IHS and VA, the providers do not routinely share medical information with each other (Kramer et al., 2009). This lack of

⁸ Yaffe, K. et al. (2010). Post-Traumatic Stress Disorder and Risk of Dementia among U.S. Veterans. *Arch Gen Psychiatry*. Retrieved November 1, 2016 from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2933793/>

coordination can result in delayed and duplicated treatment for Native veterans (Kramer et al., 2009b). Improved coordination between IHS and VA is critical, as dual use of IHS and VA may be the best approach to handle the complex health and LTSS needs of Native veterans (Reifel et al., 2009b).

IHS and VA's Efforts to Improve Care for Native Veterans

IHS and VA are working to improve their coordination of care, availability of services, and understanding of each other's abilities and limitations to better serve Native veterans. Coordination and educational efforts are detailed in the IHS-VA Memorandum of Understanding (MOU), while improved access to VA services is a highlight of the Veterans Access, Choice and Accountability Act (Choice Act). VA is also developing some promising LTSS practices that may improve Native veterans' access to care.

Memorandum of Understanding

IHS and VA acknowledge the need to improve their coordination and have taken several steps to address their shortcomings. In 2003, IHS and VA signed an MOU to improve their coordination of care for Native veterans. The MOU was updated in 2010 to further address the need to coordinate LTSS implementation for Native veterans, particularly as VA already provides LTSS (VA, 2010, and IHS, 2011).

Choice Act

In 2014, the Choice Act was signed into law. The Choice Act aims to improve veteran access, including Native veterans, to health care by allowing veterans to "receive care from eligible non-VA health care entities or providers."⁹ The law further states that "Eligible non-VA entities or providers must enter into agreements with VA to furnish care."⁹ This language initially caused concern in Indian Country, as IHS is not part of VA. However, in a tribal consultation letter, VA clarified that IHS and tribal health programs "will remain members of [VA's] core providers network".¹⁰ The Choice Act seeks to strengthen VA's relationship with IHS and further their partnership, which could lead to improved access to care for Native veterans.

The Alaska Native Tribal Health Programs (ATHP) exemplifies the strengthened partnership between VA and IHS. In 2012, ATHP entered into an agreement with VA that enabled VA to pay IHS and tribal facilities for health care services provided to Alaska Native veterans.¹⁰ This agreement led to increased access to health care services for Alaska Native veterans in Alaska.¹⁰ Given the remote nature of many communities in Alaska, this increased access to care is especially promising. Further innovative collaboration between IHS and VA has the potential to improve access to LTSS for Native veterans throughout Indian Country.

⁹ VA. (2014). Summary: Veterans Access, Choice and Accountability Act of 2014 ("Choice Act"). Retrieved November 29, 2016, from <https://www.va.gov/opa/choiceact/documents/choice-act-summary.pdf>

¹⁰ National Indian Health Board (NIHB). (2015). NIHB Letter on the VA Choice Act. Retrieved November 1, 2016 from <http://www.nihb.org/tribalhealthreform/wp-content/uploads/2015/10/NIHB-Letter-on-VA-Choice-2.pdf>

VA's Promising LTSS Practices

VA has established innovative LTSS programs that may benefit Native veterans. VA's Home-Based Primary Care (HBPC) is a promising alternative to institutional long-term care for Native veterans (Kramer et al., 2016). HBPC provides primary care in the home to elderly, frail, or chronically ill veterans who are homebound and would otherwise have to receive care in an institution. AI/AN communities have an overall cultural preference to provide care for family members in their own homes and communities, rather than in formal institutions, which makes the HBPC program particularly appealing (Kramer et al., 2016). Fourteen VA medical centers have expanded access to HBPC through collaborations with IHS or tribal programs. The HBPC program's holistic approach and focus on case management appears to lend itself to a high level of cultural sensitivity and respect for Native veterans (Kramer et al., 2016). Furthermore, HBPC programs engage in proactive outreach to tribal communities and are generally well received by those communities.

VA also has a Medical Foster Home (MFH) program, which is now nation-wide and is a viable, community-based alternative to VA nursing homes. The MFH program allows veterans with physical and mental disabilities to reside in their communities by pairing veterans with trained caregivers who share their homes with the veterans (Levy et al. 2016). The MFH program is intended for veterans with no available family caregiver and VA inspects and approves all MFH facilities. A study of the program found that MFH residents experience fewer hospitalizations due to mental health problems and bacterial infections than those in VA nursing homes, which alludes to a higher quality of care and a higher quality of life for MFH residents (Levy et al. 2016). Although the effectiveness of the MFH program has not yet been evaluated among Native veterans, it is a promising model that should be explored.

Recommendations

The LTSS needs of Native veterans are complex and challenging. The enormous respect and pride for this population in Indian Country, coupled with IHS and VA's improvement actions and innovative programs, show promising efforts to better serve Native veterans. Overall, more research is needed that examines Native veterans' LTSS needs. Based on information gained from the literature summarized in the next section, the following recommendations may help improve LTSS access for Native veterans.

- Increase culturally specific LTSS that is provided by culturally knowledgeable providers, such as onsite tribal outreach workers (Shore et al., 2012).
- Increase VA's cultural sensitivity and cultural competency efforts to gain the trust and respect of Native veterans (Kaufman et al., 2016).
- Invest further time and resources into proven home- and community-based services for Native veterans, such as through VA's HBPC program (Kramer et al., 2016).
- Encourage advocacy by tribal governments and community members to improve Native veterans' health (Kaufman et al., 2016).
- Expand innovative VA LTSS programs, such as the MFH program to include Indian Country (Levy et al., 2016).
- Improve communications about medical records between IHS and VA (Kramer et al., 2009b).

- Improve the identification of Native veterans who use IHS and VA (Kramer et al., 2009b, and Kramer et al., 2006).
- Explore available LTSS resources at the tribal and community levels, which could include additional coordination services funded by IHS and VA (IHS, 2011)

LTSS for Native Veterans: Annotated Literature Review

Reaching Rural Communities with Culturally Appropriate Care: A Model for Adapting Remote Monitoring to American Indian Veterans with Posttraumatic Stress Disorder

Brooks, E., Novins, D. K., Noe, T., Bair, B., Dailey, N., Lowe, J., . . . Shore, J. H. (2013). Reaching rural communities with culturally appropriate care: a model for adapting remote monitoring to American Indian veterans with posttraumatic stress disorder. *Telemedicine and e-Health, 19(4)*, 272-277. doi:10.1089/tmj.2012.0117

Telehealth technologies provide care to patients through remote monitoring, providing patients with text-based health status information from a distance (p. 272). This article addresses the need to adapt remote monitoring telehealth systems to patients' cultures. The authors describe a model they developed to address this need, alongside a case study showing how they implemented their model in a preexisting program.

The authors' case study follows the successful implementation of their cultural adaptation model in a remote monitoring program that was initially designed for generalized patients undergoing care for post-traumatic stress disorder alone or in combination with other psychiatric disorders (p. 274). The model implemented a process to cater this program to American Indian veterans (p. 274).

The model cycled through the following four steps to adapt the program to the local culture.

- **Dialogue changes** – Modifications were made to reduce the length of the program and add general information about Native populations, local health resources, U.S. Department of Veterans Affairs (VA) contacts, and VA navigation; standardized and non-standardized assessment tools; and spirituality and traditional healing components (p. 274).
- **Process changes** – The care delivery process was adapted to increase communication between the care provider and the care coordinator, which resulted in patients receiving more consistent and systematic treatment while still receiving substantial individual care (p. 274–275).
- **Testing** – Testing gauged technical issues, which were rare; the program's readability, which was found to be appropriate; and the patients and providers' opinions on the program changes, through which they noted particular appreciation for the traditional healing content (p. 275).
- **Gathering feedback** – Data was analyzed from the remote monitoring device; patient-level reports; and direct feedback from patients, clinicians, and coordinators (p. 275).

Particularly for American Indian communities, the authors recommend that providers engage in community consultation, involve family members, and directly connect patients to their treatment to provide more culturally appropriate care (p. 275–276). The authors further note that their cultural adaptation model could expand beyond remote monitoring programs into various forms of evidence-based treatment (p. 276).

American Indian and Alaska Native Veterans: Lasting Contributions

Holiday, L. F., Bell, G., Klein, R. E., & Wells, M. R. (2006). *American Indian and Alaska Native Veterans: Lasting Contributions*. Office of Policy, Assistant Secretary for Policy, Planning, and Preparedness, U.S. Department of Veterans Affairs, Washington, DC. Retrieved November 22, 2016, from <https://www.va.gov/vetdata/docs/specialreports/aianpaper9-12-06final.pdf>

Contributions of Native veterans' can be seen in every major U.S. battle. Documentation of American Indian and Alaska Native (AI/AN) involvement in the military can be found through various sources including this report developed by the U.S. Department of Veterans Affairs (VA).

This report uses 2000 Census data to identify developing trends and significant comparisons among Native veterans. Specifically, the report focuses on Native veterans' geographic distribution, education, income, home ownership, employment, health care, and use of VA programs.

Below are important 2000 Census findings discussed in this report:

- The five states with the largest Native veteran populations were California, Oklahoma, Texas, Arizona, and Florida, which represented 41% of the 72,670 Native veterans (p.9).
- More than 383,000 veterans identified as AI/AN, representing 1.5% of over 26 million veterans. Within the Native veteran population, nearly 73,000, (19%) were 65 or older with men making up more than half of this group (p.7).
- Native veterans were less likely to complete high school or have at least some college compared to older veterans of all races (p. 13).
- Veterans ages 65 or older had lower incomes than their younger counterparts (p. 13), in part because roughly 80% of this age group was no longer in the labor force or actively seeking employment (p. 14).
- Nearly all Native veterans had some form of insurance, including public, private, or a combination of the two. However, Native veterans were less likely to be insured compared to veterans of all races (p. 14).
- Native veterans were more likely than veterans of all races to report ever using VA health care services. Native veterans age 65 and older used VA health care services more often than their younger counterparts (p. 15).
- Native veterans had the highest percentage of VA home loans than all other races (p. 17).

While this report provides valuable insight into Native veterans, it is not meant to be detailed and all-inclusive. If anything, its content brings to surface some of the leading factors that influence Native veterans' lifestyles, health service choices, and socioeconomic conditions.

Long Term Care in Indian Country: New Opportunities and New Ideas – Report of the Conference

Indian Health Service. (2011). Long Term Care in Indian Country: New Opportunities and New Ideas. Report of the Conference. Retrieved November 22, 2016, from http://www.npaih.org/images/resources_docs/weeklymailout/2011/february/week4/Long%20Term%20Care%20in%20Indian%20Country%20Report.pdf

In November 2010, Indian Health Service (IHS) held the conference “Long Term Care in Indian Country: New Opportunities and New Ideas.” During the conference, participants discussed how to further support the development of long-term care services and supports (LTSS) in Indian Country under the Indian Health Care Improvement Act (IHCIA) (p. 4). Highlights from these discussions are listed here:

- IHS and tribes need to further explore available LTSS resources at the tribal and community levels, which could include coordinating services funded by IHS, the Administration on Aging (AoA), and the U.S. Department of Veterans Affairs (VA) (p. 5).
- IHS and other federal agencies should coordinate access to LTSS and clarify the meaning of “Payer of Last Resort” (p. 6).
- IHS should partner with VA to increase LTSS for veterans (p. 21). It was later noted that the IHCIA updates and modernizes IHS to improve IHS-VA facilitation (p. 29).

Participants also discussed the following recent IHS-VA coordination efforts:

- IHS and VA signed an updated Memorandum of Understanding to help improve IHS-VA veteran care coordination and IHS’ understanding of LTSS that VA already provides (p. 34).
- AoA is working to build a bridge with VA between health care services and supports, and AoA would like to partner with IHS in a similar way (p. 39–40).
- The Cherokee Nation Program of All-Inclusive Care for the Elderly contracts with VA to provide services to veterans in the area (p. 49).

Healthcare Disparities for American Indian Veterans in the United States: A Population-Based Study

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

This article analyzes findings from a comparative, population-based study of Native veterans. Researchers compared Native veterans with non-Hispanic White veterans ages 18 to 64 using 1997 and 2006 survey data from the National Health Interview Survey (NHIS). Comparisons were made under two indicators—health care coverage and access to care (p. 564).

Health care coverage is defined as whether a person was insured or uninsured at the time of the survey. In this study, coverage included private, public (Medicaid, Medicare, State Children's Health Insurance Program, and state-sponsored and government programs), and military insurance through the U.S. Department of Veteran's Affairs (VA). Coverage did not include Indian Health Service (IHS).

Health care access was examined through barriers to care and forgone care. Barriers included reported reasons for delaying care, such as cost; limited office hours; or being unable to get a timely appointment, speak with someone over the phone, or find transportation. Forgone care was defined as health care (medical, mental health, dental, prescription, and vision) that was needed, but was not received due to cost (p. 564). Researchers gained the following insights based on NHIS responses:

- Native veterans were significantly less likely to report private coverage and were more likely to have public or military coverage or be uninsured (p. 564).
- Compared with non-Hispanic White veterans, Native veterans were more likely to delay care, because they could not get timely appointments or they had limited to no transportation (p. 564).
- Native veterans were nearly twice as likely to be uninsured compared to non-Hispanic White veterans (p. 566). Consequently, Native veterans were more likely to forego medical, dental, prescription, and vision care because of cost (p. 565).
- Native veterans were more likely to use IHS for health care needs, rather than VA, due to several factors, including cultural sensitivity, racial discrimination, and geographic location (p. 567).

As a population-based study, these results identified significant trends and relationships pertaining to Native and non-Hispanic White veterans. However, researchers acknowledge certain limitations around NHIS data. For example, this study was limited to honorably discharged, self-reported veterans (p. 564). Additionally, American Indians and Alaska Natives tend to be underrepresented in national surveys, because data collection produces greater numbers for urban areas, and a significant number of American Indians and Alaska Natives reside on rural reservations (p. 568). Even with these limitations, this study encourages further understanding of veterans' health care coverage and access in varying circumstances.

Rural Native Veterans in the Veterans Health Administration: Characteristics and Service Utilization Patterns

Kaufman, C. E., Brooks, E., Kaufmann, L. J., Noe, T., Nagamoto, H. T., Dailey, N., . . . Shore, J. (2013). Rural Native veterans in the Veterans Health Administration: characteristics and service utilization patterns. *The Journal of Rural Health, 29(3)*, 304-310. doi:10.1111/j.1748-0361.2012.00450.x

This article was created in response to the U.S. Department of Veterans Affairs and Indian Health Service's (IHS) goal of improving health care for Native veterans. The authors largely focus on comparisons between demographic and service-related characteristics of rural Native and non-Native veterans.

Little research exists regarding rural Native veterans' health care, and this analysis is the first to look at rural Native veterans' use of Veterans Health Administration (VHA) services (p. 308). The findings of this analysis demonstrate many distinctions between rural Native veterans and rural non-Native veterans (p. 308), summarized as follows.

- Native veterans are more likely to live in highly rural areas than non-Native veterans (p. 308).
- Rural Native veterans are younger, more likely to have served recently, and more likely to be female compared to rural non-Native veterans (p. 308).
- Rural Native veterans earned similar median incomes to rural non-Native veterans (p. 308).
- Rural Native veterans have fewer diagnoses on average, but higher levels of combat service and service-connected disabilities compared to rural non-Native veterans (p. 308–309).

The authors noted that their findings were limited in several ways, including:

- Challenges to the accuracy and consistency of patients' racial identifications;
- The use of ZIP codes to define rurality, which do not accurately distinguish between areas;
- The limitation of data for veterans who access VHA services, and the likelihood that many Native veterans only receive care from IHS or non-VHA sources; and
- The lack of VHA data on barriers to care, use of IHS or other medical services, or cultural dimensions of health, such as tribal affiliation or cultural practices (p. 309).

Despite these limitations, this analysis is the first to describe rural Native veterans' health care access, providing broader information on Native veterans' health and service use, which will assist future VA-IHS collaborative efforts to provide appropriate care for this population (p. 304).

American Indian Veterans and VA Services in Three Tribes

Kaufman, C. E., Kaufman, L. J., Shangreau, C., Dailey, N., Blair, B., & Shore, J. (2016). American Indian veterans and VA services in three tribes. *American Indian and Alaska Native Mental Health Research, 23*(2), 64-83. doi:10.5820/aian.2302.2016.64

This article provides a qualitative analysis of American Indian and Alaska Native (AI/AN) experiences with U.S. Department of Veterans Affairs (VA) health services and facilities. The study focuses on three culturally and geographically distinct tribal communities in the Northern Plains, Northwest, and Oklahoma regions of the United States. This community-based, participatory research used focus groups and individual interviews to identify core themes found among Native veterans' experiences, access to care, and levels of support within VA's system. The survey included 42 tribal member participants, including veterans, community advocates, and family members (p. 65-67).

This report presents valuable local perspectives that reveal models of practice where effectiveness is determined by local circumstances. For example, one VA facility in close proximity to an urban or suburban center generated positive experiences compared to facilities in rural areas where a lack of reliable transportation prevented access to care (p. 71). The study found several commonalities among participants, summarized as follows.

- Tribal members, communities, and partners lacked care coordination between VA and other AI/AN health providers, like the Indian Health Service (IHS). Eligibility procedures and requirements were not always clearly communicated, creating an ill-defined and discouraging system (p. 72).
- Many participants indicated frustration, distrust, dissatisfaction, and anger with VA services and personnel who overlooked Native veterans' concerns, and that these experiences began once they transitioned from active duty to civilian life (p. 70).
- Local advocacy by family, community members, and tribal governments and organizations was necessary. These advocates were often trusted figures with a complete understanding of the individual, the local Native veteran population, and factors that influence resource availability for this community (p. 76).
- AI/ANs have long been victims of systematic deculturation, resulting in issues related to kinship and intergenerational trauma. Post war experiences create more anguish for Native veterans and families, which can further dismantle kinship (p. 74-75).

While most of the article discusses problematic features of VA's system, valuable lessons can be learned from this research approach. The researchers realized these discussions provided an opportunity for Native veterans to tell their stories and engage in some level of personal healing. They also brought up key elements of consideration for anyone who works with this particular population, as exposure to these personal experiences can help improve a primary source of veteran health care.

Improving Access to Noninstitutional Long-Term Care for American Indian Veterans

Kramer, B. J., Creekmur, B., Cote, S., & Saliba, D. (2016). Improving access to noninstitutional long-term care for American Indian Veterans. *Journal of the American Geriatrics Society*, 63(4), 789-796. doi:10.1111/jgs.13344

This article describes the emerging models for home-based primary care (HBPC) as an innovative, collaborative, and noninstitutional long-term care service for Native veterans. The research primarily focuses on rural Native veterans who have limited to no access to Veterans Affairs Medical Centers (VAMCs). In most cases, these individuals get health services from Indian Health Service (IHS) or tribal health programs; however, these facilities can be limited by funding or unable to provide treatment on service-related injuries and conditions (p. 2–3). VAMCs deploy HBPC models to supplement these deficiencies through tribal or IHS partnerships, reimbursements to tribes, facility-based programs, streamlined staffing, mobile clinics, and purchased care (p. 5–6).

Using a series of interviews and surveys from 14 VAMC collaborations with IHS or tribal programs, the researchers identified the HBPC benefits in Indian Country listed below. These benefits speak to developing positive working relationships between federal agencies and tribal communities.

- HBPC emphasizes case management and holistic approaches that treat individuals in their homes, making it an ideal clinical program for VAMCs to test co-management strategies. This testing is particularly important given the level of cultural sensitivity and respectful approaches needed to work with American Indians and Alaska Natives (AI/ANs) (p. 9).
- HBPC reduces the stigma associated with federal programs, which is especially important when most AI/ANs are skeptical of federal agencies. Securing the trust of tribal communities is essential to ensure the sustainability and longevity of a program (p. 8–9).
- HBPC programs reach out to tribal communities, rather than expecting them to come to VAMC facilities, which is a significant gesture given the transportation issues found among remote households. Additionally, HBPC offers long-term care in AI/ANs' homes where they are most comfortable and prefer to be (p. 7–9).
- HBPC allows federal agencies, including the U.S. Department of Veterans Affairs and IHS, to fulfill their respective obligations to their communities. Through an expansion to include non-Native veterans, VA can use HBPC programs to serve rural veterans within the AI/AN service area. IHS can also uphold its federal treaty obligation to provide AI/ANs, namely Native veterans, with health services (p. 9).

While significant lessons can be learned from this analysis, it is important to note that the sample is not large enough to make general conclusions about HBPC programs in Indian Country. Nevertheless, the HBPC programs presented here are promising examples of interagency, intergovernmental, and co-management initiatives that utilize national and local resources for a common purpose.

Do Correlates of Dual Use by American Indian and Alaska Native Veterans Operate Uniformly Across the Veterans Health Administration and the Indian Health Service?

Kramer, B. J., Jouldjian, S., Wang, M., Dang, J., Mitchell, M. N., Finke, B., & Sailba, D. (2011). Do correlates of dual use by American Indian and Alaska Native veterans operate uniformly across the Veterans Health Administration and the Indian Health Service? *Journal of General Internal Medicine*, 26(Suppl. 2), 662-668. doi:10.1007/s11606-011-1834-2

This report looks into the efforts of Indian Health Service (IHS) and the U.S. Department of Veterans Affairs Veterans Health Administration (VHA) to increase Native veterans' access to health care. Specifically, the authors aim to inform policy and practices involved with improving Native veterans' access to health care (p. S622). In this report, the authors looked at patient- and organizational-level factors to determine Native veterans' likelihood of accessing services from both agencies (p. S662).

Patient factors included demographic and clinical characteristics, and organizational factors reviewed the agencies' structures and strategies to improve access (p. S662). The authors created two models of comparison to see how these factors might influence which agency's services a patient might access (p. S666).

While there were notable similarities and differences between the two models, the findings were contradictory (p. S665). For example, old age was significant to patients using IHS and VHA services compared to IHS services only, but not VHA use only (p. S665). Further, the authors note that organizations may characterize the same potential population of IHS-VHA dual users differently, which could affect their planning efforts (p. S666).

While IHS-VHA dual use may extend the range of resources available for Native veterans, it can also duplicate efforts, cause treatment conflicts, and introduce other inefficiencies (p. 667). Regarding policy considerations, the authors note the following characteristics:

- Native veterans who access IHS and VHA services are more likely to be:
 - Younger and less likely to need intensive health care resources than those who only access VHA health care services, and
 - Older and more likely to need intensive health care resources than those who only access IHS health care services (p. 667).
- IHS may already be serving a segment of the increasingly younger VHA user-population (p. 667).
- Over time, Native veterans access health care services from IHS, VHA, and the U.S. Department of Defense (p. 667).

Health Care for American Indian & Alaska Native Women: The Roles of the Veterans Health Administration and the Indian Health Service

Kramer, B. J., Jouldjian, S., Washington, D. L., Harker, J. O., Saliba, D., & Yano, E. (2009a). Health care for American Indian and Alaska Native women: the roles of the Veterans Health Administration and the Indian Health Service. *Women's Health Issues, 19(2)*, 135-143. Retrieved November 29, 2016, from http://www.rand.org/pubs/external_publications/EP20090332.html

This article discusses American Indian and Alaska Native (AI/AN) women's use of the U.S. Department of Veterans Affairs Veterans Health Administration (VHA) and Indian Health Service (IHS). Participants in the study included female veterans and non-veterans who were enrolled members of federally recognized tribes and received services from VHA, IHS, or both systems over a 2-fiscal-year period (FY2002 and FY2003). Women composed 5,856 (9.0%) of the 64,746 AI/ANs seen across both health care organizations during this time.

The researchers identified participants as VHA, IHS, or dual users and categorized them as either veterans or non-veterans who were eligible for VHA programs (p. 137–138). Findings from this study provide a descriptive summary on the types of care female Native veterans receive and which system they are likely to use, including the following significant usage correlations:

- Primary care and general medical service use among veteran dual users were nearly split in half, with 46.7% of users going to VHA and 53.3% going to IHS; however, VHA had greater usage rates for specialty care, including diagnostic services, surgical procedures, and mental health (p. 139).
- Among health encounters for VHA and IHS, the top three most frequent diagnoses for female Native veterans were hypertension, diabetes, and depression. Post-traumatic stress disorder was only a leading diagnosis for VHA facilities (p. 139).
- Roughly 23.3% of all female Native veterans' inpatient hospital stays were for psychiatric conditions that were primarily treated at VHA facilities, and 15.9% of these inpatient stays were for OB/GYN conditions that were primarily treated through IHS (p. 139).

Most of the study participants could receive dual VHA-IHS services, but had varying experiences on accessing care and navigating the two systems. The researchers discussed factors that influence Native veterans' treatment and coordinated care outcomes, including strong facilitation of national, tribal, and local initiatives to implement existing agreements and encourage further collaboration. These initiatives include a 2003 VHA and IHS Memorandum of Understanding to improve Native veterans' health and access to care and increase resource sharing (p. 136). Care coordination will be particularly beneficial as women's military roles expand. It will be in VHA and IHS' interest to identify their respective strengths for serving female Native veterans and offer supplemental resources to each other to create a single, all-inclusive health service system (p. 142).

Dual Use of Veterans Health Administration and Indian Health Service: Healthcare Provider and Patient Perspectives

Kramer, B. J., Vivrette, R. L., Satter, D. E., Jouldjian, S., & McDonald, L. R. (2009b). Dual Use of Veterans Health Administration and Indian Health Service: healthcare provider and patient perspectives. *Journal of General Internal Medicine*, 24(6), 758-764. doi:10.1007/s11606-009-0962-4

This report examines stakeholders' perspectives on Native veterans' dual use of health care services from Indian Health Service (IHS) and the U.S. Department of Veterans Affairs Veterans Health Administration (VHA) (p. 758). The authors conducted focus groups to research behavioral factors that affect Native veterans' dual use and primary care preferences, IHS-VHA care coordination, and providers' interest levels in fostering closer VHA-IHS collaboration (p. 759).

The Native veteran, VHA staff, and IHS staff participants had varied perspectives regarding IHS-VHA care coordination and use preferences. For example, the Native veterans did not largely distinguish between IHS or VHA for primary care, while VHA clinicians tend to view IHS clinicians as the primary providers (p. 761). The Native veterans were more likely to match their health care resources to their medical needs, primarily using IHS and reserving VHA to access specialty care, supplement IHS, and save IHS money since IHS funds are limited (p. 760).

The VHA providers noted that care provision limitations can prevent them from being able to provide comprehensive services for Native veterans, which may lead them to seek IHS services (p. 760). Meanwhile, IHS providers said they actively refer Native veterans to VHA for specialized services. These referrals garnered mixed opinions of appreciation and frustration from the Native veterans, as medical information is not routinely shared between providers and many of the Native veterans found the medical release process burdensome (p. 761). Providers also lack awareness of the other system's policies, structures, and resources (p. 762), resulting in:

- Provider frustration in trying to treat chronic conditions,
- Longer patient visits,
- Duplicated care,
- Delays in treatment, and
- Resource shortages at IHS and tribal facilities (p. 761).

The focus group indicated little coordination between IHS and VHA, though the participants were interested in further collaborative efforts and suggested several recommendations to foster closer VHA-IHS collaboration and improve accountability (p. 762).

Identification of American Indian and Alaska Native Veterans in Administrative Data of the Veterans Health Administration and the Indian Health Service

Kramer, B. J., Wang, M., Hoang, T., Harker, J. O., Finke, B., & Saliba, D. (2006). Identification of American Indian and Alaska Native veterans in administrative data of the Veterans Health Administration and the Indian Health Service. *American Journal of Public Health, 96(9), 1577-1578.* doi:10.2105/AJPH.2005.073205

This study evaluates the accuracy of how Indian Health Service (IHS) identifies veteran enrollees who also use the U.S. Department of Veterans Affairs Veterans Health Administration (VHA). This article comes after IHS and VHA initiated a partnership to improve their care coordination and resource sharing for Native veterans.

The study states that, despite high rates of American Indian and Alaska Native (AI/AN) military participation reported in the U.S. 2000 Census, the number of veterans served by VHA and IHS is unknown (p. 1). The report indicates neither VHA nor IHS have mechanisms in place to identify veteran enrollees of each other's systems. As a result, the study analyzed and compared veteran status from the VHA National Patient Care Database and the IHS National Patient Information Reporting System (IHS-NPIRS) administrative records.

The study linked IHS veterans' data through social security numbers and IHS records of active and non-active users for enrollees ages 18 years and older to match VHA records in outpatient, inpatient, and fee-based files between fiscal years 2002 and 2003 (p. 1). The results of the study identified a total of 37,170 AI/AN IHS enrollees who received VHA care during these fiscal years (p.1).

The study found significant differences in how IHS and VHA identified veterans (p. 1). While VHA verifies past military service as a condition of enrollment, IHS-NPIRS uses unverified, self-reported veteran identification for eligibility. Less than half of IHS self-reported records matched VHA records on verified military experience. For this study, VHA's verified data was used as a standard for comparison, showing that veterans are significantly underrepresented in IHS data (p. 1). The inability to identify veterans within IHS service populations limits treatment options and VHA referrals (p. 1). It also prevents VHA from partnering with IHS as a community provider, undermining IHS and VHA's care coordination and resource sharing abilities (p.1).

The study recommends identifying IHS veteran enrollees as the first step in determining VHA and IHS processes and planning. The authors recommend a focused campaign to improve the identification and coding of IHS veterans (p. 2). Sharing information and improving coordination are key elements to improving the quality of Native veterans' health care between IHS and VHA.

Shared Homes as an Alternative to Nursing Home Care: Impact of VA's Medical Foster Home Program on Hospitalization

Levy, C. R., Alemi, F., Williams, A. E., Williams, A. R., Wojtusiak, J., Sutton, B., . . . Argyros, L. (2016). Shared homes as an alternative to nursing home care: impact of VA's Medical Foster Home program on hospitalization. *Gerontologist*, 56(1), 62-71. doi:10.1093/geront/gnv092

This study compares the hospitalization rates for common conditions in the U.S. Department of Veteran Affairs (VA) Medical Foster Home (MFH) program to VA nursing homes, also known as Community Living Centers (CLCs). The study used a nested, matched, case control design to examine 817 MFH residents and compare each resident to 3 CLC residents. MFH and CLC residents were matched based on several criteria, including a baseline time period, a follow-up time period, demographical characteristics, the risk of mortality calculated from comorbidities, and the history of hospitalization for the selected condition during the baseline period (p. 1).

The study compared MFH cases to CLC controls across 14 categories, including adverse medical care and a variety of disorders and medical conditions. The researchers found that, when compared with CLC-matched controls, the MFH residents experienced fewer hospitalizations for mental health problems, such as anxiety and mood disorders. Hospitalization was not significantly higher among the MFH residents for any of the conditions measured (p. 4–6).

The authors suggest that steady hospitalization rates may reflect the stability provided by consistent caregivers in smaller environments. The authors also suggest that given fewer residents, there is a reduced opportunity for infections to spread (p. 6–7). Multiple authorities, including the Centers for Medicare & Medicaid Services, consider pressure ulcers to be an important marker of quality of care. The study revealed that MFH residents experience fewer hospitalizations for pressure ulcers than the control groups, suggesting a higher quality of care (p. 7–8).

Overall, the authors find that residence in the MFH program does not appear to increase hospitalization for common medical conditions compared with traditional VA nursing home care. This study is limited to predominantly male veterans who are prone to chronic illness, and the results may not translate to other population groups (p. 8). However, if the findings from the study are replicable, and the outcomes are favorable, MFH may be a safe alternative to nursing home care to study the qualities of caregivers and their contributions to resident outcomes (p. 8).

Providing Culturally Competent Services for American Indian and Alaska Native Veterans to Reduce Health Care Disparities

Noe, T. D., Kaufman, C. E., Kaufman, L. J., Brooks, E., & Shore, J. H. (2014). Providing culturally competent services for American Indian and Alaska Native veterans to reduce health care disparities. *American Journal of Public Health, 104*(S4), S548-S554. doi:10.2105/AJPH.2014.302140

Cultural competency is essential to programs or organizations that serve American Indians and Alaska Natives (AI/ANs). When it comes to Native veterans' health, there is a significant correlation between health outcomes and the providers and facilities' abilities to provide culturally competent care. This article explores these correlations to determine what organizational characteristics help create culturally competent services for Native veterans in U.S. Department of Veterans Affairs (VA) health facilities.

Using an adapted Organizational Readiness to Change Assessment, researchers surveyed 27 VA facilities to assess their organizational readiness and capacity to adopt and implement AI/AN-specific services and identify existing Native veteran programs for each facility. The study also gauged stakeholder interest in developing AI/AN-specific programs that address growing health disparities. The assessment addressed four specific areas—Needs, Leadership, Resources, and Organizational Climate—and was conducted with 135 respondents representing various positions within the 27 facilities (p. S549–S550).

Researchers identified facility, personnel, and organizational characteristics that respondents felt were necessary for VA facilities to properly serve Native veterans. These characteristics, summarized below, influence VA facilities' levels of cultural competency and readiness for AI/AN-specific programs.

- Facilities need to clearly define their missions and establish staff and organizational goals for new programs. They also need to provide supportive communication, documentation, and financial structures to ensure smooth operation. Facilities must be able to evaluate program and staff performance and identify strengths and areas that need improvement (p. S552).
- Senior leadership or clinical managers need to propose feasible new projects, provide clear goals for improvement in patient care, establish project schedules and deliverables, and delegate tasks to the appropriate support staff (p. S552).
- As a whole, organizations should be able to provide venues for open and secure discussions about issues and challenges, especially as they pertain to management. Organizations must keep staff well informed and continuously develop formal and informal modes of communication (p. S552).

The researchers realize that further evaluation on this topic is needed; however, these preliminary results provide important guidance for the adoption and creation of AI/AN-specific programs and services. They may also be generally referenced to create other VA population- or group-specific services to increase their effectiveness and responsiveness to Native veterans' health care needs.

American Indian Veterans' Views about Their Choices in Health Care: VA, IHS, and Medicare

Reifel, N., Bayhille, R., Harada, N., & Villa, V. (2009). American Indian veterans' views about their choices in health care: VA, IHS, and Medicare. *American Indian Culture and Research Journal*, 33(3), 23-33. doi:<http://dx.doi.org/10.17953/aicr.33.3.b352774775510522>

Native veterans have several options for accessing health services depending on their eligibility and geographic location, including Indian Health Service (IHS) and the U.S. Department of Veterans Affairs (VA). They can also access non-federal or private practice health centers using public or private insurance, including Medicare, Medicaid, or employer-based coverage. This article discusses these options and Native veterans' preferences for using IHS, VA, or a combination of systems to serve their health care needs.

Through nine group interviews, researchers spoke with 85 male Native veterans from rural and urban Southern California and Southern Nevada communities. A written questionnaire was also used to gather data on participant health status, use of ambulatory care, cultural and military identity, and perceptions of IHS and VA health systems (p. 24–25). Within this group of veterans, 18 used VA, 23 used IHS, 17 used private practices, 3 used a combination of services, and 6 did not use any of the services (p. 26).

The study identified common VA and IHS characteristics, particularly pertaining to Native veterans. American Indians and Alaska Natives have long relied on IHS to meet their health care needs, using more than 550 hospitals and clinics on tribal lands and in urban centers. IHS facilities provide many culturally sensitive resources that make treatment more effective, though they are often underfunded. These resources include holistic approaches to healing through traditional medicine. Many participants appreciated the fact that IHS operates on a communal level and caters services to specific cultural characteristics (p. 28–29). In a similar regard, participants also recognized VA and its veteran-oriented system of care.

Native veterans can use VA facilities and programs. Some use VA because of their military service to the country. VA has the capacity and training to treat combat-related physical and psychological ailments. Treatments are based on extensive research and include methods on coping with post-traumatic stress and exposure to harmful chemical elements, like radiation. Much like how IHS considers culture and tradition in its delivery of care, VA incorporates combat-related conditions (p. 27–28).

Among the participants, 63 indicated using public or private insurance at IHS, VA, or private practice facilities. Most Native veterans considered private sector care as an individual service that is not designed to meet the needs of a specific community (p. 30). As such, they appreciate the specific type of care IHS and VA offer. They recognize that their decision to use one or both of these systems ensures the vitality and responsiveness of the service. The authors suggest that IHS and VA consider Native veterans' perspectives as they modernize their services and adapt to changing conditions (p. 30–31).

Review of American Indian Veteran Telemental Health

Shore, J., Kaufmann, L. J., Brooks, E., Bair, B., Dailey, N., Richardson, Jr., W. J., . . . Manson, S. (2012). Review of American Indian veteran telemental health. *Telemedicine and e-Health*, 87-94. doi:10.1089/tmj.2011.0057

This article reviews American Indian Telemental Health Clinics, the clinic model, and literature about these clinics to present lessons learned while establishing, maintaining, and evaluating the clinics (p. 87–88). The telemental health clinics were established in April 2002 to improve the mental health care of rural American Indian veterans. The pilot clinic began on the Rosebud Sioux Reservation through a collaboration between five organizations, including the U.S. Department of Veterans Affairs (VA), the University of Colorado Denver, and the Rosebud Sioux Tribe (p. 89).

The authors briefly summarize literature that documents the ongoing development, implementation, and expansion of these clinics. Following are a few highlights from the authors' findings regarding the operation of telemental health clinics for American Indian veterans.

- **Cultural inclusion** – Culturally specific care provided through culturally knowledgeable providers, onsite tribal outreach workers, and collaborations with community services proved essential in operating the clinics, as did building rapport, trust, and engagement with the target patient population (p. 87).
- **Collaboration** – Clearly defined roles are essential for multi-organizational collaborations to implement care that can be tailored for specific, remote populations (p. 89).
- **Building relationships** – Individual patient-provider relationships and relationships with the local tribal community are equally important to successful treatment outcomes (p. 91).

The authors note that more data on telemental health is needed to gain a better understanding of its implications for rural American Indian veterans to better assess the following areas:

- Specific assets and liabilities of patient-provider interactions for telemental health,
- Family and community consequences of post-traumatic stress disorder,
- Potential wider social consequences of post-traumatic stress disorder treatment for rural veterans through direct delivery and community-based treatment needs, and
- The cost and economics associated with this clinic model (p. 92).

The authors hope that the lessons learned and practices presented can serve as a model to help other efforts to improve health care for rural Native and non-veteran populations (p. 93).

Memorandum of Understanding Between the Department of Veterans Affairs and Indian Health Service

U.S. Department of Veterans Affairs. (2010). *Memorandum of Understanding Between the Department of Veterans Affairs (VA) and Indian Health Service (IHS)*. Retrieved November 29, 2016, from https://www.va.gov/TRIBALGOVERNMENT/docs/Signed2010VA-IHSMOU_r.pdf

This Memorandum of Understanding (MOU) between the U.S. Department of Veteran Affairs (VA) and Indian Health Service (IHS) outlines the authority of and activity sharing efforts toward improving Native veterans' health. The MOU explains the purpose, background, and goals created to combine VA and IHS' missions and goals to support Native veterans.

The MOU sets forth 5 goals:

- Increase access to and improve the quality of health care provided by VA and IHS (p. 2).
- Promote patient-centered collaborations among VA, IHS, Native veterans, tribal facilities, and urban Indian clinics (p. 2).
- Establish effective VA-IHS partnerships to support Native veterans (p. 2).
- Identify and make available appropriate resources to support Native veteran programs (p. 2).
- Improve health-promotion and disease-prevention services to address community-based wellness (p. 2).

The MOU further supports VA and IHS goals by collaborating and coordinating on the following efforts:

- Increase access to IHS and VA services and benefits by training appropriate VA and IHS staff on each agency's benefits and services (p.2).
- Improve care coordination and co-management for Native veterans served by VA, IHS, tribal, and urban Indian health programs by developing innovative approaches to care and best practices.
- Improve care for Native veterans by sharing health information technology.
- Enhance Native veterans' access to care through the use of new technologies, like tele-health services, mobile communications, and telecommunication support for remote areas (p. 3).
- Improve the efficiency and effectiveness of VA and IHS at the system level (p. 3).
- Increase care providers' cultural awareness and culturally competent care practices (p. 4).
- Address VA and IHS' emergency and disaster preparedness response and plans (p. 4).
- Develop a joint task force to accomplish the MOU goals (p. 5).

In addition, the MOU highlights all applicable federal laws and regulations with which VA and IHS will need to comply following this agreement (p. 5–6).

Department of Veterans Affairs Tribal Consultation Policy

U.S. Department of Veterans Affairs. (2011). *Department of Veterans Affairs Tribal Consultation Policy*. Retrieved November 29, 2016, from https://www.va.gov/TRIBALGOVERNMENT/docs/VA_Tribal_Consultation_Policy.pdf

This report explains the U.S. Department of Veterans Affairs (VA) tribal consultation policy with Native tribal governments, which establishes positive government-to-government relations and meaningful consultation procedures (p. 1). The report provides definitions to tribes, tribal organizations, and other tribal entities that work closely with tribes and VA (p. 1–2).

The report details a set of principles for the foundation set between VA and tribal governments, which include the following:

- Protect and respect confidentiality (p. 2),
- Recognize and respect tribal sovereignty (p. 2),
- Maintain government-to-government relations (p. 2),
- Efficiently address tribal issues and concerns (p. 2),
- Strive for meaningful collaborations and mutual resolutions (p. 3),
- Enhance respectful communication and positive relations (p. 3), and
- Include informal communication outside the consultation process (p. 3).

In addition to the list of principles, VA created the following protocols to follow when working with tribal governments:

- VA must understand the importance of tribal sovereignty and the unique political relationship between American Indian and Alaska Native (AI/AN) governments and the federal government (p. 3).
- VA must understand collaborative efforts and processes that work toward a common set of goals when interacting with AI/AN tribes (p. 3).
- VA will communicate possible decisions that may affect tribes in accordance with this policy, aiming to reach a consensus with AI/AN tribal representatives (p. 3).
- Tribal consultations function as forms of communication that emphasize trust and respect (p. 4).

The report also explains additional consultation provisions, such as the role of work groups (p.4) and further details on consultation procedures (p. 5). Lastly, the report explains limitations to the consultation process and that no legal rights will diminish federal and tribal laws, rights, and remedies available to VA or tribes (p. 6).

American Indian and Alaska Native Servicemembers and Veterans

U.S. Department of Veterans Affairs. (2012). *American Indian and Alaska Native Servicemembers and Veterans*. Retrieved November 29, 2016, from https://www.va.gov/TRIBALGOVERNMENT/docs/AIAN_Report_FINAL_v2_7.pdf

The U.S. Department of Veterans Affairs (VA) compiled this report to compare demographic, socioeconomic status, and health characteristics of Native veterans and servicemembers with those of all other races.

The following list is a summary of findings for Native servicemembers and servicemembers of the general population.

- Nearly 50% of Native servicemembers were age 24 or younger, compared to 35% of all other servicemembers, and fewer Native servicemembers fell into the 35 to 44 age group compared to all other servicemembers (p. 6–7).
- American Indians and Alaska Natives (AI/ANs) had more female servicemembers than servicemembers of all other races (p. 7).
- Nearly 50% of Native servicemembers served in the Navy, compared to 14% of all other servicemembers, and fewer served in the Army, Army National Guard, Army Reserve, and Air Force than all other servicemembers (p. 8).
- Servicemembers of all other races were 2.5 times more likely to be officers than AI/ANs (p. 9).
- More AI/ANs served 5 or fewer years, while less than half of AI/ANs served 20 or more years compared to all other servicemembers (p. 9–10).

The following list is a summary of findings for Native veterans and veterans of the general population.

- Higher percentages of Native veterans served more recently, during the pre-911 Gulf War period, and the Vietnam Era than veterans of all other races (p. 13).
- Native and Black non-Hispanic veterans had the lowest median personal incomes, while Asian, Native Hawaiian, and other Pacific Islander non-Hispanic veterans had the highest (p. 17).
- Fewer Native veterans finished a bachelor's degree or higher compared to veterans of all other races (p. 18).
- More Native veterans were unemployed and fewer were out of the labor force, compared to all other veterans, possibly because Native veterans were younger than all other veterans (p.19).
- Native veterans were more likely to use VA (p. 21), more than twice as likely to not have health insurance (p. 22), and more likely to have a disability than all other veterans (p. 23).

Data for this report was pulled from the U.S. Census Bureau American Community Survey 2010 Public Use Microdata Sample and the U.S. Department of Defense Manpower Data Center's Active Duty Master Personnel File and Reserve Components Common Personnel Data System.

American Indian and Alaska Native Veterans: 2013 American Community Survey

U.S. Department of Veterans Affairs. (2015a). *American Indian and Alaska Native Veterans: 2013 American Community Survey*. Retrieved November 29, 2016, from <https://www.va.gov/vetdata/docs/SpecialReports/AIANReport2015.pdf>

Native veterans have contributed significantly to the U.S. military for over 200 years. The U.S. Department of Veterans Affairs created this report to compile comprehensive demographic, socioeconomic status, and health characteristics of this population compared to veterans of all other races.

The following list summarizes the report's demographic findings.

- More Native veterans were female compared to the percentages of female veterans for all other races (p.4).
- Native veterans were younger than veterans of all other races, with a median age of 57.8 (p. 5).
- More Native veterans served post-9/11 than veterans of all other races (p. 6).
- More Native veterans lived in the Western United States than veterans of all other races, with 44% living in California, Oklahoma, Arizona, Texas, New Mexico, and Washington (p. 9).

The following list summarizes the report's socioeconomic findings.

- Native veterans had the lowest median personal incomes than veterans of all other races, while Native Hawaiian, other Pacific Islander, and Asian veterans had the highest (p.11).
- More Native veterans had some college credit than veterans of all other races, but fewer obtained advanced degrees (p. 12).
- Native veterans and veterans of all other races were similarly employed, unemployed, or out of the labor force (p. 13).

The following list summarizes the report's health findings.

- Native veterans were more likely to use VA and be covered by public plans than veterans of all other races, but Native veterans were more than twice as likely to be uninsured (p. 15–16).
- More Native veterans were likely to have a disability, service-connected or otherwise, than other veterans (p. 2).

Data for the report was pulled from the Census Bureau American Community Survey 2013 Public Use Microdata Sample. The report also defines American Indian and Alaska Native geographic areas (p. 20) and provides a brief overview of Native veterans' contributions during previous wars (p. 23–24).

MyVA Integrated Plan

U.S. Department of Veterans Affairs. (2015b). *MyVA Integrated Plan (MIP)*. Retrieved November 29, 2016, from <http://www.gao.gov/products/GAO-13-354>

This report provides an overview of significant challenges and changes needed to improve the U.S. Department of Veterans Affairs (VA) services and benefits delivery system for veterans. The report discusses VA's new MyVA approach, which allows veterans to be in control of their care delivery services. VA discusses the importance of returning to its simple mission: serving veterans through a veteran-centered institution.

The report discusses the challenges VA faces with increasing demands for services and benefits. In 1975, there were 2 million veterans over the age of 65. By 2017, that number is expected to be near 10 million, with a majority of veterans having served in the Vietnam era (p. 1).

The report also highlights VA crises related to patient wait times, financial management missteps, and the lack of confidence within VA. The report details how VA is reorganizing its functions to fit veterans' needs. Based on the direction of Secretary Bob McDonald's movement toward building a high-performing organization, the outline includes the following goals:

- Improve veterans' experiences,
- Improve employees' experiences,
- Achieve excellence in support services,
- Establish a culture of continuous performance improvement, and
- Enhance strategic partnerships.

The report also breaks down MyVA for veterans, employees, and citizens and discusses the following goals that will extend into and beyond 2017:

- Improve customer service practices for easy access to care and services (p. 4),
- Engage and empower VA employees through leadership and training programs (p. 5),
- Improving the efficiency of VA internal operations (p. 5),
- Standardize performance measurements (p. 6), and
- Enhance collaborations with stakeholders (p. 6).

VA is working toward transformation, which will take time. The MyVA initiative provides VA with an opportunity to circle back to its simple mission of serving veterans. With MyVA, veterans will have personalized VA health care services, programs, and resources.

Report on Enhancement of Collaboration Between the Department of Veterans Affairs and the Indian Health Service

U.S. Department of Veterans Affairs. (2015c). *Report on Enhancement of Collaboration Between the Department of Veterans Affairs and the Indian Health Service*. Retrieved November 29, 2016, from https://www.va.gov/TRIBALGOVERNMENT/docs/S-D_Ltrs_w_Encls.pdf

In this report, the U.S. Department of Veteran Affairs (VA) reviews its collaboration with the Indian Health Service (IHS) on reimbursement agreements between VA, IHS, tribally operated health programs (THPs), and urban Indian health programs to improve access to health care by expanding veterans' health care options. VA's Veteran Health Administration (VHA) delivers health care to nearly 9 million veterans (p. 5). The report discusses the challenges veterans face when services are unavailable within their VA networks, medical centers prevent veterans from receiving timely care, and travel distances negatively impact their access to health care (p. 5).

For the past 3 years, VA, IHS, and THPs have had collaboration agreements where VA reimburses IHS and THPs for direct health care services provided to eligible American Indian and Alaska Native veterans. The report highlights the Alaska THP-VA partnership. As a vast, rural state, Alaska has few VA facilities, which limits its veterans' access to care. In January 2015, IHS and VA covered 108 IHS facilities, and VA successfully negotiated 81 direct care THP service reimbursement agreements. Since December 5, 2012, reimbursements have exceeded \$24 million, covering over 5,500 eligible veterans (p.6).

Using the same reimbursement agreement framework, VA, IHS, and THPs will discuss opportunities to increase health care delivery across Indian Country to all eligible, enrolled veterans. VA and IHS considered the following issues for the terms of these agreements:

- Wait times for veterans, particularly for primary and specialty care, oral health, behavioral health, alcohol/substance abuse treatment, and rehabilitation (p. 6);
- Travel distances to the nearest VA facility (p. 7);
- IHS and THPs' interest in and ability to provide care to all eligible enrolled veterans in their communities (p.7); and
- Urban Indian health programs' interest in and capacity to potentially serve as veteran health care access points (p.7).

Based on the success of existing VA, IHS, and THP partnerships in providing health care services to veterans in Alaska, VA and IHS further advise VA to utilize IHS and THPs to provide direct health care services to eligible veterans. These services would improve access to care, expand access to care that is closer to home, and reduce appointment wait times. The report also provides a supplemental consultation report with comments and questions from tribal leaders on partnership agreements (p. 11).

Proposed Rule: Recognition of Tribal Organizations for Representation of VA Claimants

U.S. Department of Veterans Affairs. (2016, July 20). *Proposed Rule: Recognition of Tribal Organizations for Representation of VA Claimants, 81 Fed. Reg. 47087 (to be codified at 38 C. F. R. 14)*.

The U.S. Department of Veterans Affairs (VA) is proposing to amend regulation 38 CFR Part 14, which concerns recognition of certain national, state, regional, and local organizations for purposes of VA claims representation (p. 47,088). VA hopes to address the needs of American Indian and Alaska Native populations that may not be utilizing Veterans Service Organizations (VSOs) due to geographic isolation, cultural barriers, or a lack of familiarity with VSOs (p. 47,088).

Through this proposed rule, VA intends to improve Native veterans' access to benefit claims assistance through VA-recognized VSOs (p. 47,088). If 38 CFR Part 14 is amended, the Secretary of VA would be able to:

- Recognize tribal organizations in a similar manner as state organizations and
- Approve tribal government employees as accredited representatives of state organizations, similar to county employees (p. 47,088).

Under the current regulations, any organization, including tribal organizations, may apply for VA recognition as a national, regional, or local organization (p. 47,088). Under this proposed rule, tribal organizations created and funded by tribal governments would no longer need to apply as national, regional, or local organizations (p. 47,088). This proposed rule also affords VA the opportunity to acknowledge and affirm tribal sovereignty and work with tribal organizations that are already serving Native veterans (p. 47,088).

For tribal governments that do not want to establish their own tribal VSO, the rule would also allow a tribal government employee who is not associated with a tribal VSO to become accredited as a representative of a state organization (p. 47,089). VA believes this option will further facilitate veterans' representation across county, state, and tribal borders (p. 47,089).

Department of Veterans Affairs and Indian Health Service Memorandum of Understanding Annual Report, Fiscal Year 2014

U.S. Department of Veterans Affairs Center for Applied Systems Engineering on Behalf of the Office of Rural Health. (2015). *Department of Veterans Affairs (VA) and Indian Health Service (IHS) Memorandum of Understanding (MOU) Annual Report Fiscal Year 2014*. Retrieved November 29, 2016, from file:///C:/Users/yvette.journey/Downloads/2014_VA-IHS_Report.pdf

This report summarizes the Memorandum of Understanding (MOU) between the U.S. Department of Veteran's Affairs (VA) and the Indian Health Service (IHS), including a brief history of the MOU since it was revised in 2010, activities during FY 2014, and next steps. Under the MOU, VA reimburses IHS for services provided to enrolled Native veterans. VA also has separate reimbursement agreements with tribal health programs (THPs). The MOU's implementation is handled through 13 cross-agency, inter-departmental workgroups (p. 4–7), the FY 2014 accomplishments of which are summarized in the report (p. 12–18).

The report lists the Government Accountability Office's recommendations for VA-IHS' implementation process, the National Center for Organizational Development's recommendations for VA-IHS' organizational dynamics, and VA-IHS' efforts to implement them (p. 9–10). The report also emphasizes VA, IHS, and tribal partners' FY 2014 successes through topic-focused, joint workgroups, such as:

- 440,575 prescriptions were transmitted through VA's Consolidated Mail Outpatient Pharmacy to Native veterans served by IHS facilities;
- 18,618 Native veterans and family members were impacted by VA-IHS tribal contacts, outreach events, and training events, and 11,500 contacts were made through suicide prevention outreach activities;
- VA reimbursed IHS and THPs for \$11,377,388 of direct medical care to Native veterans, and 3,759 veterans were served through VA-THP's reimbursement program;
- VA and IHS held 186 shared, clinically related training programs, and 726 trainees attended educational presentations from the Post-Traumatic Stress Disorder Work Group;
- 8 IHS facilities added the Bar Code Medication Administration program to increase patient safety and avoid medication loss;
- 64% of tribal and urban sites and 98% of federal sites using the Electronic Health Record system installed the 2014 certified version;
- VA and IHS piloted an improved method for a direct point-to-point telemedicine connectivity model serving Native veterans (p. 11).

The report concludes with a brief discussion of future opportunities for improvement, including refining outreach strategies, increasing tribal representation in the MOU's implementation, and developing standard performance metrics to accurately assess the MOU's progress (p. 19).

VA and IHS: Further Action Needed to Collaborate on Providing Health Care to Native American Veterans

U.S. Government Accountability Office. (2013). *VA AND IHS: Further Action Needed to Collaborate on Providing Health Care to Native American Veterans*. Retrieved November 29, 2016, from <http://www.gao.gov/assets/660/654223.pdf>

Because Native veterans may access services from the U.S. Department of Veterans Affairs (VA) and the Indian Health Service (IHS), these agencies developed a Memorandum of Understanding (MOU) to improve their collaborative efforts (p. 5). The U.S. Government Accountability Office (GAO) created this report to examine:

- The extent to which the agencies arranged for the MOU's implementation and monitoring and
- Key challenges they faced during this process and their progress toward overcoming them (highlights page).

The agencies formed 12 joint workgroups to address the MOU's goals (p. 8). The agencies also formed a Joint Implementation Task Force to oversee the MOU's implementation (p. 8). Three performance metrics were developed to assess the MOU's implementation (p. 13). GAO found two of these metrics to be inadequate in terms of how they measured progress toward the MOU's goals, which could limit VA and IHS managers' abilities to make key decisions about their programs and activities (p. 13).

The agencies noted three main challenges in implementing the MOU:

- Federally recognized tribes have differing customs and policy-making structures, which present logistical challenges in the widespread implementation of the MOU (p. 17).
- Tribes are not required to participate in MOU-related activities (p. 18).
- Tribal stakeholders indicated that VA and IHS tribal consultation processes do not always meet the tribes' needs (p. 19). VA and IHS acknowledged that effective consultation has been challenging (p. 19).

GAO noted that some tribal stakeholders still had concerns over the agencies' consultation processes, and recommended that the agencies show how the revised metrics and measures support the MOU's goals (p. 23). GAO also recommended that the agencies develop more effective tribal consultation processes, such as:

- Identifying and keeping a current list of appropriate tribal members for outreach efforts,
- Clearly communicating agency responses to tribal input, and
- Establishing appropriate timelines for releasing information to tribal communities (p. 23).

Posttraumatic Stress Disorder and Its Comorbidities among American Indian Veterans

Westermeyer, J., & Canive, J. (2012). Posttraumatic stress disorder and its comorbidities among American Indian veterans. *Community Mental Health Journal, 49*, 704-708. doi:10.1007/s10597-012-9565-3

This article describes the results of a study that explored comorbid characteristics associated with post-traumatic stress disorder (PTSD) among American Indian veterans with a lifetime Axis 1 disorder¹¹ (p. 704). The study focused on two groups of American Indian veterans with PTSD. One group had combat experience and the other did not. To fairly compare the rate of comorbidity between the two groups, this study only included participants with at least one Axis 1 disorder (p. 705) since comorbidity can only occur in people with psychiatric disorders (p. 707).

In other community studies and clinical samples, the following Axis 1 disorders were shown to have high comorbid rates with PTSD:

- Mood disorders,
- Anxiety disorders,
- Substance use disorders,
- Antisocial personality disorder, and
- Pathological gambling (p. 704).

In contrast, this study found that the following disorders did not have high comorbidity rates among American Indian veterans with PTSD:

- Substance use disorder,
- Antisocial personality disorder, and
- Pathological gambling (p. 707).

Mood and anxiety disorders were highly associated with PTSD in American Indian combat veterans (p. 707), the more common of which was major depressive disorder with and without mania (p. 706). The authors further note that the comorbidity rates and types in its sample of American Indian veterans showed remarkable similarity to another non-veteran American Indian group and the U.S. population at large (p. 707).

¹¹ Axis 1 is the top-level of the multiaxial system of diagnosis in *the Diagnostic and Statistical Manual IV* of mental health disorders, with Axis 1 disorders being the most widely recognized mental disorders (e.g., major depressive episode, schizophrenic episode, and panic attack). (DeepDiveAdmin. (2015, December 2). DSM IV. *PsyWeb.com*. Retrieved on December 6, 2016, from: http://www.psyweb.com/DSM_IV/jsp/dsm_iv.jsp)

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