

National Indian Health Board



March 2, 2021

Elizabeth Fowler
Acting Director, Indian Health Service
U.S. Department of Health and Human Services
5600 Fishers Lane
Rockville, MD 20857

Re: VA-IHS Memorandum of Understanding

Dear Director Fowler:

On behalf of the National Indian Health Board (NIHB),¹ I write to comment on the Memorandum of Understanding (MOU) between the United States Department of Veterans Affairs (VA) and Indian Health Service (IHS). We appreciate the efforts of the two agencies to collaborate on ways to improve health care outcomes for American Indian/Alaskan Native (AI/AN) veterans. While we generally support the MOU and the provisions contained within, we also want to ensure that measures are put in place to ensure that meaningful progress is made towards satisfying the stated goals of the MOU. We believe that the success of this MOU will depend on the ability of all parties involved to assess its success and make adjustments where needed.

Shared Resources

We generally support the outlined mutual goals of both parties. We believe that these goals are laudable and, if achieved, should result in better care for AI/AN veterans and support continuity of care for AI/AN patients using both systems. Under the “Access” goal, we support the decision to incorporate performance monitoring through quarterly meetings of VA and IHS leadership. This will allow for increased collaboration and measuring of progress towards the mutual goals of the MOU. We also support the decision to develop, coordinate, and expand new ways to connect facilities run by the VA and the IHS, Tribal, and Urban (I/T/U) systems as well as the commitment to improve care coordination processes between the VA and the IHS, and I/T/U system. **We support efforts to share resources in order to coordinate care, reduce redundancies in care, and improve the ability of AI/AN veterans to access either system.**

While we support the decision to allow both systems to share employees and access each other’s patient records, we do have concerns about ambiguity in the phrasing of these provisions and the use of “IHS employee,” in Section VI, item 2, when the phrase “IHS, Tribal, or UIO employee”

¹ Established in 1972, the National Indian Health Board (NIHB) is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/ANs). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

might be more appropriate. The MOU is unquestionably designed to improve care between the I/T/U and VA systems and it can reasonably be assumed the agreement is using “IHS employee” when it means “I/T/U employee.” We feel that this ambiguity could result in complications for Tribal and Urban Indian Organizations when attempting to access patient records.

IT Interoperability

NIHB supports the goal of mutual interoperability of the VA and IHS Electronic Health Record (EHR) systems. A 2019 Government Accountability Office (GAO) report on the VA-IHS MOU found that 66% of VA, IHS and Tribal facilities surveyed in the report indicated significant challenges in accessing each other’s HIT systems, citing lack of EHR interoperability.²

The Resource and Patient Management System (RPMS) – which is the primary health IT system used across the Indian health system – was developed in close partnership with the VHA and has become partially dependent on the VHA health IT system, known as the Veterans Information Systems and Technology Architecture (VistA). The RPMS is an early adoption of VistA for outpatient use, and the legacy system was designed with the decision to keep the same underlying code infrastructure as VistA. IHS began developing different clinical applications for their outpatient services, and the VHA adopted code from RPMS to provide this functionality for VistA. RPMS eventually began to use additional VistA code as the need for inpatient functionality increased. This type of enhancement and support for both the IHS and VHA was made possible because VistA’s software components were designed as an Open Source solution. The RPMS suite is able to run on mid-range personal computer hardware platforms, while applications can operate individually or as an integrated suite with some availability to interface with commercial-off-the-shelf (COTS) software products. Currently, the RPMS manages clinical, financial, and administrative information throughout the I/T/U, although, it is deployed at various levels across the service delivery types. However, in recent years, many Tribes and even several Urban Indian Health Programs (UIHPs) have elected to purchase their own COTS systems that provide a wider suite of services than RPMS, have stronger interoperability capabilities, and are significantly more navigable and modern systems to use. As a result, there exists a growing patchwork of EHR platforms across the Indian health system. When the VA announced its decision to replace VistA with a COTS system in 2017 (Cerner), concentrated efforts to re-evaluate the Indian Health IT system accelerated. In these efforts, stakeholders shared significant concerns about how VHA and I/T/U EHR interoperability would continue. In 2018, IHS launched a Health IT Modernization Project to evaluate the current I/T/U health IT framework, and to develop a series of next steps and recommendations towards modernizing health IT in Indian Country.

Difficulties in achieving IT interoperability among VA, IHS, and Tribal facilities pose significant problems for AI/AN Veterans’ care coordination. Unfortunately, the VHA and IHS have yet to identify a systemic solution towards increasing EHR interoperability between I/T/U and VHA hospitals, clinics, and health stations. Without this systemic solution it is easy to foresee situations where a Tribal provider – having treated a Veteran and referred them to the VHA for specialty

² <https://www.gao.gov/assets/700/697736.pdf>

care – would not receive the Veteran’s follow-up records without taking extra steps and possibly calling on the patient to intervene to ensure records are shared.

The VA-IHS MOU, as proposed, does not outline any specific plans to address this issue. This remains one of the largest barriers to ensuring continuity of care. If providers are not able to access the health records of AI/AN veterans, the risk of redundant and needless procedures are higher, resulting in waste from both health care systems. Veterans should not be responsible for manually transferring health care records between facilities in order to ensure that their providers have their medical information.

Telehealth Expansion

We appreciate that the MOU calls for advocacy for the increased use of telehealth systems and the expansion of broadband technology. This issue has special significance to AI/AN people. As we are sure you know, much of Indian Country is rural. In fact, 46.1% of AI/ANs live in rural communities, a rate which is over twice the percentage of the rest of the population.³ We know that rural areas around the country struggle with broadband internet access, which has made the adoption of innovations such as telehealth more difficult in those spaces. The adoption of telehealth is essential for limiting in-person interactions at health facilities and slowing the spread of the COVID 19. However, adoption of telehealth has been limited by the existing infrastructure issues in Indian Country. According to a 2019 Federal Communications Commission (FCC) Report, only 46.6% of homes on rural Tribal lands had access to a fixed terrestrial broadband at standard speeds, an astounding 27 points lower than non-Tribal lands.⁴ We are pleased that the VA has committed to helping address this issue.

Accountability

We support the decision of the two agencies to work together yearly to create an operational plan that will incorporate the goals of the MOU and the strategies and activities used to achieve them. We believe that accountability will help ensure that these goals are met. However, we note the lack of quantifiable metrics in the MOU. The MOU says the two sides must meet to ensure that the goals in the MOU are on track to be achieved but it does not provide a starting place for this discussion. Additionally, without more clarity on targets, the two parties may disagree on whether they have reached the goals, , which in turn can affect the successful implementation of the MOU. **We believe that the MOU should have measurable targets so success can objectively be measured. We also believe that these targets must be set after Tribal consultation.**

³ Janice C. Probst, Fozia Ajmal, “Social Determinants of Health among Rural American Indian and Alaska Native Populations,” Univ. of S.C. Rural and Minority Health Research Center, July 2019 https://www.sc.edu/study/colleges_schools/public_health/research/research_centers/sc_rural_health_research_center/documents/socialdeterminantsofhealthamongruralamericanindianandalaskanativepopulations.pdf

⁴ “Report on Broadband Deployment in Indian Country, Pursuant to the Repack Airwaves Yielding Better Access for Users of Modern Services Act of 2018,” Federal Communications Commission, May 2019 <https://docs.fcc.gov/public/attachments/DOC-357269A1.pdf>

Conclusion

We appreciate the work on the VA-IHS MOU and believe that increased cooperation between the two agencies has the potential to improve access to care for AI/AN veterans. We believe that shared resources and IT interoperability will help ensure continuity of care, reduce redundancies, and result in a better and more streamlined care experience for AI/AN veterans. We also believe that a mutual push towards telehealth expansion, especially through advocacy for increased access to broadband, will greatly benefit Indian Country. However, we have concerns around accountability and how to measure success of this endeavor. **We believe that there should be measurable goals in the MOU so success can be objectively measured.** We call on the agencies to set these targets after Tribal consultation. Thank you in advance for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "Stacy A. Bohlen". The signature is fluid and cursive, with a long horizontal stroke at the end.

Stacy A. Bohlen, CEO

National Indian Health Board