

April 2013

VA AND IHS

Further Action Needed to Collaborate on Providing Health Care to Native American Veterans



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Why GAO Did This Study

Native Americans who have served in the military may be eligible for health care services from both VA and IHS. To enhance health care access and the quality of care provided to Native American veterans, in 2010, these two agencies renewed and revised an MOU designed to improve their coordination and resource sharing related to serving these veterans. GAO was asked to examine how the agencies have implemented the MOU.

This report examines: (1) the extent to which the agencies have established mechanisms through which the MOU can be implemented and monitored; and (2) key challenges the agencies face in implementing the MOU and the progress made in overcoming them. To conduct this work, GAO interviewed VA and IHS officials and reviewed agency documents and reports. GAO also obtained perspectives of tribal communities through attendance at two tribal conferences; interviews with tribal leaders and other tribal members, including veterans; and interviews with other stakeholders, such as health policy experts and consultants.

What GAO Recommends

GAO recommends that the agencies take steps to improve the performance metrics used to assess MOU implementation and to develop better processes to consult with tribes. VA and the Department of Health and Human Services agreed with these recommendations.

VA AND IHS

Further Action Needed to Collaborate on Providing Health Care to Native American Veterans

What GAO Found

The Department of Veterans Affairs (VA) and the Indian Health Service (IHS) have developed mechanisms to implement and monitor their memorandum of understanding (MOU); however, the performance metrics developed to assess its implementation do not adequately measure progress made toward its goals. VA and IHS have defined common goals for implementing the MOU and developed strategies to achieve them. They have also created two mechanisms to implement the MOU—12 workgroups with members from both agencies to address the goals of the MOU, and a Joint Implementation Task Force, comprised of VA and IHS officials, to oversee the MOU's implementation. These steps are consistent with practices that GAO has found enhance and sustain agency collaboration. The agencies have also developed three metrics aimed at measuring progress toward the MOU's goals. However, two of the three metrics are inadequate because their connection to any specific MOU goal is not clear and, while they include quantitative measures that tally the number of programs and activities increased or enhanced as a result of the MOU, they lack qualitative measures that would allow the agencies to assess the degree to which the desired results are achieved. The weaknesses in these metrics could limit the ability of VA and IHS managers to gauge progress and make decisions about whether to expand or modify their programs and activities.

VA and IHS face unique challenges associated with consulting with a large number of diverse, sovereign tribes to implement the MOU, and lack fully effective processes to overcome these complexities. VA and IHS officials told us the large number (566 federally recognized tribes) and differing customs and policy-making structures present logistical challenges in widespread implementation of the MOU within tribal communities. They also told us that tribal sovereignty—tribes' inherent right to govern and protect the health, safety, and welfare of tribal members—adds further complexity because tribes may choose whether or not to participate in MOU-related activities. Consistent with internal controls, VA and IHS have processes in place to consult with tribes on MOU-related activities through written correspondence and in-person meetings. However, according to tribal stakeholders GAO spoke with, these processes are often ineffective and have not always met the needs of the tribes, and the agencies have acknowledged that effective consultation has been challenging. For example, one tribal community expressed concern that agency correspondence is not always timely because it is sent to tribal leaders who are sometimes not the tribal members designated to take action on health care matters. Similarly, some tribal stakeholders told GAO that the agencies have not been responsive to tribal input and that sometimes they simply inform tribes of steps they have taken without consulting them. VA and IHS have taken steps to improve consultation with tribes. For example, VA has established an Office of Tribal Government Relations, through which it is developing relationships with tribal leaders and other tribal stakeholders. Additionally, in Alaska, VA has been consulting with a tribal health organization for insight on reaching tribes. However, given the concerns raised by the tribal stakeholders GAO spoke with, further efforts may be needed to enhance tribal consultation to implement and achieve the goals of the MOU.

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Abbreviations

CMOP	Consolidated Mail Outpatient Pharmacy
EHR	electronic health record
HBPC	home-based primary care
IHS	Indian Health Service
MOU	memorandum of understanding
NCAI	National Congress of American Indians
OTGR	Office of Tribal Government Relations
VA	Department of Veterans Affairs

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United States Government Accountability Office
Washington, DC 20548

April 26, 2013

Congressional Requesters:

Native Americans (American Indians and Alaska Natives) have historically served in the military at a higher rate than any other ethnic group, according to the Department of Defense. Once separated from the military, some Native American veterans are eligible to receive health care services from both the Department of Veterans Affairs (VA) and the Indian Health Service (IHS), an agency within the Department of Health and Human Services.¹

To improve the health status of Native American veterans through coordination, collaboration, and sharing of resources among VA, IHS, and tribes, in 2010, VA and IHS expanded upon a 2003 memorandum of understanding (MOU). This 2010 MOU outlined mutual goals for the agencies' collaboration and coordination of resources and care in providing health care services to Native American veterans. For example, it included provisions for joint contracts and purchasing agreements, sharing staff, ensuring providers in VA and IHS could access the electronic health records of shared patients, and the development of payment and reimbursement policies and mechanisms to support care delivered to Native American veterans eligible for care in both systems.

In a May 2012 congressional hearing, both VA and IHS reported that they have taken steps to collaborate to improve access to and quality of health care services for Native American veterans.² However, questions have been raised by members of Congress about the extent of collaboration between the two agencies. For example, a 2012 Senate report noted that stronger partnerships among VA, IHS, and tribally operated health facilities are essential to ensuring Native American veterans have access to health care services.³ We were asked to examine how the agencies

¹According to the U.S. Census Bureau, in 2011 approximately 150,000 individuals identified themselves as Native American veterans. This includes only individuals who identified as American Indian or Alaska Native alone and not in combination with another racial group. Therefore, it likely underestimates the number of Native American veterans.

²*Oversight Hearing on Programs and Services for Native Veterans*: hearing before the Committee on Indian Affairs, United States Senate, 112th Cong (May 24, 2012).

³S. Rep. No. 112-168, at 45 (May 22, 2012).

have implemented the MOU. In this report, we address the (1) extent to which VA and IHS have established mechanisms through which the MOU can be effectively implemented and monitored; and (2) key challenges that VA and IHS face in implementing the MOU, and the progress they have made in overcoming them.

To address both of these objectives, we reviewed the MOU and documentation related to the MOU's implementation, including periodic updates and descriptions of sharing agreements. We also reviewed the signed reimbursement agreement between VA and IHS as well as signed reimbursement agreements between VA and tribes.⁴ We interviewed VA and IHS officials, including VA's Director of the Office of Rural Health and Office of Tribal Government Relations, the IHS Chief Medical Officer, and leaders of 8 of 12 VA/IHS workgroups tasked with addressing and implementing the MOU to learn about the steps that have been taken to implement and monitor the MOU and any related challenges. We selected these eight workgroups because they were involved in addressing issues regarding agency coordination and sharing resources.⁵

To assess the MOU's implementation and related challenges, we took several actions to obtain the views of tribal communities. We attended a VA tribal consultation on MOU implementation at the National Indian Health Board Consumer Conference in Denver, Colorado, in September 2012, and attended the National Congress of American Indians (NCAI) Annual Conference in Sacramento, California, in October 2012. At the NCAI conference, we conducted listening sessions for tribal members to solicit their views on MOU implementation. We also interviewed various other tribal health representatives outside of the listening sessions and

⁴VA is required to reimburse federally and tribally operated facilities for health care services provided to beneficiaries who are eligible for such services from VA. 25 U.S.C. § 1645(c).

⁵The eight workgroups we interviewed were: (1) Coordination of Care; (2) Health Information Technology; (3) System Level; (4) Payment and Reimbursement; (5) Sharing of Care Process, Programs and Services; (6) Training and Recruitment; (7) Oversight; and (8) Alaska. VA and IHS count the Training and Recruitment Workgroup as two separate workgroups. However, because these two workgroups share similar goals, an IHS official told us they combined them into one workgroup, and for the purposes of this report we considered them as one workgroup. There are also four other workgroups covering: (1) Services and Benefits, (2) New Technologies; (3) Cultural Competency and Awareness; and (4) Emergency and Disaster Preparedness. We did not interview these workgroups because they did not directly relate to our objectives.

the conferences. In all, we interviewed 34 tribal members and other representatives (collectively referred to in this report as tribal stakeholders), including tribal leaders, tribal veterans, tribal health directors and administrators, and tribal health policy experts and consultants. The tribes represented in our interviews were geographically varied, including representation from 9 IHS Areas and 10 Veterans Integrated Service Networks and included representation from tribes that varied in size from approximately 500 members to 310,000 members. We cannot generalize findings from these interviews as representative of all tribal communities; however, we believe that patterns or issues identified in these interviews may illustrate issues that other tribes face as well.

To evaluate the extent to which VA and IHS have established mechanisms through which the MOU can be effectively implemented and monitored, we assessed this evidence against relevant criteria from our past work on interagency collaboration, practices from leading results-oriented public-sector organizations, and agency strategic planning.⁶ To evaluate key challenges that VA and IHS face in implementing the MOU, and the progress they have made in overcoming them, we assessed this evidence against internal controls.⁷

We conducted this performance audit from July 2012 to April 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

⁶GAO, *Results-Oriented Government: Practices That Can Help Enhance and Sustain Collaboration among Federal Agencies*, [GAO-06-15](#) (Washington, D.C.: Oct. 21, 2005); *Managing for Results: Key Considerations for Implementing Interagency Collaborative Mechanisms*, [GAO-12-1022](#) (Washington, D.C.: Sept. 27, 2012); *Executive Guide: Effectively Implementing the Government Performance and Results Act*, [GAO/GGD-96-118](#) (Washington, D.C.: June 1996); and *Agencies' Strategic Plans Under GPRA: Key Questions to Facilitate Congressional Review*, [GAO/GGD-10.1.16](#) (Washington, D.C.: May 1997).

⁷GAO, *Internal Control Standards: Internal Control Management and Evaluation Tool*, [GAO-01-1008G](#) (Washington, D.C.: August 2001).

Background

Native American Veteran Demographics

While Native American veterans are geographically dispersed throughout the United States, the West and South regions contain the majority of the Native American veteran population, according to Census data. Some Native American veterans are members of the 566 federally recognized tribes that are distinct, independent political communities that possess certain powers of self-government, which we refer to as tribal sovereignty. Specifically, federally recognized tribes have government-to-government relationships with the United States, and are eligible for certain funding and services provided by the United States. In addition, some Native American veterans are members of the more than 400 Indian groups that are not recognized by the federal government (which we refer to in this report as non-federally recognized tribes).⁸ Many—but not all—Native American veterans are dually eligible for health care services in VA and IHS. For example, a veteran who is a member of a non-federally recognized tribe may be eligible for VA health care services, but would not be eligible for IHS health care services.⁹

VA and IHS Structure and Benefits

VA is charged with providing health care services to the nation's veterans, and estimates that it will serve 6.3 million patients in fiscal year 2013. VA's fiscal year 2012 budget for medical care was approximately \$54 billion. The department provides health care services at VA-operated facilities and through agreements with non-VA providers.¹⁰ Veterans who served in the active military, naval or air service and who were discharged or released under conditions other than dishonorable are generally eligible for VA health care.

⁸For more information on federal funding for non-federally recognized tribes, see GAO, *Indian Issues: Federal Funding for Non-Federally Recognized Tribes*, [GAO-12-348](#) (Washington, D.C.: Apr. 12, 2012).

⁹To be eligible for IHS health care services, an individual must be closely affiliated with a federally recognized tribe, as evidenced by such factors as membership; enrollment; residence on tax-exempt land; ownership of restricted property; active participation in tribal affairs; or other relevant factors indicative of Native American descent. See 42 C.F.R. § 136.12.

¹⁰To manage its provision of health care services for eligible veterans, VA operates a system of annual patient enrollment in accordance with eight listed priorities. See 38 U.S.C. § 1705.

IHS is charged with providing health care to the approximately 2.1 million eligible Native Americans. IHS's fiscal year 2012 budget for medical care was approximately \$3.9 billion. Similarly to VA, IHS provides health care services at IHS-operated facilities through direct care and pays for services from external providers through contract health services. In addition to IHS-operated facilities, some federally recognized tribes choose to operate their own health care facilities, which receive funding from IHS.¹¹ Like their IHS-operated counterparts, tribally operated facilities provide direct care services and pay for contract health services. IHS also provides funding through grants and contracts to nonprofit urban Native American organizations through the Urban Indian Health program in order to provide health care services to Native Americans living in urban areas.

VA and IHS Collaboration through Memorandums of Understanding

In 2003, VA and IHS signed an MOU to facilitate collaborative efforts in serving Native American veterans eligible for health care in both systems. In 2010, the agencies developed a more detailed MOU to further these efforts. The 2010 MOU contains provisions related to several areas of collaboration, including actions related to the following:

- *Joint contracts and purchasing agreements:* Development of standard, preapproved language for inclusion of one agency into contracts and purchasing agreements developed by the other agency; and processes to share information about sharing opportunities in early planning stages.
- *Sharing staff:* Establishment of joint credentialing and privileging, sharing specialty services, and arranging for temporary assignment of IHS Public Health Service commissioned officers to VA.

¹¹Under the Indian Self-Determination and Education Assistance Act, as amended, federally recognized tribes can enter into self-determination contracts or self-governance compacts with the Secretary of Health and Human Services to take over administration of IHS programs for Native Americans previously administered by IHS on their behalf because of their status as Indians. Self-governance compacts allow tribes to consolidate and assume administration of all programs, services, activities, and competitive grants administered throughout IHS, or portions thereof, that are carried out for the benefit of Native Americans because of their status as Indians. Self-determination contracts allow tribes to assume administration of a program, programs, or portions thereof. See 25 U.S.C. §§ 450f(a) (self-determination contracts) and 458aaa-4(b)(1) (self-governance compacts).

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- *Electronic Health Record (EHR) access*: Establishment of standard mechanisms for VA providers to access records in IHS and tribally operated facilities, and vice versa, for patients receiving care in both systems.
 - *Reimbursement*: Development of payment and reimbursement policies and mechanisms to support care delivered to dually eligible Native American veterans.

VA and IHS Tribal Consultation Policies

Executive Order 13175, issued on November 6, 2000, required federal agencies to establish regular and meaningful consultation and collaboration with Indian tribe officials in the development of federal policies that have tribal implications.¹² IHS issued a tribal consultation policy in 2006 to formalize the requirement to seek consultation and participation by Indian tribes in policy development and program activities. According to the policy, IHS will consult with Indian tribes to the extent practicable and permitted by law before any action is taken that will significantly affect Indian tribes. In November 2009, a Presidential Memorandum directed federal agencies to develop plans, after consultation with Indian tribes and tribal officials, for implementing the policies and directives of Executive Order 13175.¹³ VA's plan included development of a tribal consultation policy, which the agency released in February 2011. VA's tribal consultation policy asserts that VA will establish meaningful consultation to develop, improve, or maintain partnerships with tribal communities. The policy states that consultation should be conducted before actions are taken but acknowledges there may not always be "sufficient time or resources to fully consult" on an issue.¹⁴

¹²Federal agencies are required to consult with Alaska Native corporations on the same basis as Indian tribes under Executive Order 13175. Pub. L. No. 108-199, div. H, § 161, 118 Stat. 3, 452 (2004), as amended.

¹³See 74 Fed. Reg. 57,881 (Nov. 9, 2009).

¹⁴According to the policy, the principal focus of consultation is the tribally designated "tribal official" and that consultation will be initiated by means of written notification.

Best Practices and Internal Control Standards for Interagency Collaboration and Performance Monitoring

In past work we have reported on key practices to enhance and sustain interagency collaboration¹⁵ including

- agreeing on roles and responsibilities;
- establishing compatible policies, procedures, and other means to operate across agency boundaries; and
- developing mechanisms to monitor, evaluate, and report on results.

Additionally, our past work has identified a range of mechanisms that the federal government uses to lead and implement interagency collaboration.¹⁶ We found that regardless of the mechanisms used, there are key actions the government can take, including (1) having clear goals; (2) ensuring relevant participants are included in collaboration; and (3) specifying the resources—human, information, technology, physical, and financial—needed to initiate or sustain the collaboration. We have also found in past work on leading public-sector organizations and agency strategic planning that it is important to (1) define clear missions and desired outcomes; (2) use performance measures that are tangible, measurable, and clearly related to goals to gauge progress; and (3) use performance information as a basis for decision making.¹⁷ Finally, internal control standards emphasize the importance of effective external communications that occur with groups that can have a serious effect on programs, projects, operations, and other activities, including budgeting and financing.¹⁸

¹⁵ [GAO-06-15](#) and [GAO-12-1022](#).

¹⁶ [GAO-12-1022](#).

¹⁷ [GAO/GGD-10.1.16](#) and [GAO/GGD-96-118](#) (for this report, GAO studied a number of leading public-sector organizations that were successfully becoming more results-oriented, including state governments such as in Florida, Texas, and Virginia; and foreign governments such as in Australia and the United Kingdom).

¹⁸ [GAO-01-1008G](#).

VA and IHS Have Developed Mechanisms to Implement and Monitor the MOU, but Metrics to Monitor Performance Do Not Adequately Measure Progress toward MOU Goals

VA and IHS have documented common goals in their MOU, created 12 workgroups that are tasked with developing strategies to address the goals of the MOU, and created a Joint Implementation Task Force to coordinate tasks, develop implementation policy, and develop performance metrics and timelines—actions that are consistent with those we have found enhance and sustain agency collaboration. However, most of the performance metrics developed by VA and IHS to monitor the implementation of the MOU need to be more clearly related to the goals of the MOU in order to allow the agencies to gauge progress toward MOU goals.

VA and IHS Have Defined Common Goals and Created Mechanisms to Implement the MOU

Consistent with our past work on practices that can enhance and sustain collaboration, VA and IHS have defined common goals for implementing the MOU and developed specific strategies the agencies plan to take to achieve them. Table 1 summarizes the five goals in the 2010 MOU and selected strategies for implementing them.

Table 1: Goals and Associated Strategies in the Department of Veterans Affairs (VA) / Indian Health Service (IHS) 2010 Memorandum of Understanding (MOU)

MOU goal	Selected strategies to achieve goal
1. Increase access to and improve quality of health care and services to the mutual benefit of both agencies. Effectively leverage the strengths of the VA and IHS at the national and local levels to afford the delivery of optimal clinical care.	<ul style="list-style-type: none"> • Share specialty services • Develop joint credentialing and privileging of staff • Develop joint training initiatives • Develop and implement new models of care using new technologies, including telehealth services
2. Promote patient-centered collaboration and facilitate communication among VA, IHS, Native American veterans, tribal facilities, and Urban Indian Clinics.	<ul style="list-style-type: none"> • Establish mechanism to share electronic health records for patients receiving care in both systems and from tribally operated facilities • Improve the delivery of care through sharing of care processes, programs, and services (for example, post-traumatic stress disorder and diabetes management)
3. In consultation with tribes at the regional and local levels, establish effective partnerships and sharing agreements among VA headquarters and facilities, IHS headquarters and IHS, tribal, and Urban Indian Health programs in support of Native American veterans.	<ul style="list-style-type: none"> • Develop standard preapproved language for inclusion of one agency into the other agency's existing contracts • Develop preapproved templates for agreements to facilitate local, regional, and national collaboration
4. Ensure that appropriate resources are identified and available to support programs for Native American veterans.	<ul style="list-style-type: none"> • Develop payment and reimbursement policies and mechanisms for veterans receiving care in both systems
5. Improve health promotion and disease prevention services to Native Americans to address community-based wellness.	<ul style="list-style-type: none"> • Improve the delivery of care through sharing of care processes, programs, and services (for example, post-traumatic stress disorder and diabetes management)

Source: GAO analysis of information provided by VA and IHS.

VA and IHS have created two mechanisms to implement the MOU—workgroups and a Joint Implementation Task Force. We have reported that MOUs are most effective when they are regularly updated and monitored, actions that can be achieved by workgroups and task forces.¹⁹

Workgroups

VA and IHS created 12 workgroups tasked with responsibility for implementing and developing strategies to address the goals of the MOU, such as interoperability of health information technology; developing payment and reimbursement agreements; and sharing of care processes, programs, and services.²⁰ Each workgroup includes members from VA

¹⁹GAO-12-1022.

²⁰The 12 workgroups are: (1) Coordination of Care; (2) Health Information Technology; (3) System Level; (4) Payment and Reimbursement; (5) Sharing of Care Process, Programs and Services; (6) Training and Recruitment; (7) Oversight; (8) Alaska; (9) Services and Benefits; (10) New Technologies; (11) Cultural Competency and Awareness; and (12) Emergency and Disaster Preparedness.

and IHS, a step that can foster mutual trust across diverse agency cultures and facilitate frequent communication across agencies to enhance shared understanding of collaboration goals, according to our previous work on interagency collaboration. According to VA and IHS officials, most of the workgroup members volunteered to serve on the workgroups and were self-selected, and VA officials told us that they have consulted with tribes on how to increase tribal participation in the workgroups. The agencies also told us that some workgroup members were asked to participate because of their subject-matter expertise.²¹

Goals established by each workgroup appear to be aligned with MOU goals. Specifically, all eight of the workgroups we interviewed described goals that were consistent with the MOU goals.²² Table 2 lists each workgroup we interviewed and provides a crosswalk between workgroup goals and the corresponding MOU goal or strategy.

²¹The officials told us that in cases where a workgroup lacks authority to implement an MOU task, workgroup members would notify MOU coordinators designated by each agency, who would then notify the appropriate agency officials about the issue.

²²We did not interview 4 workgroups because they did not directly relate to our objectives: (1) Services and Benefits; (2) New Technologies; (3) Cultural Competency and Awareness; and (4) Emergency and Disaster Preparedness.

Table 2: Goals of Eight Workgroups Interviewed and Corresponding Department of Veterans Affairs (VA) / Indian Health Service (IHS) Memorandum of Understanding (MOU) Goals

Workgroup	Goals	Crosswalk to MOU goals
Coordination of Care	<ul style="list-style-type: none"> Increase access to and quality of care. Promote patient-centered collaboration and increase coordination of care, including comanagement of dual- eligible veterans. Work with tribal urban organizations. 	<p>Goal 1: Increase access to and improve quality of health care and services to the mutual benefit of both agencies.</p> <p>Goal 2: Promote patient- centered collaboration and facilitate communication.</p>
Health Information Technology	<ul style="list-style-type: none"> Improve care through the development of health information technology. Establish system to share electronic health records. 	<p>Goal 1: Increase access to and improve quality of health care and services to the mutual benefit of both agencies.</p> <p>Goal 2: Promote patient-centered collaboration and facilitate communication.</p>
System Level	<ul style="list-style-type: none"> Plan and implement system-level resources to share information about contracts and purchasing arrangements. 	<p>Goal 3: Establish effective partnerships and sharing agreements.</p> <p>Goal 4: Ensure that appropriate resources are identified and available to support programs.</p>
Payment and Reimbursement	<ul style="list-style-type: none"> Design system to ensure VA and IHS systems are compatible for the billing and collecting process under contracts or agreements. 	<p>Goal 4: Ensure that appropriate resources are identified and available to support programs.</p>
Sharing of Care Process, Programs and Services	<ul style="list-style-type: none"> Several MOU goals, including improving access to and quality of care for post-traumatic stress disorder among Native American veterans. Conduct outreach to tribal areas in areas such as public health and suicide prevention. Develop and update suicide prevention training. Provide IHS pharmacists access to VA programs to streamline pharmacy dispensing activities. Coordinate and collaborate to improve the lives of elderly and frail Native Americans, and increase access to VA’s home-based primary care program. 	<p>Goal 1: Increase access to and improve quality of health care and services to the mutual benefit of both agencies.</p> <p>Goal 2: Promote patient- centered collaboration and facilitate communication.</p> <p>Goal 3: Establish effective partnerships and sharing agreements.</p> <p>Goal 5: Improve health-promotion and disease-prevention services to Native Americans to address community-based wellness.</p>
Training and Recruitment	<ul style="list-style-type: none"> Increase capability and improve quality through training and workforce development, sharing of educational and training opportunities, and the development of joint training initiatives. Increase access to care through sharing of staff and enhanced recruitment and retention of professional staff. 	<p>Goal 1: Increase access to and improve quality of health care and services to the mutual benefit of both agencies.</p>

Workgroup	Goals	Crosswalk to MOU goals
Alaska	<ul style="list-style-type: none"> Increase access to services and benefits of IHS and VA. Improve coordination of care, including comanagement, for Native American veterans served by both VA and tribal organizations. Increase availability of services, in accordance with law, by the development of payment and reimbursement policies and mechanisms. 	<p>Goal 1: Increase access to and improve quality of health care and services to the mutual benefit of both agencies.</p> <p>Goal 2: Promote patient- centered collaboration and facilitate communication.</p> <p>Goal 3: Establish effective partnerships and sharing agreements</p> <p>Goal 4: Ensure that appropriate resources are identified and available to support programs.</p> <p>Goal 5: Improve health-promotion and disease-prevention services to Native Americans to address community-based wellness.</p>
Oversight	<ul style="list-style-type: none"> Set priorities for the Joint Implementation Task Force to identify the strategies and plans for accomplishing the tasks and aims of the MOU, and help the task force follow the strategy and plans of the MOU. Meet with and receive updates from other workgroups and elevate issues identified by the workgroups. Develop reports on progress in implementing the MOU. 	<p>Goal 1: Increase access to and improve quality of health care and services to the mutual benefit of both agencies.</p> <p>Goal 2: Promote patient- centered collaboration and facilitate communication.</p> <p>Goal 3: Establish effective partnerships and sharing agreements.</p> <p>Goal 4: Ensure that appropriate resources are identified and available to support programs.</p> <p>Goal 5: Improve health-promotion and disease-prevention services to Native Americans to address community-based wellness.</p>

Source: GAO evaluation of interviews with workgroups and agency officials and the MOU.

Joint Implementation Task Force

VA and IHS created the Joint Implementation Task Force to oversee the overall implementation of the MOU. This task force comprises officials from both agencies including from the Office of the Secretary of Veterans Affairs, the IHS Chief Medical Officer, and the director of VA's Office of Tribal Government Relations, and is scheduled to meet quarterly. It develops implementation policy and procedures for policy-related issues identified by the workgroups; creates performance metrics and timelines, evaluates progress; and compiles an annual report on progress in MOU implementation. Creating a mechanism, such as a task force, intended not only to address issues arising from potential incompatibility of standards and policies across agencies but also to monitor, evaluate, and report on MOU results, can help to facilitate collaboration, according to our previous work on interagency collaboration.

VA and IHS Performance Metrics Do Not Adequately Measure Progress on the MOU Goals

The process developed by the Joint Implementation Task Force to monitor the implementation of the MOU includes obtaining data on three performance metrics; however, two of the three metrics do not allow the agencies to measure progress toward the MOU's goals. Our previous work has found that successful performance metrics should be tangible and measurable, clearly aligned with specific goals, and demonstrate the degree to which desired results are achieved.²³ Although all three of the performance metrics are tangible and measurable, only one is also clearly aligned with a specific goal and defined in a manner that would allow the agencies to adequately measure the degree to which desired results are achieved. The other two metrics are inadequate because their connection to a specific goal is not clear and they lack qualitative measures that would allow the agencies to measure the degree to which desired results are achieved. For example, one MOU goal is to increase access to and improve quality of health care services, but none of the metrics mention any targets specifically linked to increased access or improved quality of care. Another goal is to establish effective partnerships and sharing agreements among the agencies and the tribes in support of Native American veterans. Although one of the metrics appears to be related to this goal, in that it is focused on measuring the number of outreach activities that are a result of partnerships, it lacks measures to determine how well the outreach activities are meeting the goal of establishing effective partnerships or other potential goals to which the outreach may contribute, such as facilitating communication among VA, IHS, veterans, and tribally operated facilities. The metrics would therefore not enable VA and IHS to determine how well these specific goals are being achieved. Table 3 describes the performance metrics and performance measures and our evaluation of them.

²³ [GAO/GGD-96-118](#) and [GAO/GGD-10.1.16](#).

Table 3: GAO Evaluation of Performance Metrics and Measures Developed to Monitor Progress toward Department of Veterans Affairs (VA) / Indian Health Service (IHS) Memorandum of Understanding (MOU) Goals

Metric	Measures	GAO evaluation
Metric 1: Programs increased or enhanced as a result of the VA-IHS MOU	<ol style="list-style-type: none"> 1. Number of programs enhanced and increased 2. Number of events and activities to increase or enhance the programs 3. Number of veterans impacted 4. Met purposes of MOU (yes or no) 5. Met intent of MOU (yes or no) 6. Level of VA-IHS-Tribal participation (poor, fair, good, excellent) 	<p>Inadequate</p> <p>Tangible and measurable, but not clearly aligned with an MOU goal and would not allow agencies to determine how well MOU goals are achieved.</p>
Metric 2: Outreach activities that are the result of MOU partnerships	<ol style="list-style-type: none"> 1. Types of outreach events held 2. Number of outreach events held 3. Number of veterans and others (families, caregivers) impacted 4. Met purposes of MOU (yes or no) 5. Met intent of MOU (yes or no) 6. Level of VA-IHS-Tribal participation (poor, fair, good, excellent) 	<p>Inadequate</p> <p>Tangible and measurable but not clearly aligned with an MOU goal, and would not allow agencies to determine how well MOU goals are achieved.</p>
Metric 3: Development of reimbursement agreements and sharing agreements as a result of the MOU	<ol style="list-style-type: none"> 1. Number of sharing agreements developed 2. Number of tribes impacted 3. Number of reimbursement agreements developed 4. Number of tribes impacted 5. Met purposes of MOU (yes or no) 6. Met intent of MOU (yes or no) 7. Level of VA-IHS-Tribal participation (poor, fair, good, excellent) 	<p>Adequate</p> <p>Tangible and measurable, aligned with an MOU goal, and allows the agencies to measure progress toward goals three and four.</p>

Source: GAO analysis of information provided by VA and IHS.

Note: The five MOU goals are:

- (1) Increase access to and improve quality of health care and services to the mutual benefit of both agencies. Effectively leverage the strengths of the VA and IHS at the national and local levels to afford the delivery of optimal clinical care.
- (2) Promote patient-centered collaboration and facilitate communication among VA, IHS, Native American veterans, tribal facilities, and Urban Indian Clinics.
- (3) In consultation with tribes at the regional and local levels, establish effective partnerships and sharing agreements among VA headquarters and facilities, IHS headquarters and IHS, tribal, and Urban Indian Health programs in support of Native American veterans.
- (4) Ensure that appropriate resources are identified and available to support programs for Native American veterans.
- (5) Improve health promotion and disease prevention services to Native Americans to address community-based wellness.

Using these metrics, the agencies have issued MOU progress reports, but the metrics included in the reports generally are not clearly tied specifically to the goals of the MOU, nor do they allow the agencies to

determine how well MOU goals have been achieved. Leading public-sector organizations have found that metrics that are clearly linked to goals and allow determination of how well goals are achieved are key steps to becoming more results-oriented. For example:

- According to the agencies' fiscal year 2011-2012 metrics report,²⁴ for Metric 1 (programs increased or enhanced as a result of the MOU), more than 15 programs were enhanced or increased as the result of the MOU, and 440 events and activities occurred that increased or enhanced the programs. The report then provides examples of programs that have been enhanced, such as a care coordination program in which a registered nurse "works with Indian Health, Tribal Programs, and other agencies and hospitals through direct meetings at various facilities to ensure communication and improved care." However, the report does not always describe information that would allow the agencies to determine how well each activity contributes to meeting MOU goals. For instance, in the description of an enhanced care coordination program noted above, the report does not indicate how the agencies determined that communication has improved among participants. Absent this information, it is not clear how the agencies could draw conclusions about whether improved communication has actually been facilitated and therefore how well the activity contributed to meeting the MOU goal of promoting patient-centered collaboration and facilitating communication.
- According to the metrics report, for Metric 2 (outreach activities increased or enhanced as a result of MOU partnerships), eight types of activities were increased or enhanced. However, the report lists only seven types of outreach and does not include enough information to determine how well the outreach contributes to meeting MOU goals. For example, one outreach activity cited in the report, "Outreach to promote implementation of new technologies," includes the activity "VA Office of Telehealth Services (OTS) Coordinator participated in Web-ex sessions with IHS on use of technology to improve patient care." Although not stated in the report, this activity appears to help implement the MOU strategy of enhancing access through the development and implementation of new models of care using new technologies, including telehealth, related to the MOU

²⁴Department of Veterans Affairs and Indian Health Service, *Department of Veterans Affairs (VA) Indian Health Service (IHS) Memorandum of Understanding (MOU) Metrics Report—Fiscal Year (FY) 2011/2012*.

goals of promoting patient-centered care and increasing access to care. However, while outreach activities are measurable and tangible, and might help to achieve goals of the MOU, the report does not state how the agencies will determine whether the sessions actually were effective in improving patient care or increasing access, information that is necessary to allow the agencies to tell how well the activity helps achieve the MOU goals.

- For each metric, the agencies report whether the activities “met the purpose of the MOU,” “met the intent of the MOU,” and whether the “level of VA-IHS-Tribal participation” was poor, fair, good, or excellent. While determining whether the agencies’ activities meet the purpose and intent of the MOU is a critical step, and obtaining tribal participation is consistent with MOU goals, the report does not describe how these determinations were made. Agency officials told us that these determinations were made subjectively by each workgroup while keeping in mind the goals and strategies in the MOU.

The weaknesses we found in these performance metrics could limit the ability of VA and IHS managers to gauge progress and make decisions about whether to expand or modify programs or activities, because the agencies will not have information on how well programs are supporting MOU goals. VA and IHS officials told us that they developed these performance metrics because the initial performance metrics, drafted by the workgroups themselves and other VA and IHS staff, varied in quality. The three metrics and measures were intended to provide some simple, measurable ways for workgroups to report on their progress. However, they also acknowledged that there were weaknesses in the measures and told us that refining these performance metrics is a priority. According to the officials, they plan to revise workgroup metrics by April 2013 and on a continuous basis going forward. In doing so, they plan to consult subject-matter experts and existing VA and IHS performance metrics, for example, prevention of hospital admissions in home-based primary care programs.

VA and IHS Lack Effective Processes to Overcome the Challenges of Consulting with a Large Number of Diverse, Sovereign Tribes

Mainly because of the large number of diverse tribal communities and tribal sovereignty, VA and IHS face unique challenges associated with coordinating and communicating to implement the MOU. VA and IHS have processes in place for consulting with tribes, but these measures fall short in several respects and do not ensure such consultation is effective.

VA and IHS Face Challenges Implementing the MOU Related to the Large Number of Diverse, Sovereign Tribes

VA and IHS officials told us the large number (566) of federally recognized tribes and differing customs and policy-making structures present logistical challenges in widespread implementation of the MOU within tribal communities.²⁵ For instance, according to some VA officials, in some tribes as a matter of protocol, an agency must be invited on tribal lands or be sponsored by a council member in order to address a tribal council. Such a policy could add administrative processes that might delay implementation and require greater sensitivity from agency officials, adding to the challenge of consulting with tribes. As another example, the title or position of the tribal person designated to make decisions regarding health care may differ from tribe to tribe, complicating the decision-making process among VA, IHS, and tribes. VA officials told us in some tribes, for example, a tribal leader may have several roles, only one of which is making decisions on health care, whereas in other tribes there may be a tribal health director whom the tribal leader has designated to manage health care in the tribal community. Potentially, these differences can affect the speed and degree at which collective decisions can be made.

In addition, VA and IHS officials noted that tribal sovereignty further adds to the logistical complexity of the efforts of the agencies to implement the MOU. Tribal sovereignty includes the inherent right to govern and protect the health, safety, and welfare of tribal members. Indian tribes have a

²⁵In addition to the federally recognized tribes, there are more than 400 non-federally recognized tribes. Although these non-federally recognized tribes may not receive IHS funding and members may not be eligible for IHS services, VA has an obligation to serve their members who are eligible for VA services.

legal and political government-to-government relationship with the federal government, meaning federal agencies interact with tribes as governments, not as special interest groups or individuals. VA and IHS officials told us that because of tribal sovereignty, tribally operated facilities may choose whether or not to participate in a particular opportunity for collaboration related to the MOU, which makes it challenging to achieve some of the goals of the MOU. VA and IHS can inform tribes of an opportunity but cannot require them to participate. For example:

- In order to meet the MOU goal to establish standard mechanisms for access to electronic health record (EHR) information for shared patients, VA and IHS have coordinated to adapt their information technology systems to allow them both to participate in the eHealth Exchange, a national effort led by the Department of Health and Human Services for sharing EHR information.²⁶ However, EHR workgroup members told us that some tribally operated facilities have opted to use an off-the-shelf product in place of the IHS system, which the workgroup members do not have the resources to support.
- In another instance, as a part of their efforts to meet the MOU goal to establish effective partnerships and sharing agreements, VA and IHS are working to implement VA's Consolidated Mail Outpatient Pharmacy (CMOP) throughout IHS. Workgroup members assigned to these activities said they plan to implement the program in all IHS-operated facilities by spring 2013 but cannot require tribally operated facilities to participate. Some smaller tribal communities with more limited postal access are not interested in using the CMOP program, according to the workgroup members.

²⁶The eHealth Exchange is a set of standards, services, and policies that enable the secure exchange of health information over the Internet.

VA and IHS Processes in Place to Overcome the Complexities Associated with Consulting with Tribes Do Not Always Ensure Effective Consultation

Written Correspondence

VA and IHS communicate MOU-related information with the tribes through written correspondence, in-person meetings, and other steps, as is consistent with internal controls calling for effective external communications with groups that can have a serious effect on programs and other activities; however, according to tribal stakeholders we interviewed, these methods for consultation have not always met the needs of the tribal communities, and the agencies have acknowledged that effective consultation has been challenging.

VA and IHS send written correspondence (known as “Dear Tribal Leader” letters) regarding the MOU to tribal communities. However, the agencies have acknowledged that because of the large and diverse nature of the tribes, they have struggled to reach the tribal member designated to make health care decisions with information about the MOU. Both VA officials and members of tribal communities told us that, because tribal leaders are not always the tribal person designated to make decisions regarding health care, the “Dear Tribal Leader” letters may not always make their way to tribal members designated to take action on health care matters. VA officials told us that their formal consultation is conducted with tribal leaders. However, these officials also noted that, in addition to the letters sent to tribal leaders, they have a network of contacts within each tribe that includes, among others, tribal health directors, and this network receives concurrent notice of communication with tribal leaders via conference calls, listservs, and newsletters. IHS officials said sometimes, in addition to the tribal leader, they may also send letters to, or otherwise communicate directly with, tribal health program directors if they know of them. However, they also noted they do not maintain a specific record—such as a listserv—of tribal health program directors. Without reaching the tribal members responsible for decision-making on healthcare matters, VA and IHS may not always be effectively communicating with tribes about the status of the MOU and its related activities nor be obtaining tribal feedback that is critical with respect to implementation of the MOU.

Likewise, seven tribal stakeholders we spoke with noted similar concerns regarding the “Dear Tribal Leader” letters as VA and IHS. For example, one tribal stakeholder said letters should go to a specific person, such as a tribal health director, to ensure that the information is seen by the right people in a timely manner. It may take the tribes time to pass along letters sent only to tribal leaders to the tribal health director or other appropriate people, by which point any deadlines included in the correspondence could be missed. Once the information has reached the tribal leader,

tribes bear the responsibility to ensure it is passed on to the appropriate audience in a timely manner.

Another specific concern tribal stakeholders that we spoke with expressed relating to written correspondence was that the agencies sometimes use the letters to simply inform them of steps the agencies have taken without consulting the tribes, as called for by the agencies' tribal consultation policies. For example, some tribal stakeholders said VA and IHS did not include them in the original development of the 2010 MOU, even though the goals and activities in the MOU could directly affect them. According to 10 of the tribal stakeholders we spoke with, tribes should have been included in developing the MOU, which addresses proposed plans, policies, and programmatic actions that may affect tribes. For example, the MOU seeks to improve delivery of health care by developing and implementing new models of care using new technologies, including telehealth services such as telepsychiatry. Instead, the agencies solicited tribal comments after the agencies had signed the MOU. According to two tribal stakeholders, the agencies were not responsive to the comments provided on the MOU. One stakeholder said their comments were not acknowledged upon receipt nor did IHS ever follow up on the issues raised by their comments. The stakeholder suggested IHS designate a point person to track feedback and ensure follow-up. VA and IHS officials told us that they did not hold tribal consultation meetings before the signing of the MOU because they viewed the MOU as an agency-to-agency agreement rather than as an agreement between the agencies and the various tribes.

In-person Meetings

VA and IHS officials said they hold quarterly meetings with tribal communities and also attend events, such as conferences held by Native American interest organizations. Three tribal stakeholders told us that when the agencies have held consultation meetings, the meetings are not interactive enough—stating that agency officials speak for the majority of the time—and that VA does not provide enough information prior to these meetings. These tribal stakeholders said providing information ahead of time could allow tribes to better prepare for meetings, discuss issues as a tribe beforehand, and determine which tribal members should attend. If tribal officials with the authority and desire to work with VA and IHS do not receive needed information on opportunities because of an ineffective consultation process, local facility leadership may not have readily available access to information necessary to examine which collaborative opportunities are present, and thus VA and IHS may be hindered in their efforts to coordinate health care for Native American veterans.

VA and IHS are undertaking other efforts designed to enhance consultation with tribes. These include the following steps:

- In January 2011, VA established the Office of Tribal Government Relations (OTGR) to serve as the point of contact for tribes. According to VA officials, this office conducted four consultation meetings in 2012 and employed five field staff to help manage communication with tribal communities and to work with IHS on local MOU implementation efforts.
- In February 2011, VA released the agency's tribal consultation policy. VA officials said they are developing a report that will explain the process for evaluating comments from tribes and making decisions based on them. The officials expect the report to be released to the public in the spring of 2013.
- The agencies have made more local efforts to communicate with tribes, which have led to some success. For example, agency officials and tribal stakeholders noted that the workgroup assigned to implement MOU activities in Alaska used successful methods for working with tribes. The Alaska workgroup told us they cultivated a relationship with an Alaskan tribal health organization in order to get advice on the appropriate customs for consulting with individual tribes there. In addition, the workgroup said they scheduled consultation meetings in conjunction with other meetings, which would limit the amount of travel tribal community members would need to undertake. VA employees also took cultural awareness training, and VA officials visited Alaska to demonstrate the agency's dedication to providing care to Native American veterans, which, according to the workgroup, led to buy-in from tribal communities. VA and Alaskan tribes have signed 26 reimbursement agreements.

Some tribal stakeholders that we spoke with have acknowledged the steps taken by the agencies thus far as positive but in some cases expressed concerns regarding tribal consultation. In the case of the tribes working with the Alaska workgroup, one stakeholder praised VA's efforts to work with tribal health organizations to communicate with tribes. In another example, two tribal stakeholders said they approved of OTGR's establishment as an office dedicated to Native American veterans' issues. However, four tribal stakeholders expressed concerns that, despite the creation of OTGR, VA still has not always been effective in its efforts to consult with tribes or be responsive to tribal input provided during consultation. For example, one stakeholder questioned whether

consultation was done with every tribe and described VA's consultation process as sporadic. This stakeholder's concern implies that VA's outreach efforts may not be systematically reaching all tribal communities. However, VA officials told us that, in addition to issuing notices in the Federal Register and Dear Tribal Leader letters, they have a systematic process of hosting training summits for tribes and scheduling regular conference calls and presentations to tribal leadership. In another instance, one tribal community member said OTGR lacks—and thus cannot disperse to tribes—the technical knowledge necessary for tribes to partner with VA on activities such as negotiating reimbursement agreements. VA officials noted that OTGR staff may not always be technical experts on a given topic but said they are able to identify those experts and play a key role in linking tribes with them.

Conclusions

Coordination between VA and IHS is essential to ensuring that high-quality health care is provided to dually eligible Native American veterans. While the 2010 MOU includes common goals that should facilitate agency coordination, and the agencies have created workgroups tasked to implement the MOU, we found that a critical mechanism for monitoring the implementation of the MOU, the agreement's performance metrics, has weaknesses. Specifically, the inadequacies we found in performance metrics could limit the agencies' ability to measure progress towards MOU goals and ultimately make decisions about programs or activities.

Overcoming the challenges related to working with a large number of diverse, sovereign tribes is also essential to successfully achieving the goals of the MOU. Although steps have been taken to consult with tribes regarding the MOU and related activities, consultation has not always been effective in assuring that the people designated to make health care decisions in each tribe are reached and tribes are included in planning and implementation efforts. Ineffective consultation with tribal communities could delay or limit potential VA, IHS, and tribal community partnerships to achieve the goals of the MOU and could hinder agency efforts to gain support for MOU activities and address the health care needs of Native American veterans.

Recommendations for Executive Action

To ensure the health care needs of Native American veterans are addressed most efficiently and effectively, we recommend that the Secretary of Veterans Affairs and Secretary of Health and Human Services take the following two actions:

-
- As the agencies move forward with revising the MOU's performance metrics and measures, ensure that the revised metrics and measures allow decision makers to gauge whether achievement of the metrics and measures supports attainment of MOU goals.
 - Develop processes to better ensure that consultation with tribes is effective, including the following:
 - A process to identify the appropriate tribal members with whom to communicate MOU-related information, which should include methods for keeping such identification up-to-date.
 - A process to clearly outline and communicate to tribal communities the agencies' response to tribal input, including any changes in policies and programs or other effects that result from incorporating tribal input.
 - A process to establish timelines for releasing information to tribal communities to ensure they have enough time to review and provide input or, in the case of meetings, determine the appropriate tribal member to attend the event.

Agency Comments

We provided draft copies of this report to VA and the Department of Health and Human Services for review. Both agencies concurred with our recommendations. In addition, VA provided us with comments on the draft report, which we have reprinted in appendix I, as well as general and technical comments, which were incorporated in the draft as appropriate.

We are sending copies of this report to appropriate congressional committees; the Secretary of Veterans Affairs; the Secretary of Health and Human Services; and other interested parties. In addition, the report is available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs are on the last page of this report. GAO staff who made major contributions to this report are listed in appendix II.

A handwritten signature in black ink that reads "Randall Williamson". The signature is written in a cursive style with a large initial "R".

Randall Williamson
Director, Health Care

List of Requesters

The Honorable Patty Murray
Chairman
Committee on the Budget
United States Senate

The Honorable Bernie Sanders
Chairman
Committee on Veterans' Affairs
United States Senate

The Honorable Mark Begich
United States Senate

The Honorable Jon Tester
United States Senate

Appendix I: Comments from the Department of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

April 5, 2013

Mr. Randall Williamson
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Williamson:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, "**VA AND IHS: Further Action Needed to Collaborate on Providing Health Care to Native American Veterans**" (GAO-13-354). VA concurs with GAO's two recommendations to the Department.

VA's Office of Rural Health (ORH) is the VA point of contact with oversight of the VA/Indian Health Service (IHS) Memorandum of Understanding (MOU) (VA/HIS MOU) and associated Workgroups. VA's Office of Tribal Government Relations (OTGR), established two years ago, supports the agency (Veterans Health Administration, Veterans Benefits Administration and National Cemetery Administration) in expanding its relationships and collaborative activities with tribes in order to effectively serve Veterans residing in tribal communities; members of 566 Federally recognized tribes. OTGR supports the agency's efforts by using its employees' knowledge of tribal leaders, governance structures, geography, political structure, cultural distinctions, tribal priorities, and through demographic data. During the past two years, VA has made significant strides in relationship building, being responsive to the needs of Veterans in tribal communities, and establishing positive communications, through the establishment of the OTGR.

In 2012, VA hosted 7 regional training summits inviting Veterans, tribal leaders, and tribal service providers (including tribal health directors), as well as colleagues from other government and private organizations that serve Veterans. VA senior leadership attended high profile tribal conferences, sponsoring outreach booths (the IHS Tribal Self-Governance Conference, the National Congress of American Indians and the National Indian Health Board Annual Consumer Conference) and Veterans training tracks, and, in partnership with ORH and the VA Medical Center in Alaska, trained over 300 tribal Veteran representatives who serve communities throughout the State. The level of engagement with tribal communities has been unprecedented for the agency the past two years and it is important that although we concur with some of the specific recommendations contained within this report, the report does not acknowledge the substantial strides made by VA.

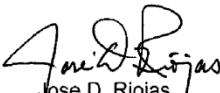
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Mr. Randall Williamson

Tribal Consultation has not been initiated on the entire MOU in the past two years or on all of its associated Workgroups. Tribal Consultation was initiated on the reimbursement agreement (associated with Workgroup 6) and in 2012 on the question of how to engage tribes in the activities and Workgroups relative to the VA/IHS MOU. Moving forward, VA plans to establish an aggressive communications plan specific to the VA/IHS MOU with a strong emphasis on increasing knowledge and awareness of all opportunities that exist pursuant to the MOU for tribal communities.

The enclosure specifically addresses GAO's two recommendations, provides an action plan for each, and includes general and technical comments. VA appreciates the opportunity to comment on your draft report.

Sincerely,


Jose D. Riojas
Interim Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
***“VA AND IHS: Further Action Needed to Collaborate on
Providing Health Care to Native American Veterans”***
(GAO-13-354)

GAO Recommendation: To help ensure the health care needs of Native American veterans are addressed most efficiently and effectively, we recommend that the Secretary of VA and Secretary of Health and Human Services take the following two actions:

Recommendation 1: As the agencies move forward with revising the MOU's performance metrics and measures, ensure that the revised metrics and measures allow decision makers to gauge whether achievement of the metrics and measures supports attainment of MOU goals.

VA Response: Concur. As part of the Department of Veterans Affairs (VA)/Indian Health Services (IHS) Memorandum of Understanding (MOU) (VA/IHS MOU) continuous quality improvement process, the Veterans Health Administration (VHA) is implementing improved measures that will increase the ability of the collaborating agencies to gauge progress toward the MOU goals. Each of the VA/IHS MOU workgroups will be assigned to report "how" they determined that the reported activities met the purposes and intents of one or more of the five MOU goals. Specifically, metrics one and two will have this new reporting strategy, as suggested in the draft report. VHA is implementing this strategy now and intends to use the MOU workgroup responses to inform participating agencies about "how" specific activities address the five MOU goals. Anticipated completion date is October 31, 2013.

Recommendation 2: Develop processes to better ensure that consultation with tribes is effective, including:

A process to identify the appropriate tribal members with whom to communicate MOU-related information, which should include methods for keeping such identification up-to-date.

VA Response: Concur. In 2012, VA formally consulted with tribes on how to engage tribes in workgroups and activities related to the VA/IHS MOU. Information obtained through the series of consultations informed VA as to specific actions to take moving forward that will enhance and increase awareness amongst tribes of collaborative activities the two agencies are engaged in pursuant to the MOU. The Director, Office of Tribal Government Relations (OTGR) participates in Workgroup 12. Workgroup 12 will be tasked with reviewing and applying specific communications recommendations obtained from the tribes during the 2012 tribal consultation process in developing the communications plan for the MOU. The primary point of contact to formally convey MOU information will be the 566 tribal leaders – VA uses the United States Department of Interior, Bureau of Indian Affairs Tribal Leaders Directory published annually for an up to date listing of the Federally recognized tribes to send correspondence. Additionally,

Enclosure

Department of Veterans Affairs (VA) Comments to
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VA will use social media, the internet, conference calls, Federal, state, national advocacy and inter-tribal organizations to communicate to tribal service providers and tribal program points of contact updated information regarding MOU workgroup activities, opportunities, and accomplishments.

A process to clearly outline and communicate to tribal communities the agencies' response to tribal input, including any changes in policies and programs or other effects that result from incorporating tribal input.

VA Response: Concur. On August 24, 2012, VA moved forward with issuing a Dear Tribal Leader letter providing updates and responses to the two joint VA/IHS Dear Tribal Leader letters released March 5, 2012, and April 5, 2012, initiating consultation with tribes on the topic of VA reimbursement for services provided by the IHS and Tribal Health facilities to eligible American Indian and Alaska Native (AI/AN) Veterans; and on April 5, 2012, providing the actual draft agreement. Transmitted in the August 24, 2012, letter were the following documents for tribes' review and consideration: VA Tribal Consultation response document (FAQs), Highlights of VA and Tribal Health Program Agreements, Tribal Health Program Claim Processing Site Readiness, in addition to a specific email address for tribes to submit a letter of interest to VA through their tribal leadership or governing body. The transmitted documents detailed how VA incorporated tribal feedback from the March and April 2012 consultations and the process by which tribes could move forward with establishing reimbursement sharing agreements with VA.

VA's 2012 Tribal Consultation Report (which does not include information from joint consultation sessions with the IHS held in 2012) is scheduled to be published late Spring of 2013 which will outline and communicate the agency's response to tribal input. As in the August 2012 VA correspondence to tribes, the agency will continue to work to communicate to tribes through a process that includes Dear Tribal Leader Letter updates, listserv notices, Web site postings, All Tribes conference calls, Webinars, social media, and how the input received from tribes during consultation will affect changes in policies and programs resulting from tribal input.

A process to establish timelines for releasing information to tribal communities to ensure they have enough time to review and provide input or, in the case of meetings, determine the appropriate tribal member to attend the event.

VA Response: Concur. VA agrees it is important to provide tribes with sufficient advance notice and time to provide input and prepare for attendance at scheduled meetings. On March 19, 2012, VA posted notice in the Federal Register/Vol. 77,

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Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
***“VA AND IHS: Further Action Needed to Collaborate on
Providing Health Care to Native American Veterans”***
(GAO-13-354)

No. 53 of the VA Tribal Consultation scheduled for April 5, 2012. On March 12, 2012, VA released a Dear Tribal Leader letter notifying tribes of upcoming tribal consultations scheduled for May 25, 2012, at the Dean'ina Center in Anchorage, Alaska, June 2012 in Lincoln, Nebraska, and September 2012 in Denver, Colorado. The letter specified the consultation topics being presented by all three VA administrations. On May 1, 2012, VA released a subsequent Dear Tribal Leader letter which provided the consultation topics and the location, dates, and times of each consultation session. Tribes were also notified in the Federal Register notice and Dear Tribal Leader Letters that the record for each tribal consultation would remain open for 30 days following the in-person sessions. This would allow additional time for tribes to submit comments and recommendations that would be submitted for consideration by VA leadership in making determinations regarding any changes to policy or programming as a result of the feedback received from tribes.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Randall Williamson, (202) 512-7114 or williamsonr@gao.gov

Staff Acknowledgments

In addition to the contact named above, Gerardine Brennan, Assistant Director; Jennie Apter; Lori Fritz; Hannah Marston Minter; and Lisa Motley made key contributions to this report.

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