



June 2014

# HEALTH CARE ACCESS

Improved Oversight,  
Accountability, and  
Prioritization Can  
Improve Access for  
Native American  
Veterans

## 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, but according to reports some have had problems accessing care. In 2010 these two agencies expanded upon an MOU designed to improve Native American veterans' access to care at their facilities. GAO was asked to examine how the MOU has increased access to care.

This report examines: (1) the actions that VA and IHS have taken to implement the provisions in the 2010 MOU related to access to care for Native American veterans, and (2) what is known about how access to care for Native American veterans has improved. To conduct this work, GAO reviewed agency documents and VA and IHS reimbursement data and interviewed VA and IHS officials. GAO also visited three sites selected to reflect geographic variation to learn about access to care locally through interviews with regional VA and IHS officials, health facility officials, and Native American veterans and their tribal representatives. GAO also contacted other individuals who help Native American veterans seek enrollment in the VA to obtain their insights about improvements in access to care.

## What GAO Recommends

GAO recommends that VA and IHS establish written policy or guidance designating specific roles and responsibilities for agency staff to hold leadership accountable and improve implementation and oversight of the MOU. VA and IHS agreed with GAO's recommendation.

View [GAO-14-489](#). For more information, contact Randall Williamson at (202) 512-7114 or [williamsonr@gao.gov](mailto:williamsonr@gao.gov).

## HEALTH CARE ACCESS

### Improved Oversight, Accountability, and Prioritization Can Improve Access for Native American Veterans

## What GAO Found

The Department of Veterans Affairs (VA) and the Indian Health Service (IHS) have taken a variety of actions to improve access to care for Native American veterans under their 2010 memorandum of understanding (MOU); however according to stakeholders, these agencies face substantial implementation challenges. VA and IHS have taken actions to (1) strengthen outreach and enrollment through information sharing and training; (2) expand services through national and local projects; (3) increase training about cultural competency for staff at VA and IHS facilities; and (4) establish reimbursement agreements that allow VA to reimburse IHS facilities for services provided to veterans. However, in each of these areas challenges remain, such as insufficient data to identify Native American veterans for outreach, obstacles to reaching those who live in very remote areas, and technological challenges such as lack of Internet connectivity or phone lines.

While VA and IHS have taken actions to increase access, the oversight, accountability, and prioritization of MOU implementation are lacking. Specifically:

- Oversight is inconsistent: In 2013, the officials tasked with oversight of the implementation of the MOU did not meet and did not systematically evaluate the progress of MOU implementation.
- Written policies and guidance are lacking: According to officials, the only documentation outlining the procedures to report VA and IHS progress on implementation efforts is contained in a set of training slides used in a December 2012 training session, and these slides have not been formalized in written policy or guidance.
- Prioritization of MOU implementation is lacking: Leadership of VA and IHS have not made MOU implementation a priority, which threatens the ability of the two agencies to move forward in implementing the MOU. Key officials attributed this, in part, to their perception that their non-MOU related responsibilities had a higher priority.

Without consistent oversight, formal policy or guidance on responsibilities for MOU implementation, and the prioritization of MOU implementation, VA and IHS leadership do not have reasonable assurance that the objectives of the MOU related to access to care are being addressed.

Native American veterans and their representatives that GAO contacted reported mixed views on whether access to care has improved over the past 3 years. Although a majority reported that access to care had improved, others either said that they did not think it had improved or were unsure. For example, 53 of 102 Native American veterans representatives GAO contacted reported that in the last 3 years there had been an increase in the number of Native American veterans accessing health care at VA or IHS-funded facilities; however, 12 felt there had been no change, and 36 said they did not know.

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# Contents

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Letter		1
	Background	5
	Actions VA and IHS Have Taken to Improve Access to Care for Native American Veterans Face Implementation Challenges, and Oversight and Accountability Are Lacking	9
	Native American Veterans and Their Representatives Reported Mixed Views on Whether Access to Care Has Improved	24
	Conclusions	26
	Recommendation for Executive Action	27
	Agency Comments	27
Appendix I	Comments from the Department of Veterans Affairs	30
Appendix II	Comments from the Department of Health and Human Services	33
Appendix III	GAO Contact and Staff Acknowledgments	36
Related GAO Products		37
Figure		
	Figure 1: Procedures Outlined in 2012 Training Slides for Tracking and Overseeing Actions Taken to Achieve the Goals of the Memorandum of Understanding between the Department of Veterans Affairs (VA) and the Indian Health Service (IHS)	22

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## Abbreviations

HHS	Department of Health and Human Services
IHS	Indian Health Service
MOU	memorandum of understanding
ORH	Office of Rural Health
OTGR	Office of Tribal Government Relations
PTSD	post-traumatic stress disorder
THP	Tribal Health Program
TVR	Tribal Veterans Representative
VA	Department of Veterans Affairs
VISN	Veterans Integrated Service Network

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June 10, 2014

## Congressional Requesters

Native Americans historically have served in the military at a higher rate than any other ethnic group, according to the Department of Defense.<sup>1</sup> 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 (HHS).

According to Congressional testimony and media reports, Native American veterans have had problems accessing care in both VA and IHS. For example, some Native American veterans report being turned away from both VA and IHS-funded facilities because of confusion among facility staff over eligibility requirements.<sup>2</sup> Native American veterans have also reported that a lack of cultural competency regarding tribal practices and the needs of veterans can affect their access to care at VA and IHS-funded facilities. For example, it has been reported that a lack of understanding of traditional healing practices or the varied needs of each tribe can be a barrier to accessing care at VA, and a lack of clinical expertise on certain veterans' care issues—such as expertise on how to treat post-traumatic stress disorder (PTSD)—can make it difficult for

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<sup>1</sup>For the purposes of our report, the term Native American includes both American Indians and Alaska Natives.

According to the U.S. Census Bureau, in 2012 approximately 162,000 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 underestimates the number of Native American veterans.

<sup>2</sup>IHS-funded facilities include both facilities that are operated by the IHS and tribal health program (THP) facilities that are funded by IHS, but operated by the tribes.

*Hearing on VA and Indian Health Service Cooperation:* Hearing Before the Committee on Veterans' Affairs, United States Senate, 111th Cong (November 5, 2009).

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veterans to access certain types of care at IHS-funded facilities.<sup>3</sup> Further, it has been reported that many Native American veterans live in very rural areas and have difficulty obtaining transportation to both VA and IHS-funded facilities, or face very long travel times to facilities, which can make it difficult to access care at either type of facility.<sup>4</sup>

In 2010, VA and IHS expanded upon a 2003 memorandum of understanding (MOU), which included provisions to improve Native American veterans' access to VA and IHS facilities and the agencies' coordination of efforts related to the MOU.<sup>5</sup> The 2010 MOU, which aimed to more fully address the core access problems for Native American veterans, includes goals to increase access to health care services for Native American veterans. It also describes strategies intended to achieve this goal. For example, the 2010 MOU includes provisions for expanding outreach through the Tribal Veterans Representative Program, expanding telehealth services, developing payment and reimbursement policies and mechanisms to support care delivered to Native American veterans eligible for care in both systems, and providing training to VA and IHS staff on the agencies' eligibility requirements.<sup>6</sup>

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<sup>3</sup>For the purposes of this report, we define cultural competency in terms of health care services as the respect and response to the health beliefs, practices, and cultural and linguistic needs of diverse patients. It refers to Native American traditions, beliefs and practices, but also to clinical care needs of veterans.

*Hearing on VA and Indian Health Service Cooperation:* Hearing Before the Committee on Veterans' Affairs, United States Senate, 111th Cong. (November 5, 2009).

<sup>4</sup>See *Broken Promises: Evaluating the Native American Health Care System*, U.S. Commission on Civil Rights (September 2004): 77-80; and *Frequently Asked Questions about the Native Domain*, Veterans Health Administration: Office of Rural Health, <http://www.ruralhealth.va.gov/native/faqs.asp>, accessed June 2, 2014.

<sup>5</sup>The MOU indicates that improvements in access to care may be achieved through an increase in the amount and types of services available to Native American veterans and the use of more geographically accessible services (e.g., mobile services, telehealth, and sharing of staff.) In some cases, enrollment in the VA may give Native American veterans access to services not readily available at certain IHS or Tribal Health Program (THP) facilities.

<sup>6</sup>Telehealth includes telemedicine, which is the use of medical information exchanged from one site to another via electronic communications (such as video or e-mail) to improve a patient's clinical health status through, for example, provision of health care services or clinical monitoring. Telehealth can include telemental health—the provision of mental health services to patients living in remote locations or otherwise underserved areas.

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We previously reported on the agencies' coordination of efforts related to the MOU.<sup>7</sup> We examined the extent to which the agencies established mechanisms for MOU implementation and monitoring, the key challenges the agencies faced in implementing the MOU, such as the challenge of coordinating with a large number of unique tribes, and the progress made in overcoming those challenges.

We were asked to report on the extent to which the MOU has increased access to care for Native American veterans. This report examines: (1) the actions that VA and IHS have taken to implement the provisions in the 2010 MOU related to access to care for Native American veterans; and (2) what is known about how access to care for Native American veterans has improved.

To examine the actions that VA and IHS have taken to implement provisions in the 2010 MOU related to access to care for Native American veterans, we collected information from a variety of sources. We reviewed a broad range of documents related to MOU activities, such as quarterly reports that describe MOU-related activities and progress by VA and IHS. We reviewed information and data related to reimbursement by VA to IHS-funded facilities for services provided to Native American veterans. We interviewed agency officials, including leaders of 5 of the 12 work groups that were established to implement the MOU, about actions they have taken to increase access to care, monitor progress, and assess outcomes in improving access. Finally, we conducted site visits to three regions of the country—the Upper Peninsula of Michigan, Northern Arizona, and Alaska—to learn about actions taken by VA and IHS to improve access to care at the local level. The regions were selected to reflect geographic variation, variation in the types of VA and IHS-funded facilities available, and the presence or absence of reimbursement agreements between the VA and IHS-funded facilities. We conducted interviews with: VA and IHS regional officials; VA, IHS, and tribal health facility staff such as administrators, enrollment coordinators, and business office managers; and representatives of tribes. Information obtained through these site visits cannot be generalized to the nationwide Native American veteran population.

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<sup>7</sup>See GAO, *VA and IHS: Further Action Needed to Collaborate on Providing Health Care to Native American Veterans*, [GAO-13-354](#) (Washington, D.C.: Apr. 26, 2013).

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To examine what is known about how access to care for Native American veterans has improved, we interviewed Native American veterans and their representatives—such as Tribal Veterans Representatives (TVR)—in 12 interviews during our three site visits.<sup>8</sup> We analyzed this information to determine the extent to which there were positive or negative comments related to changes in access to care for Native American veterans—such as whether interviewees thought that the number of Native American veterans obtaining care at VA or IHS facilities had increased or decreased. We used the following convention to state whether comments were made at most, many, some, or few of these interviews: most—at least one comment in 9 to 11 interviews; many—at least one comment in 5 to 8 interviews; some—at least one comment in 3 to 4 interviews; and few—at least one comment made in 1 to 2 interviews. We also obtained views from an additional 102 representatives of Native American veterans through a Web-based questionnaire.<sup>9</sup> This questionnaire included questions about the extent to which access to care for Native American veterans had changed during the past 3 years. The responses to this questionnaire are not generalizable to the entire population of representatives of Native Americans.

We conducted this performance audit from June 2013 to June 2014 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.

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<sup>8</sup>TVRs conduct outreach to educate Native American veterans about the availability of veterans' benefits and the process for enrolling for these benefits. They are often volunteers and may receive training from VA. In addition to TVRs, other staff who assist Native American veterans are Tribal Outreach Workers, Veterans Service Officers, and Tribal Veterans Service Officers. In this report we will refer to all such types of individuals as representatives of Native American veterans.

<sup>9</sup>We obtained contact information for these individuals from a variety of sources including VA, national veterans service organizations, and state offices of veterans' affairs.



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## Background

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### Native American Veterans

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.<sup>10</sup>

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### VA and IHS Structure and Benefits

VA is charged with providing health care services to the nation's eligible veterans, and served 6.5 million individual patients in fiscal year 2013. In fiscal year 2013, VA had \$56 billion in appropriations available for medical care. VA's health care system includes 21 regional networks—Veterans Integrated Service Networks (VISN)—to which each of VA's 151 medical centers are assigned.<sup>11</sup> The VA medical centers offer a variety of inpatient and outpatient services, ranging from routine examinations to complex surgical procedures. VA's health care system also includes facilities such as community-based outpatient clinics. Eligibility for VA health care is based on several factors, including the veteran's period of active service, discharge status, the presence of service connected disabilities or exposures, income, and other factors such as status as a former prisoner of war. In addition, VA categorizes eligible veterans into eight priority groups, and some veterans may be responsible for co-payments.<sup>12</sup>

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<sup>10</sup>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 because of their status as Indians.

In addition, some Native American veterans are members of the more than 400 Native American groups that are not recognized by the federal government. Veterans who are members of these Native American groups may be eligible for VA benefits, but are not generally eligible for IHS benefits. For 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).

<sup>11</sup>Each VA medical center is assigned to a single VISN.

<sup>12</sup>See 38 U.S.C. § 1705; 38 C.F.R. § 17.36(b). To manage its provision of health care services for eligible veterans, VA operates a system of annual patient enrollment in accordance with eight priorities listed in statute. VA may change which priority groups and sub-groups of veterans are eligible for enrollment by amending the applicable regulation. See 38 C.F.R. § 17.36(c).

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IHS was established for the purpose of providing, or arranging for, health care to the approximately 2.2 million eligible Native Americans. IHS's fiscal year 2013 budget was approximately \$4.1 billion. While IHS's headquarters is based in the Washington, D.C., area, overall the agency is organized into 12 federally designated geographic service areas that cover all or part of 35 states.<sup>13</sup> IHS provides health care services directly through a system of about 120 facilities that are operated by IHS—including hospitals, health clinics, and health stations. In addition to IHS-operated facilities, some federally recognized tribes choose to operate their own health care facilities—tribal health programs (THPs)—that receive IHS funding. THPs operate the majority of facilities funded by IHS, including 500 facilities, such as hospitals, clinics and health stations. IHS also provides funding to nonprofit, urban Native American organizations through the Urban Indian Health program to provide health care services to Native Americans living in urban areas. To be eligible for IHS health care services, an individual must be a person of Indian descent belonging to the Indian community, 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.<sup>14</sup> In instances where a Native American veteran is eligible for a particular health care service from both VA and IHS, VA is the primary payer.

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## Memorandum 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, VA and IHS replaced the MOU with an updated MOU, which outlines specific goals and strategies related to increasing access to care for Native American veterans, such as goals to improve outreach and cultural competency, expand services including through telehealth, and develop payment and reimbursement policies. Specifically, the MOU included the following provisions related to access to care:

- providing training for IHS and tribal staff on VA and IHS eligibility requirements to assist them with appropriate referrals for services;

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<sup>13</sup>The 12 IHS service areas are Alaska, Albuquerque, Bemidji, Billings, California, Great Plains, Nashville, Navajo, Oklahoma City, Phoenix, Portland, and Tucson.

<sup>14</sup>See 42 C.F.R. § 136.12.

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- expanding the TVR program, which uses Native American liaisons to conduct outreach to tribes to assist with veterans' eligibility questions;
  - increasing cultural awareness and culturally competent care;
  - developing and implementing telehealth services such as telepsychiatry and telepharmacy; and
  - increasing the availability of services by developing payment and reimbursement policies and mechanisms.

The MOU provides for a broad range of collaboration between VA and IHS. One goal of the MOU is to bring together strengths and expertise from each agency to improve both the care and services provided by each organization.

VA and IHS designated certain staff to implement the MOU. The two key offices within VA that have been involved in implementing the MOU are the Office of Rural Health (ORH) and the Office of Tribal Government Relations (OTGR). VA created ORH in 2007 to focus on better serving the needs of veterans residing in geographically remote areas through a combination of community-based clinic expansions, increased partnerships with non-VA providers, and increased use of telehealth services.<sup>15</sup> VA established OTGR in 2011 to work to strengthen and enhance partnerships that enhance access to services and benefits for Native American veterans. Within IHS, MOU responsibilities have been delegated to the Chief Medical Officer and staff.

To accomplish the goals set forth in the MOU, VA and IHS created interagency work groups, tasked with implementing and developing strategies to address the goals of the MOU, such as developing payment and reimbursement policies and mechanisms, and developing and implementing new models of care through new technology, including telehealth services.<sup>16</sup> Each work group includes staff from VA and IHS, and, in some cases, tribal representatives. In many cases, work group

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<sup>15</sup>ORH is located in the Office of the Assistant Deputy Undersecretary for Policy and Planning of the Veterans Health Administration.

<sup>16</sup>The work groups are: Services and Benefits; Coordination of Care; Health Information Technology; New Technologies; System Level; Payment and Reimbursement; Sharing of Care Process, Programs and Services; Cultural Competency and Awareness; Training and Recruitment; Emergency and Disaster Preparedness; Alaska; and Leadership.

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members volunteered to serve on the work groups. The goals established by each work group align with MOU goals.

One of the work groups, referred to as either the Leadership work group or the Joint Implementation Task Force, is responsible for the oversight and the overall implementation of the MOU, and charged with identifying strategies and plans for accomplishing the goals of the MOU. It includes officials from both agencies, including from the Office of the Secretary of Veterans Affairs, the IHS Chief Medical Officer, and the director of OTGR, and also includes the co-chairs of certain MOU work groups. The agencies defined responsibilities for the Joint Implementation Task Force. Specifically, it is charged with developing implementation plans and procedures for policy-related issues identified by the work groups, creating performance metrics and timelines, collecting quarterly progress reports from the work groups and from other sources such as VA VISN Native American Inventory reports, evaluating progress, identifying priority action items for work groups, and providing an annual report on progress in MOU implementation.<sup>17</sup> According to the MOU 2012 Annual Report, the Joint Implementation Task Force is expected to meet quarterly.

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<sup>17</sup>Work group reports are submitted on a quarterly basis. They are intended to collect project and program data on MOU interagency collaborations. The Native American Inventory Reports are submitted by VISNs to VA on a quarterly basis. They are intended to provide information about projects and activities conducted by VA and IHS staff in each VISN area to support Native American veterans.

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## Actions VA and IHS Have Taken to Improve Access to Care for Native American Veterans Face Implementation Challenges, and Oversight and Accountability Are Lacking

VA and IHS staff have taken actions to improve access to care, including strengthening outreach and enrollment efforts, expanding services offered, increasing efforts to improve cultural competency, and implementing reimbursement agreements. However, according to various stakeholders, these efforts face a variety of implementation challenges, such as a lack of data identifying which Native Americans are veterans, difficulty reaching Native American veterans who live in remote locations, and staff turnover at IHS and THP facilities. In addition, although VA and IHS have identified procedures for collecting information on the various actions taken by VA and IHS facilities to address the goals of the MOU, the agencies lack a defined approach to effectively track and oversee implementation of the MOU.

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## VA and IHS Have Taken Actions to Improve Access to Care, but Implementation Challenges Limit Their Effectiveness

In four main areas, VA and IHS have taken actions to improve access to care for Native American veterans: (1) outreach and enrollment, (2) expanded services including telehealth, (3) training and improvement in cultural competency, and (4) reimbursement agreements. However, in each of these areas, unresolved challenges prevent these actions from being fully or effectively implemented.

### Information Sharing, Training, and Outreach about Enrollment Have Improved, but Sufficient Information to Identify Native Americans and Resources to Help Them Are Lacking

Both agencies have taken actions to improve outreach to Native American veterans and to provide information about enrollment into the VA health system. Specifically, IHS and VA have developed various ways to share information about eligibility and enrollment and VA has conducted a variety of training programs about these topics.

- **Information sharing:** IHS and VA have supported information sharing in a variety of ways with tribes, IHS and THP facilities, and Native American veterans. For example, OTGR published a monthly newsletter focusing on resources available to tribes to promote enrollment in the VA health system. In addition, IHS officials in two of our three site visit areas reported that they organized introductions of VA staff to tribal officials and IHS and THP facility staff, and the VA medical centers in all of these site visit areas reported that they shared information in a variety of ways such as health benefit fairs held at tribal locations, regular conference calls with tribal health officials, and meetings with Native American veterans' organizations. In the Native American Inventory quarterly reports, 20 of 21 VISNs reported one or more information sharing activities, such as making

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presentations to tribal elders and providing information at tribal health fairs.

- **Training:** VA and IHS conducted a variety of training activities about eligibility and enrollment. VA holds monthly on-line training about the enrollment process that is available for staff at IHS and THP facilities and for representatives of Native American veterans. In partnership with IHS, VA funded multiple regional training events designed to increase knowledge of VA benefits, eligibility criteria, and the enrollment process. Participants in these events included tribal health officials, IHS and THP facility staff, TVRs, and members of Native American veteran military organizations. Facilities in two of our three site visit locations also reported conducting training activities. For example, at one of the sites we visited, IHS provided training to staff at its facilities about VA health benefits and services. In another site visit area, VA officials reported that they recruited and trained over 190 TVRs from 2010 through 2013.

Although VA and IHS have undertaken a variety of outreach efforts, officials from VA, IHS, and THP facilities identified two main ongoing challenges to implementing effective outreach to Native American veterans—the lack of available data to identify eligible Native American veterans and insufficient agency resources to effectively conduct outreach in rural areas.

- **Lack of available data:** VA and IHS headquarters officials, as well as local facility officials in all three of our site visit areas, reported that it is difficult to conduct outreach to Native American veterans because there is limited data identifying who they are. While officials reported that IHS health registration forms include a question about whether the patient is a veteran, officials indicated that patients are not required to report this information. While officials at some IHS and THP facilities with whom we met said they have taken actions to identify veterans in their tribes, others lack such data. An official at one THP facility, for example, said that veteran status data had not been collected from their patients; officials at another THP reported that without a list identifying who is a veteran, it is difficult to conduct outreach and enroll veterans in the VA. Similarly, while VA registration forms include a question about race/ethnicity, VA officials reported that VA facilities have not required veterans to report whether they are

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More Health Services Are Now Available to Native American Veterans, but Further Progress Has Been Slowed by Technical Issues and Delays in Finalizing Service Expansion Agreements

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Native American, and this limits VA's ability to conduct outreach to Native American veterans.<sup>18</sup>

- **Insufficient resources for effective outreach to very rural areas:** VA, IHS and THP officials, and TVRs reported that there are insufficient resources—such as outreach volunteers and funding for travel—for effective outreach to the remote areas where many Native American veterans live. For example, officials at one THP that serves an area of approximately 75,000 square miles, including terrain that requires travel by boat or plane, reported that they were not aware of any TVRs serving their region. Officials at another THP said that there was a lack of funding for TVRs to travel to conduct outreach.

Actions taken by VA and IHS to expand health care services for Native American veterans include funding for service expansion, a national effort to increase telehealth connections between VA and IHS, and local efforts to expand health services through satellite and mobile services and through telehealth.

- **Funding for service expansion:** Since the MOU was signed, both agencies have sponsored funding to support the expansion of health services. Specifically, ORH awarded about \$1.8 million in funding from 2012 through 2014 for five telemental health projects for eligible veterans in Native American communities, including the development and operation of programs in certain areas of Alaska, Michigan, and Oklahoma; and IHS provided financial support to enable the expansion of three THP clinics in Alaska, Mississippi, and Oklahoma in 2011.
- **National effort to expand telehealth consultation between VA and IHS:** Officials from the MOU work group that promotes new technology reported that VA and IHS are in the process of completing activities designed to improve the connectivity between VA and IHS required for live telehealth consultation. VA officials reported that as of April 2014, the testing phase was nearing completion. According to VA officials, the next step is the development of business plans by

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<sup>18</sup>A VA official told us that historically, VA has not required the reporting of race and ethnicity data in part because it has been accused of using race and ethnicity to bias the disability claim/adjudication process. As a result, Native American veterans may choose not to report their ethnicity because they believe that it will bias how they are treated. Race/ethnicity data may be recorded in the VA medical record as little as 50 percent of the time.

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individual IHS facilities to establish collaborative telehealth programs with VA. This work group has also identified opportunities for collaboration between the two agencies, specifically on teleretinal services for diabetes care.<sup>19</sup>

- **Local efforts to expand services and telehealth:** Data gathered from our site visits and our review of the quarterly VISN reports for 2013 identified a number of local efforts to expand the availability of health care services. For example, in one area, officials reported that the local VA medical center expanded services to Native American veterans in one location by renting space from a THP to provide onsite health services to eligible Native American veterans; further, it was seeking agreements with two THPs to establish VA-provided telehealth services. According to VA and IHS officials at another site we visited, the local VA medical center and an IHS facility collaborated to establish a VA primary care presence at the IHS facility. This VA medical center also initiated similar plans to partner with another IHS facility and two THP facilities, established a mobile clinic that serves eligible veterans on Native American reservations, and added telehealth services to its community based outpatient clinics that serve Native American veterans.<sup>20</sup> In the quarterly Native American Inventory reports submitted to VA by VISNs, 14 of 21 VISNs listed one or more efforts to expand telehealth services for Native American veterans in their region.

Agency officials and staff at VA, IHS, and THP facilities described three main challenges that need to be addressed to better ensure the successful implementation of expansion efforts: (1) the lack of interoperability between VA and THP computer systems; (2) a lack of technical resources; and (3) delays in finalizing service expansion agreements.

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<sup>19</sup>Diabetes is the leading cause of adult vision loss in the United States. Digital retinal imaging with remote image interpretation (teleretinal imaging) assists in providing eye care to patients with diabetes.

<sup>20</sup>The degree to which there is a need to expand VA services to IHS and THP facilities may vary by region depending on the number, size, and geographic distribution of local tribes, and also by the range of services already available at the area's IHS and THP facilities.



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- **Incompatible systems:** Agency officials said that while VA and IHS facilities have been working on connectivity between their VA and IHS platforms for telehealth, THPs may use different computer systems than IHS; therefore, connectivity between VA and THPs has to be tested and explored on a case-by-case basis. This can slow collaboration on telehealth services, and tribes that do not use the IHS or VA platform would need to obtain the necessary technology. For example, in one site visit area, integration of THP and VA telehealth has been challenged by differences in technical connectivity and information security policies. Since a majority of IHS-funded facilities are operated by THPs, the potential for collaboration on telehealth services may be limited by the interest and resources available from tribes for this purpose.
  - **Insufficient technical resources:** According to facility officials in all three site visit areas, the lack of technical resources in some rural locations has hampered the expansion of telehealth or other services such as home-based health. For example, in one area, tribal health officials said that there was no infrastructure to support telehealth services. Also in this area, VA medical center officials said that they explored expanding virtual care through the use of veterans' home computers but found that some veterans lack phone lines or adequate Internet connectivity. In another area, THP facility officials said that there was poor Internet "bandwidth" in their area that reduced the quality of transmission for telehealth.
  - **Delays in finalizing agreements to expand services:** Agency and facility officials from two of our three site visit areas reported that it can take years to finalize service expansion agreements between VA and IHS or THP facilities, which could limit incentives to pursue such agreements. There were several examples cited in which it took 3 years to finalize service expansion agreements. In one case an official reported that it took 3 years to process an agreement to allow a VA medical center to use a small area in an IHS facility for 2 days per week, in part due to lengthy legal and contracting reviews by VA and IHS. An official in another area reported that it took 3 years and many layers of approval to establish an agreement between the local VA medical center and THP provider to expand optometry services to Native American veterans.

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VA and IHS Have Provided Information and Training to Improve Cultural Competency, but Cultural Variation among Tribes and Staff Turnover Limit Its Effectiveness

VA and IHS have distributed informational resources among agency staff and some VA and IHS facilities have provided training to provider staff locally aimed at improving cultural competency. In some cases, the information and training have been targeted at informing VA staff about Native American culture, while in others it has been targeted at informing IHS and THP staff about veterans' issues.<sup>21</sup>

- **Training VA staff about Native American culture:** VA and IHS agency officials said they had promoted informational resources among some agency and health facility staff and conducted training, both of which were designed to improve cultural competency. For example, they have publicized certain informational resources available to VA and IHS staff with respect to Native Americans, including a webinar on Native American behavioral health issues and *A Guide to Build Cultural Awareness* publication.<sup>22</sup> Moreover, at all of our site visit areas, officials reported that staff training and other activities were conducted to improve the cultural competency of care provided to Native American veterans. An official at one VA medical center, for example, reported that they provide a 1-week training program covering Native American culture for providers who work with predominantly Native American patients; this training is followed by tribe-specific educational programs coordinated with a local tribe. Also, IHS-employed, traditional Native healers provided cultural orientations to VA staff. In fiscal year 2013 Native American Inventory quarterly reports submitted by VISNs to VA, 19 of 21 VISNs listed one or more activities related to improving cultural competency related to Native American culture.
- **Training IHS staff about veterans' issues:** VA and IHS agency officials reported that there are a number of training aides to inform IHS staff about veterans' issues, including (1) a video training program for IHS facility officials about PTSD; (2) a webinar distributed by a IHS facility to its staff about PTSD and sexual assault issues in

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<sup>21</sup>Cultural competency training may address the spiritual beliefs and traditional healing practices of Native Americans, including those related to beliefs about warfare as well as the nature of disease and appropriate ways to communicate about disease. Cultural competency training may also address the special issues faced by some veterans, such as PTSD, domestic violence, and combat-related poisoning.

<sup>22</sup>Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *CultureCard: A Guide to Build Cultural Awareness – American Indian and Alaska Native*, SMA 08-4354 (January 2009).

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the military; and (3) presentations by VA to THP facility staff about PTSD and traumatic brain injury.

The effectiveness of cultural competency training has been limited by cultural variation across some tribes and by the challenges of high staff turnover in some VA and IHS facilities.

- **Cultural variation:** IHS officials explained that customs and beliefs may vary in important ways across different tribes, and this presents a challenge for providing training that adequately addresses these variations, particularly in cases where VA and IHS facilities serve Native American veterans from multiple tribes. For example, in one site visit area, IHS officials at a facility that primarily served one tribe reported that their native healing practices were different than those of other nearby tribes with regard to the selection of a traditional healer to participate in healing ceremonies. Native American veterans from the tribe reported that if VA and IHS providers did not understand these differences it would make it difficult for their tribal members to obtain culturally competent health care treatment.
- **High staff turnover:** Native American veterans with whom we spoke during our site visits identified high staff turnover as an issue affecting cultural competency. Native American veterans said that the use of temporary staff and the high degree of provider turnover limit the effectiveness of any training in cultural competency, which in turn can diminish the quality of care provided. Without training in cultural competency, provider staff may not be aware of important issues, such as how to effectively communicate with Native American veterans about their health or how to diagnose certain symptoms unique to veterans.

Reimbursement Agreements Are in Place in Many Locations, but Site-Specific Factors and Circumstances Have Limited Establishing Such Agreements in Other Locations

IHS and VA collaborated at the national and local levels to establish a VA-IHS reimbursement agreement that applies to all IHS facilities and to encourage THPs to develop reimbursement agreements with VA. Under such agreements, VA pays IHS and THP facilities for eligible services that they provide to eligible Native American veterans. VA, IHS, and THP officials said that reimbursement agreements may improve access to care because the presence of the agreements may encourage IHS and THP facilities to be more active in outreach and encouraging of enrollment of Native American veterans into VA. This could provide more opportunities for Native American veterans to obtain health care at any type of facility, as well as obtain services they would not otherwise have access to, including services targeted at veterans, such as PTSD counseling and treatment, as well as specialty services unavailable at the IHS or THP

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facility. The actions taken by the agencies include the development of a national reimbursement agreement between VA and IHS facilities and the development of individual reimbursement agreements between VA and some THPs.

- **National reimbursement agreement covering IHS:** VA and IHS officials explained that together the agencies developed a national reimbursement agreement as well as procedures and systems through which VA payments may be made to IHS facilities. In addition, VA and IHS agency staff worked at the local level to complete implementation plans with each IHS facility and its area VA medical center. Officials reported that all 81 local implementation plans were in place as of July 2013. According to these officials, implementation planning at the local level involved: (1) “get to know you” sessions, in which local VA and IHS officials shared information about what services were provided by their respective facilities; (2) training of IHS staff about VA’s eligibility, billing, and enrollment processes; (3) registration of the IHS facility into VA’s payment system; and (4) setting up the IHS facility site for billing to VA. Data provided by VA indicates that as of April 8, 2014, VA had paid a total of \$3.28 million for services provided to 2,047 Native American veterans at IHS facilities.
- **Reimbursement agreements with THPs:** In addition to a national agreement, VA officials said that VA had established 53 reimbursement agreements with THPs as of May 16, 2014, and conducted additional outreach through tribal letters and events to educate other THPs about the option of establishing these agreements.<sup>23</sup> Data provided by VA indicate that as of April 8, 2014, VA had paid a total of \$1.99 million for services provided to 307 Native American veterans at THP facilities.

Challenges cited by officials at VA, IHS, and THP facilities included delays in activating established reimbursement agreements and obstacles to establishing agreements with additional THPs.

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<sup>23</sup>The earliest THP reimbursement agreements were completed in Alaska where, as of August 2012 there were 26 agreements that collectively covered nearly all THPs in that state. Unlike agreements in other parts of the United States, these reimbursement agreements also provide Alaska THPs with payment for eligible services for eligible veterans who are not Native American. This arrangement is meant to address the fact that VA has a limited number of health facilities in the state.

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- **Delays in starting reimbursement under established agreements:**  
Not all IHS and THP facilities that are covered under reimbursement agreements have received reimbursement. While there are currently over 130 facilities covered under such agreements, as of April 8, 2014 only 86 had received reimbursement for services provided in fiscal year 2014. According to agency officials, although many agreements are in place, it may take some time before reimbursement will begin at some IHS and THP facilities. Before reimbursement can begin, eligible Native American veterans must be identified as such. However, the previously mentioned challenges of a lack of data that identifies veterans as Native Americans and high staff turnover among IHS facilities have hindered efforts to identify these eligible individuals, according to officials. VA officials said that it takes time to firmly establish the procedures for providing and transmitting complete claims information. For example, some THP facilities do not have the ability to file electronic claims and therefore the process for submitting claims needs to be worked out at each THP, sometimes using paper filing. Officials also said that in some cases the time required to establish reimbursement procedures is extended as a result of staff turnover at THPs. In one case it took a year before the THP's staff consistently provided the necessary information on submitted claims forms.
  - **Obstacles to establishing agreements with additional THPs:**  
Factors such as the time it may take to establish a reimbursement agreement as well as the perceived lack of need for agreements may discourage some THPs from pursuing such agreements. Officials said that while the reimbursement agreement between VA and IHS applies to all IHS facilities, VA's agreements with THPs need to be negotiated individually and are based on each tribal facility's specific circumstances, such as whether it has the accreditation status required by VA to provide care for veterans, and assessment of these unique situations will require time and resources.<sup>24</sup> VA and IHS officials said that some THPs may choose not to invest the time and resources needed to establish agreements for a variety of reasons. For example, the THP may be located near a VA facility and not

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<sup>24</sup>Under the Indian Self-Determination and Education Assistance Act, as amended, federally recognized Indian tribes can enter into self-determination contracts or self-governance compacts with the Secretary of Health and Human Services to take over the administration of certain IHS programs for Indians. In such cases the VA must work with each tribe individually regarding its specific program. See 25 U.S.C. §§ 450f(a), 458aaa-3.

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believe it is necessary to establish such an arrangement. One THP official we interviewed noted that it can take a long time to develop a reimbursement agreement with VA. THP officials cited a range of issues that need to be worked out in these agreements, such as the reimbursement rate, requirements for provider credentialing and privileging, and whether electronic health records would be exchanged. VA has created a template for agreements with THPs which addresses these issues and may expedite the process of finalizing agreements. However, VA officials noted that THPs may propose changes to the template language, and each agreement requires a legal review and a contracting officer's review and signature. VA may have disincentives to sign such agreements as well. For example, VA officials at one facility reported the concern that pursuing a reimbursement agreement with area THPs could divert funds from VA facilities if Native American veterans shifted from using VA services to using THP services.

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### VA and IHS Lack a Defined Approach for Effectively Implementing and Overseeing the MOU

VA and IHS lack a defined approach for effectively implementing and overseeing the MOU, and we identified three main contributing factors. First, oversight of the MOU's implementation is inconsistent and, in 2013, the officials tasked with this oversight did not meet and did not systematically evaluate the progress of MOU implementation. Second, according to agency officials, no formal policies or guidance have been developed that outline the procedures to implement the MOU, which limits the agencies' ability to hold individuals accountable for its implementation. Third, leadership in VA and IHS have not made MOU implementation a priority, which threatens the ability of the two agencies to move forward in implementing the MOU. Without consistent oversight, formal guidance on responsibilities for MOU implementation, and the prioritization of MOU implementation, leadership in VA and IHS do not have reasonable assurance that the objectives of the MOU related to access to care are being addressed.

### Implementation and Oversight Are Inconsistent

*Standards for Internal Control in the Federal Government* require that the agency's organizational structure define key areas of authority and responsibility, and also that appropriate and clear internal reporting relationships be established.<sup>25</sup> The standards further require top-level

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<sup>25</sup>GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: Nov. 1999). Internal controls are components of an organization's management that provide reasonable assurance that certain objectives are being met.

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reviews of actual performance to track achievements and compare goals and objectives, as well as the assessment of the quality of performance over time to ensure that actions are promptly taken in response to findings or recommendations. They also specify that it is important not only to establish, but also to review, performance measures to ensure they are working as intended. Furthermore, our prior work on interagency collaborations found that collaborating agencies should work together to define and agree on respective roles and responsibilities, including how the efforts will be led.<sup>26</sup> This work also found that federal agencies working together need to create the means to monitor and evaluate efforts to identify areas for improvement.<sup>27</sup>

In implementing the MOU, VA and IHS have not complied with these standards or good practices. For example,

- While the Joint Implementation Task Force held meetings in 2011 and 2012, the full Joint Implementation Task Force has not met since 2012 according to several agency officials, and it was the understanding of one agency official that this group was on a hiatus. Another official with a key role on the Joint Implementation Task Force reported being unaware of who actually led this task force. Another official with a key role on the Joint Implementation Task Force reported that while some of its members met in 2013 to work on implementing the national VA/IHS reimbursement agreement, these meetings did not focus on MOU oversight.
- As of April 2014, officials responsible for leading the Joint Implementation Task Force told us that they had not systematically reviewed or analyzed information in the work group or Native American Inventory quarterly reports for fiscal year 2013, although officials in VA said they had reviewed selected reports for specific purposes, such as learning what types of training were being provided by VISNs. However, the leaders of the Joint Implementation Task Force did not comprehensively track the information provided and therefore did not provide oversight to identify priority action items for

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<sup>26</sup>GAO, *Results-Oriented Government: Practices That Can Help Enhance and Sustain Collaboration among Federal Agencies*, [GAO-06-15](#) (Washington, D.C.: Oct. 21, 2005).

<sup>27</sup>[GAO-06-15](#).

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work groups or possible obstacles to achieving the goals of the MOU.<sup>28</sup>

- As of fiscal year 2013, the Joint Implementation Task Force has not systematically identified strategies and plans for accomplishing tasks related to the MOU moving forward or addressed challenges or implemented best practices.
- Furthermore, although work groups were tasked with reporting MOU-related activities each quarter, only 28 of the 44 work group quarterly reports due for fiscal year 2013 (64 percent) were submitted. Members of one of the five work groups with whom we spoke reported that they no longer held work group meetings regularly.

Based on our assessment, these problems occurred in 2013 because VA and IHS leaders were not holding themselves or others accountable for their role in implementing the MOU. Without reviewing the quarterly work group reports, and ensuring that all required reports are submitted, VA and IHS leaders do not have reasonable assurance that the objectives of the MOU related to access to care are being addressed. In addition, they may be unaware of challenges and obstacles that VISNs, IHS and THP facilities, and work groups are encountering.

#### Written Policies and Guidance Are Lacking

While VA and IHS have informal procedures to track and oversee actions taken under the MOU, the agencies have not developed written policies and guidelines governing implementation of the MOU. Our prior work on interagency collaborations found that agencies that articulate agreements—in areas such as leadership, roles and responsibilities and accountability—in formal documents can strengthen their commitment to working collaboratively.<sup>29</sup> According to VA and IHS agency officials, the only documentation outlining the procedures to report VA and IHS progress in implementing the MOU is contained in a set of training slides used in a December 2012 staff training session. Based on the information presented in the slides, the procedures are generally consistent with *Standards for Internal Control in the Federal Government*.<sup>30</sup> (See figure 1

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<sup>28</sup>VA officials told us that they do have plans to review the quarterly reports for the first quarter of 2014.

<sup>29</sup>[GAO-06-15](#).

<sup>30</sup>[GAO/AIMD-00-21.3.1](#).



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for a diagram of our interpretation of the procedures outlined in the training slides).

For example:

- The slides include an organizational chart and other information that establish clear reporting relationships and assign key roles and responsibilities to agency staff.
- Each MOU work group is required to collect information and develop a quarterly report detailing the types of activities it has conducted related to MOU objectives, including the objectives aimed at taking actions to improve access to care.<sup>31</sup>
- The MOU coordinators are responsible for providing assistance and training to work groups, aggregating information from the work group reports and other sources such as VA's Native American Inventory Reports, and submitting a quarterly report for review by the Joint Implementation Task Force.<sup>32</sup>
- The Joint Implementation Task Force, made up of officials from VA and IHS including leaders from certain work groups, is responsible for oversight, including reviewing quarterly reports that are submitted by the MOU coordinators, and identifying plans for accomplishing MOU goals going forward.<sup>33</sup> These slides stipulate that the Joint Implementation Task Force should hold regular meetings to review progress and set priorities.

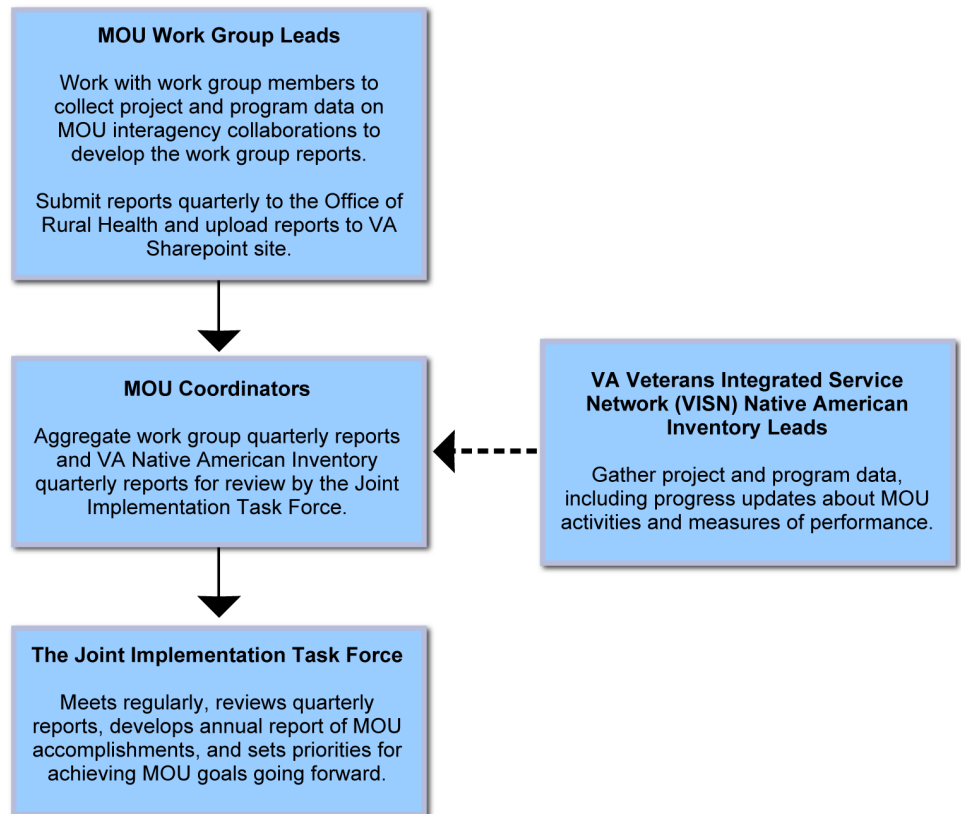
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<sup>31</sup>The slides stipulate that work groups should upload the reports to a centralized, internal VA website. VA developed a quarterly reporting template for the work group reports aligned according to MOU goals. In addition to describing activities conducted, these reports may also note accomplishments or barriers to activities conducted.

<sup>32</sup>The Native American Inventory Reports submitted by VISNs are aligned according to MOU goals. At the same time, VA officials told us that these reports are intended to serve other purposes within VA, in addition to those of the MOU.

<sup>33</sup>The Joint Implementation Task Force is also referred to as the leadership work group, which was established by the 2010 MOU.

**Figure 1: Procedures Outlined in 2012 Training Slides for Tracking and Overseeing Actions Taken to Achieve the Goals of the Memorandum of Understanding between the Department of Veterans Affairs (VA) and the Indian Health Service (IHS)**



Source: GAO interpretation of Office of Rural Health December 2012 training slides | GAO-14-489.

However, VA and IHS officials said that these training slides are not binding because they have not been formalized in written policy or guidance, including establishing clearly defined roles and responsibilities. Without formal written policy or guidance to govern the implementation of the MOU, VA and IHS have little basis to hold those responsible for implementing the MOU accountable for effectively managing the implementation process.

## Prioritization of MOU Implementation Is Lacking

VA and IHS leaders have not made MOU implementation a priority, which threatens the ability of the two agencies to move forward in implementing the MOU as it relates to access to care. This is demonstrated in a number of ways. First, according to officials, the Joint Implementation Task Force has not created any written policy or guidance that specifically defines

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roles and responsibilities for agency staff under the MOU. Moreover, key members of the Joint Implementation Task Force attributed their lack of tracking and oversight of the MOU activities in part to their perception that other work-related responsibilities had a higher priority than some of their MOU related responsibilities. The leaders of the Joint Implementation Task Force from both agencies reported that MOU responsibilities were not their top priority, and that resource constraints have affected their ability to focus attention on oversight of MOU implementation. For example, officials from ORH reported that, while it is the lead office within VA responsible for MOU-related activities, it is also responsible for many other initiatives. The office experienced staff turnover in 2012 and 2013, replacing 4 of its 11 staff members, including members of the leadership team. As a result, current leadership and some staff have only been in their current positions since April 2013 or later and have not had time to fully focus on MOU implementation and oversight. Similarly, an IHS official stated that IHS has limited resources, that agency staff are stretched in order to complete their primary responsibilities, and that activities related to the MOU are a part of their additional responsibilities.<sup>34</sup>

VA and IHS officials reported that they have plans to examine efforts to implement the MOU by looking at the effectiveness of the work group structure.<sup>35</sup> Specifically, VA and IHS have entered into an agreement to have VA's National Center for Organization Development undertake an assessment of the views of work group members about their experience and about whether they think the goals of the MOU are being met. The assessment is scheduled to be completed by May 2014 and, according to officials, will be used to identify best practices for improved efficiency and effectiveness, or the need for adjustments to organizational structure or processes. It is unclear at this point, however, whether this study will fully address the implementation and oversight shortcomings we have noted and whether it will spur greater focus on the leadership required to effectively implement the MOU.

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<sup>34</sup>The 2013 and 2014 individual performance plans for two key leaders in VA and IHS who are involved with the MOU indicate general expectations relating to the MOU, for example "provide leadership to MOU implementation and report on MOU progress."

<sup>35</sup>This is consistent with our past work on practices that can enhance and sustain collaboration by revisiting and refreshing interagency groups. See GAO, *Managing for Results: Implementation Approaches Used to Enhance Collaboration in Interagency Groups*, [GAO-14-220](#) (Washington, D.C.: Feb. 14, 2014).

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## Native American Veterans and Their Representatives Reported Mixed Views on Whether Access to Care Has Improved

Although the majority of Native American veterans and their representatives we contacted reported that they thought access to care for Native American veterans had improved over the past 3 years, a number of others said either that they did not believe that access to care had improved during that time or they did not know whether it had. In addition, there were mixed perceptions about the degree to which VA and IHS-funded facilities had made improvements in providing care that was culturally competent with regard to the needs of Native Americans or veterans.

Most Native American veteran representatives that we contacted via questionnaire perceived that there had been improvements in access to care, such as increases in the number of Native American veterans being enrolled in the VA health system and getting health care services. However, others did not see that any gains had been made or did not know. For example, Native American veteran representatives that we contacted provided the following responses to our web-based questionnaire when asked about whether there has been a change in the number of Native American veterans enrolled in the VA:<sup>36</sup>

- Of the 102 representatives, 63 said they thought enrollment had increased, 11 said enrollment had remained the same, 5 said that enrollment had declined, and 23 said they did not know whether enrollment had changed.
- Of the 102 representatives, 53 reported that in the last 3 years there had been an increase in the number of Native American veterans accessing health care at a VA, IHS, or THP facility. However, 12 felt that there had been no change and 36 reported that they didn't know. Of the 53 respondents who reported that there had been an increase in access, 41 reported that access had improved at VA facilities, 25 reported that access had improved at IHS-run facilities, and 24 reported that access had improved at THPs.<sup>37</sup>

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<sup>36</sup>The responses to this questionnaire are not generalizable to the entire population of representatives of Native Americans; however, they provide insights about improvements in access to care.

<sup>37</sup>Respondents could report increases at more than one type of facility. Also, the type of facilities available in a respondent's service area may vary. For example, there may be only THP or IHS-run facilities in a service area but not both.

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Native American veterans and their representatives we interviewed reported similar opinions about whether there had been improvements to access to care. Specifically, most of the 12 interviews we conducted with veterans or their representatives included one or more comments indicating that access to health care had improved.<sup>38</sup> Examples of comments indicating that access had improved included the statements “the area VA liaison had played a big part in increasing [health care] use and enrollment,” and “as a result of the assistance provided by TVRs to Native [American] veterans, they have better access to more health care services.” However, all of the interviews included one or more comments specifying challenges to access, such as the lack of awareness on the part of Native American veterans about VA benefits and what services are available to them, lack of transportation, long waiting times, and the lack of enough providers in certain areas such as behavioral health and substance abuse. In addition, some of the interviews included one or more comments by Native American veterans and their representatives that indicated that they thought that access had not improved.

There were also mixed views about the extent to which VA and IHS facilities had made improvements in providing care that was culturally competent with regard to the needs of Native Americans or veterans. For example, Native American veteran representatives who responded to our web-based questionnaire reported the following when asked whether they thought there had been changes in culturally competent care for Native American veterans at different types of facilities:

- Of 102 representatives, 38 said care at VA facilities had generally improved with respect to its cultural competency, 28 said there had been no change, 9 said it had declined, and 26 said they did not know if there had been improvements;
- Of 102 representatives, 36 said care at IHS-run facilities had generally improved with respect to its cultural competency, 25 said there had been no change, 9 said it had declined, and 32 said they did not know; and for THPs, 37 said care at THPs had generally improved with respect to its cultural competency, 25 said there had been no change, 8 said it had declined, and 32 said they did not know.

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<sup>38</sup>We used the following convention to state whether specific types of comments were made at most, some, or few of these interviews: most—at least one comment in 9 to 11 interviews; many—at least one comment in 5 to 8 interviews; some—at least one comment in 3 to 4 interviews; and few—at least one comment made in 1 to 2 interviews.

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In many of the 12 site visit interviews we conducted, Native American veterans made one or more comments that care was not culturally competent. For example, in one interview a Native American veteran said that the local VA providers did not understand the cultural needs of his tribe. In another interview, Native American veterans and their representatives said that veterans have significant issues around PTSD and domestic and sexual violence, but that the local IHS health facility was not addressing these issues. At the same time, many of the 12 site visit interviews we conducted also included one or more positive comments about cultural competency. One noted that there had been an increase in the provision of culturally competent care provided by VA because VA had hired a Native American to help with outreach, and another noted that care from their tribal clinic was culturally competent with respect to veterans' needs in part because the facility had a specialist providing wound care who had experience working with veterans.

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## Conclusions

Native American veterans have historically faced many issues in accessing health care and to their credit, both VA and IHS have taken actions under the 2010 memorandum of understanding to improve access to care for Native American veterans. However, significant unresolved challenges still remain that the agencies need to address. Moreover, many Native American veterans and their representatives we contacted believed that the agencies need to build upon actions already taken to improve access for Native American veterans. Addressing access challenges and further improving the overall access to care for Native American veterans is hampered by ineffective oversight and the lack of accountability and prioritization of MOU-related responsibilities among those tasked with implementing the MOU. Written policies, procedures, and guidelines have not been developed to lay out roles and responsibilities, methods for collecting and disseminating information about MOU implementation activities, oversight mechanisms, and the process for assessing progress and developing strategies going forward. Absent clear, binding policies and guidance, oversight and accountability have waned and staff have not assessed progress, addressed barriers, or set priorities for how to accomplish the MOU goals going forward. The lack of oversight also makes it difficult for VA and IHS to know how well MOU activities are being carried out, to identify potential best practices for nationwide implementation, or to address existing or future challenges and strategies. Ultimately, access to VA and IHS facilities could be negatively affected and further progress in improving access compromised.

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## Recommendation for Executive Action

To improve access to care for Native American veterans through MOU implementation, we recommend that the Acting Secretary of Veterans Affairs and the Secretary of Health and Human Services take the following action:

Establish written policy or guidance designating specific roles and responsibilities for agency staff to hold leadership accountable and improve implementation and oversight of the MOU. In developing written policies and guidelines, strong consideration should be given to the guidance embodied in the training slides from December 2012, including the following:

- Develop an organizational chart clearly outlining the VA and IHS MOU structure and detailing agency staff roles and responsibilities.
- Require that regularly scheduled meetings be held by the Joint Implementation Task Force or other groups charged with the oversight of MOU implementation.
- Ensure that VISNs and the MOU work groups submit reports to VA and IHS quarterly, as well as ensure that the groups charged with the oversight of MOU implementation complete reviews and analyses of the information collected to assess MOU progress and address any deficiencies.
- Ensure that the Joint Implementation Task Force, or other groups charged with oversight of MOU implementation, identifies strategies and plans for accomplishing tasks related to the MOU to implement best practices and address challenges.

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## Agency Comments

We provided draft copies of this report to VA and HHS for review. Both agencies concurred with our recommendation and in their comments on the draft described the plans for implementing the recommendation. Most noteworthy, they reported that the agencies will develop an organizational chart outlining VA and IHS MOU structure and agency roles and responsibilities, hold quarterly leadership meetings to provide oversight and guide the direction of MOU implementation efforts, and adopt and disseminate a Standard Operating Procedure outlining data reporting and submission requirements for work groups responsible for MOU implementation. We have reprinted the comments from VA in appendix I and the comments from HHS in appendix II. VA also provided technical comments, which were incorporated in the draft as appropriate.

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We are sending copies of this report to appropriate congressional committees, the Acting Secretary of Veterans Affairs, and the Secretary of Health and Human Services. The report is also available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or [williamsonr@gao.gov](mailto: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 III.

A handwritten signature in black ink, reading "Randall B. Williamson". The signature is written in a cursive style with a large, stylized "R" and "W".

Randall B. Williamson  
Director, Health Care



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*List of Requesters*

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

The Honorable Jon Tester  
Chairman  
Committee on Indian Affairs  
United States Senate

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

The Honorable Mark Begich  
United States Senate

The Honorable Mazie Hirono  
United States Senate

# Appendix I: Comments from the Department of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS  
WASHINGTON DC 20420

MAY 23 2014

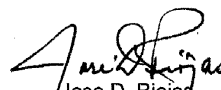
Mr. Randall B. Williamson  
Director, Health Care  
U.S. Government Accountability Office  
441 G Street, NW  
Washington, DC 20548

Dear Mr. Williamson:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, ***"HEALTH CARE ACCESS: Improved Oversight, Accountability, and Prioritization Can Improve Access for Native American Veterans"*** (GAO-14-489). VA generally agrees with GAO's conclusions and concurs with GAO's recommendations to the Department.

The enclosure specifically addresses GAO's recommendations and provides technical comments to the draft report. VA appreciates the opportunity to comment on your draft report.

Sincerely,

  
Jose D. Riojas  
Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to  
Government Accountability Office (GAO) Draft Report  
***"HEALTH CARE ACCESS: Improved Oversight, Accountability, and Prioritization  
Can Improve Access for Native American Veterans"***  
(GAO-14-489)

**GAO Recommendation:** To improve access to care for Native American Veterans through MOU implementation, GAO recommends that the Secretary of the Department of Veterans Affairs take the following action:

**Establish written policy or guidance designating specific roles and responsibilities for agency staff to hold leadership accountable and improve implementation and oversight of the MOU. In developing written policies and guidelines, strong consideration should be given to the guidance embodied in the training slides, including the following:**

**Recommendation 1:** Develop an organizational chart clearly outlining the VA and IHS MOU structure and detailing agency staff roles and responsibilities.

**VA Comment:** Concur. The Department of Veterans Affairs (VA) and Indian Health Service (IHS) will jointly develop an organizational chart that clearly outlines the VA/IHS Memorandum of Understanding (MOU) administrative structure. The organizational chart will outline staff roles and responsibilities within that structure. Target Completion Date: July 31, 2014.

**Recommendation 2:** Require that regularly scheduled meetings be held by the Joint Implementation Task Force or other groups charged with the oversight of MOU implementation.

**VA Comment:** Concur. The VA/IHS MOU leadership team, comprised of the Office of Rural Health (ORH) Director and IHS Chief Medical Officer, will hold quarterly meetings to provide oversight and guide the strategic direction of VA/IHS MOU implementation efforts through coordination with key stakeholders.

ORH and IHS have engaged the Veterans Health Administration National Center for Organization Development (NCOD) to assess all MOU work groups' functionality, including that of the Joint Implementation Task Force. That assessment is currently in progress. NCOD's subsequent recommendations will assist the VA/IHS MOU leadership team in the development of an action plan to improve organizational effectiveness. Target completion date: July 31, 2014.

**Recommendation 3:** Ensure that VISNs and the MOU work groups submit reports to VA and IHS quarterly, as well as ensure that the groups charged with the oversight of MOU implementation complete reviews and analyses of the information collected to assess MOU progress and address any deficiencies.

Enclosure

Department of Veterans Affairs (VA) Comments to  
Government Accountability Office (GAO) Draft Report  
***"HEALTH CARE ACCESS: Improved Oversight, Accountability, and Prioritization  
Can Improve Access for Native American Veterans"***  
(GAO-14-489)

**VA Comment:** Concur. The VA/IHS MOU leadership team will adopt and disseminate a Standard Operating Procedure (SOP) for work groups responsible for MOU implementation outlining data reporting and submission requirements. The SOP will also establish data review, analysis, and annual reporting requirements. Target Completion Date: September 30, 2014.

**Recommendation 4:** Ensure that the Joint Implementation Task Force, or other groups charged with oversight of MOU implementation, identifies strategies and plans for accomplishing tasks related to the MOU to implement best practices and address challenges.

**VA Comment:** Concur. The recommendations resulting from NCOD's in-progress assessment will provide strategies the VA/IHS MOU leadership team will employ to implement the MOU, highlight best practices, and address challenges. Specifically, VA and IHS leadership will facilitate leadership review and discussion of MOU progress and implementation through regular meetings with work group leads or other groups charged with MOU oversight. Target Completion Date: September 30, 2014.

# Appendix II: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation  
Washington, DC 20201

MAY 28 2014

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

Dear Mr. Williamson:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "Health Care Access: Improved Oversight, Accountability, and Prioritization Can Improve Access for Native American Veterans" (GAO-14-489).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in black ink, appearing to read "Jim R. Esquea".

Jim R. Esquea  
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "HEALTH CARE ACCESS: IMPROVED OVERSIGHT, ACCOUNTABILITY, AND PRIORITIZATION CAN IMPROVE ACCESS FOR NATIVE AMERICAN VETERANS" (GAO-14-489)**

The Department appreciates the opportunity to review and comment on this draft report.

**GAO Recommendation**

To improve access to care for Native American veterans through MOU implementation, we recommend that the Secretary of the Department of Veterans Affairs and of the Department of Health and Human Services take the following action:

Establish written policy or guidance designating specific roles and responsibilities for agency staff to hold leadership accountable and improve implementation and oversight of the MOU. In developing written policies and guidelines, strong consideration should be given to the guidance embodied in the training slides, including the following:

- *Develop an organizational chart clearly outlining the VA and IHS MOU structure and detailing agency staff roles and responsibilities.*
- *Require that regularly scheduled meetings be held by the Joint Implementation Task Force or other groups charged with the oversight of MOU implementation.*
- *Ensure that VISNs and the MOU work groups submit reports to VA and IHS quarterly, as well as ensure that the groups charged with the oversight of MOU implementation complete reviews and analyses of the information collected to assess MOU progress and address any deficiencies.*
- *Ensure that the Joint Implementation Task Force, or other groups charged with oversight of MOU implementation, identifies strategies and plans for accomplishing tasks related to the MOU to implement best practices and address challenges.*

**HHS Response:**

- *Develop an organizational chart clearly outlining the VA and IHS MOU structure and detailing agency staff roles and responsibilities.*

The Indian Health Service (IHS) and Veterans Health Administration (VHA) Office of Rural Health (ORH) have developed jointly an organizational chart that will clearly outline the VA/IHS MOU structure. The organizational chart outlines staff roles and responsibilities within this structure. Plans are to have the organizational chart completed by July, 2014.

- *Require that regularly scheduled meetings be held by the Joint Implementation Task Force or other groups charged with the oversight of MOU implementation.*

The IHS Chief Medical Officer and ORH Director are holding quarterly meetings to provide oversight and guide the strategic direction of VA/IHS MOU implementation efforts through coordination with key stakeholders. IHS and ORH have engaged the VHA National Center for Organization Development (NCOD) to assess all MOU work groups' effectiveness and

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "HEALTH CARE ACCESS: IMPROVED OVERSIGHT, ACCOUNTABILITY, AND PRIORITIZATION CAN IMPROVE ACCESS FOR NATIVE AMERICAN VETERANS" (GAO-14-489)**

functionality, including that of the Joint Implementation Task Force and others. The NCOD assessment is currently in progress. NCOD's subsequent recommendations will serve to assist the IHS and ORH leadership team in the development of an action plan to improve organizational effectiveness and enhance outcomes. An IHS and VA IHS MOU leadership team quarterly meeting schedule is completed.

- *Ensure that VISNs and the MOU work groups submit reports to VA and IHS quarterly, as well as ensure that the groups charged with the oversight of MOU implementation complete reviews and analyses of the information collected to assess MOU progress and address any deficiencies.*

The IHS and ORH MOU leadership team will adopt and disseminate a Standard Operating Procedure (SOP) to outline data reporting and submission requirements. The SOP will also establish data review, analysis, and annual reporting requirements.

- *Ensure that the Joint Implementation Task Force, or other groups charged with oversight of MOU implementation, identifies strategies and plans for accomplishing tasks related to the MOU to implement best practices and address challenges.*

The VHA NCOD assessment facilitated by VA and IHS will provide recommendations leading to MOU coordination improvement strategies. It is anticipated that recommendations resulting from the assessment will highlight current best practices and address ongoing challenges. IHS and ORH leadership will facilitate leadership review and discussion of MOU progress and implementation through regular meetings with work group leads or other groups charged with MOU oversight.

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# Appendix III: GAO Contact and Staff Acknowledgments

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## GAO Contact

Randall B. Williamson, (202) 512-7114 or [williamsonr@gao.gov](mailto:williamsonr@gao.gov)

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## Staff Acknowledgments

In addition to the contact named above, Gerardine Brennan, Assistant Director, Ashley Dixon, Carolyn Fitzgerald, Lori Fritz, Mary Giffin, Laurie Pachter, and Jeanette Soares made key contributions to this report.



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# Related GAO Products

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The following is a list of related products.

*VA and IHS: Further Action Needed to Collaborate on Providing Health Care to Native American Veterans.* [GAO-13-354](#). Washington, D.C.: April 26, 2013

*Native American Veterans: DOL Needs a Clear Plan to Improve Employment and Training Services on Tribal Lands.* [GAO-13-664](#). Washington, D.C.: September 26, 2013.

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