WORKING TOGETHER

Collaboration and Sharing with the Indian Health Service and Tribal Health providers to better serve American Indian and Alaska Native Veterans

Implementation Information
November 2005

This document reviews the goal and objectives of the memorandum of understanding (MOU) between the Indian Health Service (IHS) and the Veterans Health Administration (VHA) and provides information and ideas for the successful implementation of the MOU, including ideas on how to work with Tribes.

VISN should use this material to update IHS sharing and collaboration plans under ***Strategy 8.1****: Partnering with local communities, industry organizations, and other Federal agencies to promote health.*

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OVERVIEW

In February 2003 the Departments of Health and Human Services and Veterans Affairs signed a memorandum of understanding (MOU) to promote cooperation and sharing between the Veterans Health Administration (VHA) and the Indian Health Service (IHS) to further each Department's respective mission (Appendix A). The leadership and staff of both organizations, in the field and at headquarters, are responsible for ensuring that the goals and objectives of the MOU are met. The MOU includes the expectation that VHA will communicate and work with Tribes, as appropriate, in addition to any activities undertaken with the IHS.

Field implementation of the MOU is supported through the annual strategic planning process and quarterly monitoring system. Unless a Network is exempt from action on the MOU, each VISN should have a sharing plan in place based on a thorough needs assessment. The activities and programs established under each objective of the MOU depend on the level of need, interests of the VISN and partner organizations, consistency with national priorities and availability of funding. VISNs with greater numbers of AI/AN veterans should create more opportunities to advance the health and well being of these veterans than those with a lower density of AI/AN veterans. (See Table I, p26.)

Overall, the Networks have made good progress in developing closer relationships with IHS and the Tribes and in considering means to improve services and access for AI/AN veterans. This document shares information and ideas to assist VISNs in updating their sharing plans and help them establish robust, successful programs.

Goals and Objectives

Goal: Enhance the health of American Indian and Alaska Native (AI/AN) veterans through the delivery of quality health services using the strengths and expertise of IHS and VHA.

Objective 1 – Improve communication among the VA, American Indian and Alaska Native veterans and Tribal governments with assistance from the IHS. This objective can be accomplished through such activities as

- ✓ Establishing regular communications between VA, IHS and Tribes at both a national and regional level;
- ✓ Establishing a structure and process within VACO and the VISN to facilitate internal communication;
- ✓ Identifying a senior staff lead at the VISN level for IHS and Tribal activities;
- ✓ Establishing relationships between Network Directors and Tribal leaders;
- ✓ Understanding the needs and concerns of AI/AN veterans through direct communications, town hall meetings, forums, reservation visits, etc...

Objective 2 – Encourage partnerships and sharing agreements among VHA headquarters and facilities, IHS headquarters and facilities, and Tribal governments in support of American Indian and Alaska Native veterans. This objective can be accomplished by

- ✓ Exploring partnership and sharing opportunities with IHS and Tribes;

- ✓ Developing a priority list for sharing and collaboration;
- ✓ Developing a timeline for implementing these priorities.

Objective 3 – Improve beneficiary's access to quality healthcare and services. This objective can be accomplished by

- ✓ Determining access needs for AI/AN veterans in the Network;
- ✓ Establishing a priority list of enhanced access programs in the Network;
- ✓ Establishing a timeline for implementing enhanced access programs consistent with national priorities and the availability of funding.

Objective 4 – Improve health promotion and disease prevention services to American Indians and Alaska Natives. This objective can be accomplished by

- ✓ Discussing health promotion / disease prevention needs and existing programs with IHS and Tribes;
- ✓ Identifying needs and gaps in services for AI/AN veterans;
- ✓ Developing Health Promotion, Disease Prevention program(s) consistent with national priorities and the availability of funding.

Objective 5 – Ensure that appropriate organizational resources are available to support programs for American Indian and Alaska Native veterans. This objective can be accomplished through such activities as:

- ✓ Establishing consistent performance goals across the VISN for outreach, including regular information to AI/AN veterans on services and eligibility;
- ✓ Offering support for AI/AN traditional spiritual practices analogous to services for veterans of other faiths.

Mandatory actions: The strategies outlined above and described in the remainder of this document are intended to help the Networks accomplish the objectives of the MOU. Only four actions are required by each Network (unless the Network is exempt, Table I, p26):

A. Improve communications with IHS and Tribes (Objective 1). Networks can fulfill this objective by any means they deem appropriate. Suggestions for meeting this objective are provided in the text of the document.
B. Identify a senior staff lead for the VISN and provide the name of that individual to VACO in your annual plan.
C. Offer support for AI/AN spiritual practices equivalent to support provided for other faiths.
D. Complete a needs assessment and develop an implementation plan that considers opportunities to implement initiatives such as those described under objectives 2, 3, 4, and 5 in the remainder of the document. The timeline for implementing these initiatives is negotiable for each Network and should balance need and opportunity with available resources and other priorities within the VISN.

Problem Statement

American Indians and Alaska Natives (AI/AN) have a distinguished history of exemplary military service to the United States. A strong tradition of duty and service exists within many Tribes and Indian families. Historically, a higher percentage of Indian people serve in the armed forces compared to the general US population (24% compared to 19%). Surveys conducted among Vietnam era veterans indicate that Indian people frequently served in forward combat areas, largely in the infantry, and 42% were exposed to heavy combat. As a result, these veterans have a high level of service related health care needs, including the highest rate of Post Traumatic Stress Disorder (PTSD) among ethnic groups studied.

AI/AN veterans are eligible for health care from VHA under the same eligibility requirements as all veterans. At the same time, AI/AN veterans may also be eligible to receive health care from IHS. This eligibility stems from treaty obligation established by the US government with Tribes in return for the relinquishing of land rights. These treaty obligations have been further codified and detailed through federal law, regulation and court decisions.

Despite the potential to receive health care from either VHA or IHS, Indian veterans are four times more likely than other veterans to report unmet health care needs, according to CDC and IHS. In VHA studies, AI/AN veterans report high rates of disease risk factors, including the highest level of obesity among veterans, the lowest level of consumption of fruits and vegetables and the greatest percentage of those leading a sedentary life. Furthermore, Indian veterans are more likely than other veterans to be current smokers and heavy to very heavy drinkers. Thirty-five percent of AI/AN veterans rate their health status as fair to poor and report more than one functional limitation in daily living, compared to about a quarter for all other races. Overall, Indian veterans report a higher utilization of mental health services (11.6%) compared to other veterans (6.7%).

The 2001 Survey of Veterans implies that more than two-thirds of Indian veterans do not receive health care from VHA, which is comparable to utilization of VHA services by other veteran groups. Data from the IHS user population show that nearly 65,000 or 4.8% of the active users of that health system are veterans. The number of dual users of both systems can not be determined from current databases.

Studies and testimony from Indian veterans indicate that travel distance and a lack of coordination between the two agencies are key factors that inhibit Indian veterans' access to health care at VHA. Another barrier is the perception that VHA staff will not understand or accommodate the needs and unique perspectives of Indian veterans or that VHA care is not culturally or linguistically sensitive. Finally, Indian veterans indicate that the eligibility requirements and application process for receiving care from VHA can be very confusing. Although this complaint may be voiced by many veterans, Indian veterans can find the process particularly baffling as many of them may have been

receiving health care from the federal government, IHS, all their lives under a different system of eligibility and rules for access.

The decision of where to seek care, from IHS or VHA, is entirely the choice of the eligible AI/AN veteran. VHA and IHS have an obligation to ensure that barriers to care are minimized. When an Indian veteran does enroll for health care, VHA should ensure that he or she is provided the very highest quality service that meets the physical, mental and spiritual needs of the veteran in an effort to enhance his or her health and welfare.

GETTING STARTED: CONDUCTING A NEEDS ASSESSMENT

Each VISN should have developed an operational plan to achieve the five objectives of the IHS / VHA MOU and submitted such a plan to VACO. At this time, Networks should update those plans after consulting with IHS and Tribes. Most Networks can skip this introductory section in FY2006 unless you plan to substantially revise your existing plan. However, every network should review appendixes B-G for updated information.

As a first step toward developing such a plan, the VISN should complete an assessment of the needs of AI/AN veterans in the Network. As part of the needs assessment each VISN should

- ✓ Meet with IHS Area leadership and staff, IHS Urban Indian program staff and local Tribal and Urban programs (as appropriate) to share information and gain an understanding of one another's programs: IHS can assist in making initial contacts with Tribal and Urban programs if needed;
- ✓ Meet with local Indian veteran groups, as appropriate;
- ✓ Complete, in partnership with IHS, Tribal providers and VBA regional staff, a local assessment of needs and opportunities to address the five objectives of the IHS MOU;
- ✓ As best as possible, understand the local demographic information on AI/AN veterans at the level of the VISN and VAMC.

Through these discussions and analysis Networks should seek to answer the following kinds of questions:

1. How many AI/AN veterans, according to the US Census, reside within the VISN service area and how is this number distributed across the facilities in the Network? Does the VISN meet the standard threshold criteria for access for these veterans?
2. How many AI/AN veterans are currently enrolled in the VISN? (N.B. Most Networks are likely to have inadequate race / ethnicity data available at this time and should work to improve the collection of accurate race and ethnicity data.)
3. How many AI/AN veterans are currently enrolled in the corresponding IHS or Tribal health systems?
4. Which IHS Area (s) corresponds to the VISN, what IHS facility reside within this area, who are the IHS Area and facility leaders? What services are currently provided by IHS within the VISN? What are the greatest IHS needs for services, administrative functions, infrastructure etc, over the next several years? What are the greatest organizational priorities for IHS in the Area over the next several years?
5. Which Tribes reside within the VISN service area, what Tribal facilities operate in the area and who are the Tribal leaders and Tribal facility directors? What services are currently provided by Tribal health facilities within the VISN? What are the greatest Tribal health needs for services, administrative functions, infrastructure etc, over the next several years? What are the greatest

organizational priorities for Tribal health providers in the area over the next several years?

6. What are the greatest needs for services, administrative functions, infrastructure etc, over the next several years for the VISN? What are the greatest organizational priorities for the VISN? How might VISN needs and strengths be either complimentary or synergistic with those of IHS and / or the Tribes?
7. Do Urban Indian Health programs exist within your VISN? If so, where are they located, who are the leaders of the organizations and what services do they offer and to whom? What needs do these programs have for the coming years? How might you work together to meet the needs of AI/AN veterans?

Background Information

Consultation

Executive Order 13175 states:

> The United States has a unique legal relationship with Indian tribal governments as set forth in the Constitution of the United States, treaties, statutes, Executive Orders, and court decisions. Since the formation of the Union, the United States has recognized Indian tribes as domestic dependent nations under its protection. The Federal Government has enacted numerous statutes and promulgated numerous regulations that establish and define a trust relationship with Indian tribes. Our Nation, under the law of the United States, in accordance with treaties, statutes, Executive Orders, and judicial decisions, has recognized the right of Indian tribes to self-government. As domestic dependent nations, Indian tribes exercise inherent sovereign powers over their members and territory. The United States continues to work with Indian tribes on a government-to-government basis to address issues concerning Indian tribal self-government, tribal trust resources, and Indian tribal treaty and other rights. The United States recognizes the right of Indian tribes to self-government and supports tribal sovereignty and self-determination.

Therefore, representatives of the Federal Government should consult with federally recognized Tribal governments during the process of developing policies and programs that impact Tribal territory or significant numbers of Tribal members. However, it is important to note that while consultation involves active listening and discussion, consultation does not establish a requirement that the parties agree on the policies or plans to be implemented.

The Department is developing a consultation policy that will be distributed to the field. In the interim, field leadership and staff should continue to meet with local tribal representatives.

Tribes

There are 560 federally recognized Tribes in the United States. The Bureau of Indian Affairs at the Department of Interior is responsible for determining which Tribes qualify for federal recognition. Among other rights and obligations, federal recognition makes

Tribes eligible to receive health care from the Federal government. IHS is the federal agency designated to provide health care to meet the treaty obligations of the US government. However, under The Indian Self-Determination and Education Assistance Act of 1975 (P.L. 93-638, as amended) and the Indian Health Care Improvement Act of 1976 (P.L. 94-437), Tribal Nations can petition to take over administration of health care services for their people. At the end of FY 2004, more than 53% of Tribes have taken on the management of health care for their community. Each Nation that enters into such a compact receives a proportional share of the IHS budget. As this trend continues, IHS must balance the maintenance of health care delivery capacity within their own delivery system with the need to provide technical oversight, administration and assistance to both its own health providers and those of the Tribes.

Tribes have the authority to determine whether non-Indians can receive care at IHS or Tribal facilities. Under such arrangements, compensation must be provided for that care and the treatment can not result in the diminution of services to eligible Tribal members.

State governments may also recognize Tribes and grant those Tribes rights under State law. For purposes of the decennial US Census, Tribes, States and the Census Bureau have also established designated statistical areas of AI/AN populations. (http://www.census.gov/geo/www/maps/aian_wall_map/aian_wall_map.htm)
See the directory of Indian Nations and other Tribal links of the National Congress of American Indians at
http://198.104.130.237/ncai/index.jsp?pg=10

Indian Health Service

The mission of the IHS, in partnership with American Indian and Alaska Native people, is to raise their physical, mental, social and spiritual health to the highest level. IHS is an agency within the Department of Health and Human Services. It provides a comprehensive health service delivery system for approximately 1.6 million of the nation's estimated 2.7 million Indian people. IHS delivers care or coordinates care with Tribes through twelve regional offices; each led by an Area Director. It also provides grants to 34 urban programs throughout the country. In fiscal year 2004, IHS spent approximately $3.67 billion or about $1,914 on medical and non medical expenditures per enrolled patient. IHS strives for maximum tribal involvement in meeting the needs of its service population, most of who live on or near reservations and in rural communities in 35 states, mostly in the western US and Alaska.

Contact information for the IHS designated leads (Points of Contact) in each area is included in Appendix B. Contact information for IHS Area Directors is included in Appendix C and at
http://www.ihs.gov/AdminMngrResources/EmployeeServInfo/StaffDirectories/index.cfm
Additional information on IHS can be found at http://www.ihs.gov

Urban Indian Health Program

The Urban Indian Health program at the IHS provides grants and contracts to 34 non-profit organizations operating in 41 urban sites around the country. These organizations receive additional funding support from other federal, state, local and private sources. Each Urban Indian Health program offers a different range of services and may include ambulatory care, dental services, alcohol and substance abuse prevention, education, treatment and rehabilitation services, AIDS and STD information, mental health and social services, and community outreach. It is important to note that some programs provide only outreach and referral services.

In FY 2004, $31.6 million was allocated to the Urban Indian Health Program. More than 2.3 million Indians live in urban locations. The current Urban Indian Health program is unable to meet this level of need. Indeed, there are eighteen cities that have a sufficient urban Indian population to qualify for a grant under the program but which do not receive them.

A directory of the IHS supported Urban Indian Health Programs can be found in Appendix D and additional information at
http://www.ihs.gov/NonMedicalPrograms/Urban/Urban_index.asp
Also see the directory of Urban Indian Health programs at the National Council of Urban Indian Health at http://www.ncuih.org/urbanhealth/index.html

Other Organizations

Tribal governments and Indian people have formed local, regional and national organizations to advance the interests of Indian people. For example, there are such regional intertribal groups as United Southern and Eastern Tribes, Indian Tribal Council of Arizona, the Aberdeen Area Tribal Chairmen's Health Board, and the Great Lakes Indian Tribal Council. At the national level, many of the Tribes also participate in the National Council of American Indians and the National Indian Health Board.

Not all Tribes belong to such organizations and these organizations do not necessarily represent all of the interests of the member Tribes. Never the less, these groups can provide a useful point of contact and an organized forum from which to begin to explore the needs and interests of the Tribes and Indian veterans in a given region of the country.

For additional contacts and information see http://198.104.130.237/ncai/index.jsp?pg=1

Demographic Information

According to the 2000 US Census, there are about 200,000 veterans who identify themselves as AI/AN in a single race category: This number more than doubles if more than one race category is included in the tally.

No survey or database provides comprehensive, accurate information on Indian people or AI/AN veterans. Network planners should examine the State and county level data from the 2000 US Census, IHS enrollment data (Appendix E), and the race / ethnicity data

available in the VISN. A pilot study comparing IHS and VHA patient data from one VISN indicates that IHS is slightly more reliable in identifying veteran status for AI/AN but neither system of records is accurate.

Additional nationwide information is available from the 2001 National Survey of Veterans (http://www.va.gov/vetdata/SurveyResults/final.htm) and the 1999 Large Survey of Veterans (Appendix F). Some information is also available on OIF/OEF Indian veterans (Appendix G).

2000 US Census. The 2000 US Census provides data on the number of Indian veterans residing in each county. Two data sets are available; the number of Indian veterans who indicated only one race and those who indicated two or more races. Data is also available by metropolitan survey area.

For 2000 US Census data see http://www.census.gov/census2000/pubs/phc-5.html
And http://www.va.gov/vetdata/Census2000/

OBJECTIVE 1- COMMUNICATION

Improve communication among the VA, American Indian and Alaska Native veterans and Tribal governments with assistance from the IHS.

Purpose: Productive communication is the first step in building partnerships to better serve AI/AN veterans and improve the health outcomes of this population. Through communication, needs can be identified and solutions developed that apply the strengths of each organization. Working together, each organization can be more efficient than they are alone. Thus, healthcare and services are improved for all beneficiaries, including veterans.

Performance Opportunities

- ✓ Each VISN should establish regular communications with IHS and Tribes at the regional level. Meetings can occur at the Network level or at the facility level, depending on the number and location of Tribes in the Network. VISN may wish to have one-on-one talks or establish standing invitational meetings that include elected officials from all Tribes. Alternatively, the VISN may want to take advantage of existing forums such as IHS meetings with Tribes or regularly scheduled Tribal and Inter Tribal gatherings, such as meetings of the Area Indian Health Board (http://www.nihb.org/staticpages/index.php?page=200403301344375598), to brief Tribal leaders on VISN activities.
- ✓ If facilities (rather than the VISN) meet regularly with IHS or Tribes, the VISN may wish to consider establishing a structure and process within the VISN to facilitate internal communication. For example, the VISN could establish an AI/AN workgroup that meets regularly to exchange information and update the VISN on plans and progress.
- ✓ Each VISN shall identify a senior staff member responsible for planning and implementation of activities and programs for AI/AN veterans and provide the name of that individual in their plans each year.
- ✓ Network Directors are encouraged to establish relationships with Tribal leaders and participate in reservation visits, regional inter-tribal council meetings or other local events.
- ✓ VISN should work to understand the needs and concerns of individual AI/AN veterans and are strongly encouraged to consider establishing a regular forum for communicating directly with individual veterans such as holding regular talking circles, veteran town hall forums, regular reservation visits to meet with veterans or other events in relevant locations. Discussions with Tribal leaders and veterans during FY2005 indicate that town hall forums and briefings to the Tribal council held on Tribal lands are highly valued and help to build a relationship and trust with the community.

Frequently Asked Questions

Q: Why is it important to communicate with Tribes?

A: 1) There is a legal expectation that federal agencies support Tribal sovereignty and self determination and work with them on a government to government basis. 2) Regular communication is a practical step that allows both sides to identify common needs and opportunities. 3) Communication builds trust. Indian people have a long history with federal agencies and officials which has often been negative. Regular communication and the visibility of VISN leadership in Indian communities can help demonstrate respect and commitment. Of course, the very best way to demonstrate commitment it to establish useful programs and sustain them over time.

Q: We have attempted to contact a local Tribe on several occasions but have never received a response. Should we give up?

A: Not yet. The Indian Health Service is likely to know the Tribe and the Tribal leaders in your area. Ask IHS if they can help broker the first couple of meetings with the Tribe.

Q: The Tribes have large needs and extensive demands that our Network can't possibly meet. Should we still meet with them?

A: Yes. Communication and collaboration is intended to be two way. Many Tribes are unfamiliar with VA and how we operate. As a result they may hold expectations that we can not meet. Provide an overview of VA structure and operations and be forthcoming about your own financial, resource and legal limitations. You may need to share that unlike other federal departments, VHA has no legal authority from Congress to make grants or transfer funds to Tribes except where we may work with them as a business entity. Share where the VISN has unmet service needs and look for creative opportunities to leverage the assets of each of the organizations in a cooperative fashion to meet service demands.

Q: We have Tribal lands within our Network that cross into the jurisdiction of another Network. Who is responsible for establishing communications with this Tribe?

A: The Networks involved should communicate with one another and determine whether one Network should be responsible or whether coordinated communication is necessary. A primary consideration for responsibility is which of the VISNs provides care to a substantial portion of the veterans residing on the reservation.

Q: Every time we visit with AI/AN veterans and Tribal leaders we hear more questions about benefits than we do about health care. Are we responsible for answering these questions?

A: No matter what administration you come from, veterans and outside groups see us as representatives of the VA. When meeting with these individuals and groups it helps to come prepared to answer the full range of questions about VA benefits

and services. Many VHA locations around the country have found it extremely helpful to include collogues from VBA and NCA in any forums, events, meetings or trips designed to communicate with AI/AN veterans. Some areas of the country have established standing internal councils or workgroups to facilitate ongoing communication between VBA, VHA and NCA on local issues relevant to AI/AN veterans and to ensure that each administration has at least one point person familiar with the needs and culture of this community.

Promising Practices

VISN 12: IHS Task Force. Due to the unique characteristics of each Tribal center and Indian health facility, each VISN 12 facility has designated its own IHS coordinator. These coordinators are developing strong relationships with their local Tribal centers and identifying areas of collaboration to ensure that the plans developed are consistent with the local needs and resources of the Tribal center and VAMC. These coordinators make up the VISN 12 IHS Task Force along with representatives from the VISN office and the Great Lakes Acquisition Center. Local plans will be shared and discussed within the Task Force to promote further ideas and interest in expanding VA-IHS sharing opportunities throughout the VISN.

VISN 23: Leadership Visibility. The VISN Director regularly visits reservations and meets with Tribal Chairman and council members. Native American Advisory Councils (with members from the VA, IHS and each of the tribes in the respective catchment areas) have been established and meet quarterly at the Sioux Falls, VA Black Hills and St. Cloud Medical Centers.

VISN 20: Alaska Federal Health Care Partnership. To meet the needs of federal health care beneficiaries in the frontier environment of Alaska, VA, IHS, DoD and the Tribes have developed a mature administrative partnership that helps to promote sharing and collaboration. The collaboration is supported by a joint management office staffed with contributions from all of the services. Monthly meetings between the leadership of the organizations are held to discuss agency needs and plan future sharing initiatives. Various other subcommittee meetings occur monthly to include topics such as clinical, logistics, technology and education.

VISN 2 and 3: NY State Coalition. VISN 2 and 3 have successfully applied the same solution to three similar problems: coordinating mental health services for veterans, coordinating services for returning operation Iraqi Freedom / Enduring Freedom (OIF/OEF) veterans and coordinating services for Indian veterans. In each case, the Networks established a statewide coalition of all relevant agencies serving veterans including VA (VHA, RCS, VBA and NCA), state division of veterans affairs and other city and county agencies. The coalitions meet regularly to share plans and activities, raise issues encountered by each agency and devise joint solutions. Each project has established a web presence and problem solving also takes place outside of the meetings as a result of the contacts and relationships established through the coalition. In some cases, specific

workgroups have been created to tackle particular issues. A similar structure could be applied to improving services for AI/AN veterans in other states and regions. Such a task force could include VA (VHA, VBA, RCS, NCA) IHS, and Tribe(s). Other potential partners include Department of Housing and Urban Development, Bureau of Indian Affairs, Department of Labor and other State and local agencies that provide services to large numbers of Indian people (such as housing, homeless programs / transitional assistance, job training etc..) In some instances DOD and guard or reserve contacts or Department of Justice and local law enforcement may also be appropriate local partners. Regular meetings with other government agencies, whether federal, state or local and including representatives of elected governments of federally recognized Tribes do not trigger the Federal Advisory Committee Act (FACA). Consult with your regional counsel before including non governmental organizations in regular meetings to ensure that their regular participation is appropriate.

OBJECTIVE 2 – BUILDING PARTNERSHIPS

> Encourage partnerships and sharing agreements among VHA headquarters and facilities, IHS headquarters and facilities, and Tribal governments in support of American Indian and Alaska Native veterans.

Purpose: Partnerships and sharing should improve the overall efficiency, effectiveness or volume of services provided to beneficiaries, including AI/AN veterans and their families.

Performance Opportunities

- ✓ Each VISN should explore partnership and sharing opportunities with IHS and Tribes.
- ✓ VISN should be sure to consider training opportunities in collaboration with IHS, Tribal Colleges and Universities, or the American Indian Science and Engineering Society consistent with VA 2004 – 2006 plan to implement Executive Order 13270 on Tribal Colleges and Universities. VHA workforce succession plan to enhance the recruitment of American Indian and Alaska Native students.
- ✓ Each VISN should develop a list of priority opportunities for sharing and collaboration within the VISN, based on joint planning with IHS and Tribes. The list should be updated each year in the VISN operational plan
- ✓ Each VISN should develop a timeline for implementing priorities from the list. The implementation plan should balance need and opportunity with budget considerations and other organizational priorities

Frequently Asked Questions

Q: What legal authorities govern sharing and collaboration?

A: Regional counsels for both agencies should be consulted as to which authority(ies) may apply to any particular circumstance. In most cases, sharing arrangements are likely to fall under the authority of the Economy Act (31 USC 1535) or VHA sharing authority under 38 USC 8153 (particularly for sharing with Tribal providers.) However, in some circumstances, other authorities might be appropriate such as VHA Enhanced Use Lease authority (38 USC 8162) and Health-Care Personnel Education and Training programs (38 USC 7302) or the Intergovernmental Personnel Act Mobility Program, for which Tribal governments are eligible (5 USC 3371-3375).

Q: Do we have to execute a legal agreement with IHS and the Tribes to institute a sharing activity?

A: In most cases some kind of agreement must be executed. Regional counsel should provide guidance on the nature and content of the agreement (and whether a contract, MOU, IAA or other agreement is needed.) In limited cases the nature of the activity may allow for an informal arrangement that needs no agreement but this should be confirmed with regional counsel. (For instance, a one time jointly run and attended educational seminar may not require a formal agreement.) In arrangements with IHS where only an MOU is needed, the national IHS / VHA

MOU is the umbrella agreement to which local facilities should append operational agreements that specify the particular activity and obligations of each agency. Tribal sharing is not covered under the existing MOU and therefore an entirely separate MOU would be needed to govern such arrangements with Tribes.

Q: Why should VHA participate in sharing and collaborative activities?
A: Partnerships and sharing are intended to improve the overall efficiency, effectiveness or volume of services provided to beneficiaries, including AI/AN veterans, and to promote the best use of federal dollars.

Q: I am not familiar with VA plans to work with Tribal Colleges and Universities. Could you give me more information?
A: In July 2002, President Bush signed Executive Order 13270 stating that the federal government's commitments to educational excellence and opportunity must extend to Tribal Colleges and Universities. In response, each Department, including VA, developed a response plan to meet the objectives of the executive order. For its part, VHA was charged with extending academic affiliations to Tribal Colleges and Universities; increasing AI/AN participation in VA health professions clinical training programs; and continued participation in internship programs for minority students. Currently, there are 33 tribal colleges and universities located in AZ, NM, KS, NE, SD, ND, NM, WI, MI, MT and WA (See map at http://www.collegefund.org/). Medical Centers who do not have an affiliation with their local institution may wish to work with staff in academic affiliations to explore such a linkage. Support for such affiliations is consistent with VHA Workforce Succession Strategic Plan for 2006 – 2011 which stated that "it is critical to establish and maintain academic affiliations with the Tribal Colleges."

Promising Practices

VISN 19: Clinical IT Sharing. To better serve IHS and Tribal beneficiaries, including AI/AN veterans using those services, IHS and a number of the Tribes within VISN 19 are interested in implementing IHS's Electronic Health Record (EHRHER) at he point of care. VISN 19 staff is assisting IHS and the Tribes as they bring EHR on line by providing training and technical assistance during initial implementation of the system.

VISN 12: Enhanced Use Lease. The VISN is receiving payment from the HO-Chunk Nation for the use of vacant building space owned by the Network. (AttachmentAppendix H.G.)

VISN 18: Sharing Staff. The Phoenix Area Medical Center (PIMC) and the Carl T. Hayden VA Medical Center share staff under two interagency cross- service agreements under the authority of the Economy Act. Under one of the agreements, each VHA podiatry resident spends one month a year at PIMC to gain intensive experience in diabetic foot care. Under the second agreement, PIMC and the VAMC share gastroenterology services. Initially, VAMC provided services at PIMC and utilized PIMC as an additional training site for gastroenterology fellows. In recent years, PIMC gastroenterology staff joined the

VAMC GI call rotation and maintains privileges at both PIMC and VAMC. (Appendix I.)

VISN 18: Academic Affiliations with programs serving American Indian and Alaska Native Students. The southwest Consortium of Predoctoral Psychology Internship (SCPPI) has been in existence since 1995. This is a collaborative effort between the University of New Mexico Hospital, the Veterans Hospital in Albuquerque, and Indian Health Service. One intern slot is reserved for and funded by the Indian Health Service each year. Both Indian and non-Indian psychologists have been trained through the program. Interns rotate between the three sites, exposing them to the different environments of care and providing them with a variety of mentoring relationships. A number of the students have gone on to work for either VHA or IHS. Such programs are consistent with recommendations in the 2006 VHA Workforce succession plan to enhance affiliations with Tribal Colleges and Universities and with the efforts of the Department's office of Diversity Management and Equal Employment Opportunity to strengthen ties to the American Indian Science and Engineering Society.

VISN 18: Nutrition Counseling for Diabetic patients. The New Mexico VA Health Care System and Gallup IHS collaborate to provide nutrition counseling services to AI veterans. The IHS dietician provides the counseling at the VA clinic, which allowed NMVAHCS to meet JCAHO standards for nutritional counseling.

VISN 23: CPRS Sharing: The VA lack Hills Health Care System in Western South Dakota has established access for IHS Contract Health Care employees to read veteran medical records in the Computerized Patient Record System (CPRS) for specialty care referrals and care coordination of shared patients. The best practice, initially between the Pine Ridge IHS Hospital and the VA Black Hills, is slated for expansion between the Fort Yates, ND, Eagle Butte, SD, Rosebud, SD IHS Hospitals and VA Black Hills in FY2006.

VISN 23: Sharing Agreements for Non-Veterans: For several years, VA Black Hills has had sharing agreements in place with the Aberdeen Indian Health Service Area and its hospitals/clinics throughout South Dakota to serve non-veteran IHS patients in specialty care as capacity permits.

VISN 15: Radiology and Pathology Sharing. The Eastern Kansas Health Care System and the Haskell Indian Nations University Clinic established an MOU to share radiology and pathology reading services. The Haskell clinic provides 100-200 radiology readings per month while VHA pathology provides supervision and consulting services to laboratory technicians at the clinic.

OBJECTIVE 3 – IMPROVING ACCESS

Improve beneficiary's access to quality healthcare and services.

Purpose: Geographic distance and lack of coordination between IHS and VHA are barriers to AI/AN veterans accessing the VHA care they have earned. AI/AN veterans have poor health indicators and continue to report a high level of unmet health care needs. Lowering the barriers to accessing care is an initial and necessary step toward improving health outcomes for these veterans.

Performance Opportunities

- ✓ Each VISN should determine access needs for AI/AN veterans in the Network.
- ✓ VISN should establish a priority list of enhanced access opportunities in the Network. These may be such arrangements as a CBOC, telehealth programs, specialty clinics at Tribal or IHS sites, standard referral and patient coordination agreements, etc.
- ✓ Each VISN should develop a timeline for implementing priorities from the list. The implementation plan should balance need and opportunity with budget considerations and other organizational priorities. Updates and justification for changes to the timeline should be provided each year in the VISN operational plan, to include budget considerations and competing obligations.

NB: In a November 2, 2004 memorandum from the acting USH, VISN were directed to improve the coordination of mental health service for veterans with state and local agencies, including IHS (Appendix J). Progress made in improving mental health services for veterans in coordination with IHS, Tribes or Urban Indian programs under this mental health directive can also be counted as progress toward improving access for AI/AN veterans.

Frequently Asked Questions

Q: Access is a problem throughout our Network. How is this effort consistent with other VA policies and priorities relevant to beneficiary access?

A: Congress has expressed a strong interest in ensuring health care access for veterans in rural and highly rural areas of the country. In response to the congressional reporting requirement in Section 223 of the Veterans Health Care, Capital Asset, and Business Improvement Act (Public Law 108-170), VHA submitted a plan of action to Congress in April 2004 addressing how to improve access to health care for veterans residing in rural areas. Coordination and partnership with IHS was one of four core elements included in the plan of action submitted to Congress. The other strategies included in the report are the establishment of CBOC, Telehealth/Care Coordination, and participation in National Rural Development Partnerships.

In both rural and urban settings, improving access to services for AI/AN veterans supports VA's priority to care for our core constituency of patients which includes

low income veterans. In 2000, 25% of all AI/AN lived on incomes below the federal poverty limit.

Q: IHS (or Tribes) already offer extensive services to AI/AN in the areas where a large proportion of the Indian veterans in our Network reside. Is there a role, then, for VHA under these circumstances?

A: In principle, VHA has a responsibility to provide health care services to enrolled veterans regardless of the availability of health care services from other sources: For example, the availability of general health care services in large cities does not negate the obligation of VHA to provide services to enrolled veterans in those cities. However, in reality, the most effective and efficient means for AI/AN veterans to receive health services may be through existing IHS and Tribal providers particularly where there are limited numbers of Indian veterans or the veterans prefer to seek care from these providers. In such cases, VISN should explore means to help improve the services available to veterans through these providers. Establishing a clinical or telehealth presence for specific clinical needs of veterans (such as post-deployment health issues, PTSD, environmental hazard exposure associated with combat, and other VHA areas of clinical emphasis) is one such example. Another is to provide clinical training for IHS and Tribal staff in specialty areas specific to combat exposure. Finally, VISN may simply work to better coordinate the care of AI/AN who seek care from IHS while they are on Tribal lands but who access the VHA system when they travel or work in urban areas.

Q: Our Network would like to establish telehealth linkages with IHS and Tribal health facilities to improve access to services for veterans. Any suggestions for how to get started?

A: The IHS Area Directors and VHA VISN Directors endorsed the development of national and regional telehealth collaborations. Dr. Adam Darkins (Adam.Darkins@va.gov) at VHA and Dr. Mark Carroll (mark.carroll@ihs.gov) at IHS are the principal points of contact for each agency and can provide additional support and information. To establish home telehealth, telemental health, teledermatology, teleneurology and teleretinal surveillance be sure to review the VHA toolkits at http://vaww.va.gov/occ/TH/toolkits.asp.

Promising Practices

VISN 23 and 16: Community Based Outpatient Clinic (CBOC). VISN 23 established a Contract CBOC on the Cheyenne River Reservation (1989), a Contract CBOC one the Rosebud Reservation (1996) and recently reactivated a VA-staffed CBOC on the Pine Ridge Reservation. In addition, telemental health services have been provided on the Rosebud Reservation since 2000 and are being developed for the Cheyenne River and Standing Rock Reservations. In January 2003, VISN 16 and the Choctaw Nation partnered to provide healthcare to Indian and veteran beneficiaries via a Community-Based Outpatient Clinic located in the Choctaw Nation Health Center in McAlester, OK. This partnership continues to improve access to care for all residents of southeastern Oklahoma by eliminating a 130

mile round trip to the medical center. In addition, the partnership has exposed the tribal organization to VA quality and patient satisfaction indicators (which they have embraced) as well as clinical value and improved efficiency via CPRS.

VISN 20: Telemedicine. The Alaska Federal Health Care Access Network (AFHCAN) has deployed telemedicine solutions to 248 sites throughout Alaska to improve access to health services for federal and tribal beneficiaries (federal includes VHA, IHS, DoD and the Coast Guard). More than 13,000 clinical cases archived on the system by the end of 2003. The use of the system steadily increased, from 721 cases in 2001, to 2,843 cases in 2002, then 8,136 cases in 2003. The majority of the cases were for Primary Care cases, Audiology consults and Dermatology cases. In 2003, there were 6,589 Primary Care, 1,235 ENT, and 312 Dermatology cases archived in the software.

Other Examples

VISN 20: Veterans Court. Anchorage, Alaska, established a veterans court designed to direct military veterans with behavioral problems into a comprehensive rehabilitation program managed by VA. Rather than arresting and jailing veteran offenders for a few days or weeks only to return them to the same type of life, the new court connects veterans to VA resources. Veterans who want to participate in the diversion program have to plead guilty or no contest to at least one of the charges against them. Sentencing would be delayed until they complete the program.

Some Tribes and Tribal courts have established similar programs for Tribal members with substance abuse and mental health disorders. Partnering with such programs to provide additional enhanced services to veterans through VA provides additional routes to recovery for participants.

OBJECTIVE 4 – HEALTH PROMOTION, DISEASE PREVENTION

Improve health promotion and disease prevention services to American Indians and Alaska Natives.

Purpose: American Indians and Native Alaskans have poorer health indicators (obesity, nutrition, exercise, tobacco use, alcohol consumption) and consistently worse health outcomes than the US population as a whole. Tribal leaders and community health experts have recognized that the only long term solution to improving health in Indian country is to begin promoting healthy lifestyle choices and disease prevention efforts. As a result, IHS and Tribal health facilities and public health agencies have established health promotion / disease prevention as a priority within their programs. VHA can both contribute to these efforts and learn from the extensive experience gained by IHS and Tribes over the past few years as federal investments have been made toward implementing and evaluating such programs.

Performance Opportunities

- ✓ Discuss health promotion / disease prevention needs and existing programs with IHS and Tribes.
- ✓ Identify needs and gaps for AI/AN veterans.
- ✓ VISN should consider developing a health promotion / disease prevention program with assistance from IHS, Tribal or Urban Indian Program, consistent with national priorities and available resources. Examples of such a programs include
    A. OIF/OEF community outreach programs (Appendix K);
    B. Diabetes prevention collaborations (Appendix L);
    C. A VHA health promotion / disease prevention program for AI/AN veterans established with technical assistance or input from IHS and or Tribes;
    D. Or other relevant program described by the Network.

Frequently Asked Questions

Q: Our Network would like to either collaborate on a program or learn what local IHS and Tribal programs have done in health promotion / disease prevention programs. How would we identify the right contacts?

A: Program information can be found in Appendix G for community outreach and readjustment assistance for returning OIF/OEF personnel and for Diabetes prevention in Appendix L. Additional program information relevant to diabetes prevention (diet, nutrition, exercise, and health education) a good place to start is with the IHS National Diabetes Program and area diabetes consultants found at http://www.ihs.gov/MedicalPrograms/diabetes/program_directory/pd_index.asp (Descriptions of model Diabetes prevention programs can also be found at this link.) Additional fitness and nutritionist contacts can be found through the same program at http://www.ihs.gov/MedicalPrograms/diabetes/nutrition/n_ldrs.asp . For programs relevant to behavioral health (substance abuse, tobacco cessation,

social service support and counseling) see the IHS behavioral health program guide at http://www.ihs.gov/MedicalPrograms/Behavioral/index.cfm?module=BH&option=BHPrograms. It is important to note that all IHS funded behavioral health programs are run by Tribes, not IHS. Dr. Jon Perez (jon.perez@ihs.gov), Director of the IHS Behavioral Health program and his staff can provide additional guidance and contacts.

Promising Practices

IHS National Diabetes Prevention Program. See the model programs at http://www.ihs.gov/MedicalPrograms/diabetes/program_directory/pd_index.asp

Physical Activity and Nutrition. The Guide to Community Preventive Services (http://www.thecommunityguide.org/) makes recommendations on public health interventions based on a systematized review of the available literature. For physical activity, the Task Force has recommended a number of approaches based on strong evidence, including community-wide campaigns, non-family social support and individually adapted health behavior change. The VHA MOVE program is one example of an individually adapted health behavior change program. (http://vaww.nchpdp.med.va.gov/MOVEIntro.asp) IHS *Just Move It* is an example of a community wide campaign. (http://www.justmoveit.org). Additional examples of evidenced based intervention programs can be found at the NCI sponsored site, Cancer Control Planet, http://cancercontrolplanet.cancer.gov/ and references therein under diet/ nutrition and physical activity at http://cancercontrol.cancer.gov/rtips/ . VISN may want to link community wide physical activity campaigns to competitive activities such as walking challenges (http://www.ihs.gov/nonmedicalprograms/ihpes/index.cfm?module=content&option=home) or VA special events programs such as the Golden Age Games where community support and physical activities could be engaged to help competitors train and compete in VA sponsored competitions.

Finally, HHS Administration on Aging's "You Can!: Steps to a Healthier Aging" campaign provides a number of useful toolkits and opportunities for community collaborations. (http://www.aoa.gov/youcan/about/about.asp VISN can view the partner information by signing in with the user name, **VHAMurphy** and login, **veterans**. VISN should register and establish their own accounts if you plan to implement a You Can! program and contact local partners.)

OBJECTIVE 5 – ENSURING ORGANIZATIONAL SUPPORT

Ensure that appropriate resources are available to support programs for American Indian and Alaska Native veterans.

Purpose: Time, attention, staff commitment and support of the Network leadership are all required to make progress toward implementing all of the objectives of the MOU and realizing improved health outcomes for AI/AN veterans. Understanding the needs of these veterans, sharing this knowledge with front line staff and establishing specific programs and activities to meet those needs is also important toward this end.

Performance Opportunities

- ✓ Each VISN should consider establishing consistent performance goals across the VISN. At a minimum, the Network or facilities should provide regular outreach and information about services and eligibility through culturally appropriate venues. In addition VISN may also wish to consider
    A. C&P exams on a regular schedule at IHS or Tribal facilities*****;
    B. Tribal Veteran Representative Training program with ongoing technical support (A standardized national teaching guide has been developed by EES with assistance from VBA and VHA, including VISN 19 and should be available for use by mid-November 2005. Contact Karen McCoy in EES (Salt Lake City) or Amy Hertz in 10H for information and copies of the guide.)
- ✓ Each VISN shall offer support for AI/AN traditional spiritual practices analogous to services offered to veterans of other faiths. Services are to be coordinated under the auspices of the VA Chaplain service and the local chief of the Chaplain service. Some facilities may also wish to offer additional support for traditional spiritual practices such as sweat lodges, drum circles or other ceremonies and rites. (Appendix N.)

***** Veterans have noted that these services are not conducted in a culturally sensitive manner. In order to facilitate a successful clinical encounter, staff should understand Tribal culture and appropriately tailor the questions used while taking a medical history. Where TVR programs exist, the Tribal Veteran Representative can assist veterans in completing forms and facilitating the C&P process.

Frequently Asked Questions

Q: We are a health care facility with credentialed and licensed clinical staff. How do we accommodate traditional Indian healers?

A: Traditional Indian healers operate within the traditional spiritual and religious beliefs of their people. Traditional healing includes sweat lodges; formal healing ceremonies; vision quests; songs, stories, and teachings; and other rites and ceremonies based on Tribal tradition. Ceremonies seek to restore a healing balance to the mind, body, heart and spirit. Traditional healers care for patients under the management and supervision of VA chaplains. In this way, the

chaplain service can assist in assuring that the spiritual needs of all veterans are provided for. Furthermore, 42 U.S.C. § 1996 states:

> It shall be the policy of the United States to protect and preserve for American Indians their inherent right of freedom to believe, express, and exercise the traditional religions of the American Indian, Eskimo, Aleut, and Native Hawaiians, including but not limited to access to sites, use and possession of sacred objects, and the freedom to worship through ceremonials and traditional rites.

Q: What is a TVR program and how can our Network start one?

A: Tribal Veteran Representatives are Tribal members, most often veterans, who receive training and technical support from VA to help them understand the VA pension, benefits and health care system so that they can render assistance and advice to Indian veterans seeking to apply for VA benefits. Most TVR are unpaid volunteers. However, some Tribes provide some financial support to TVR working with their members.

The role of VA is to provide accurate, up to date and understandable information to TVR outlining the benefits available, explaining eligibility requirements and showing them how the application process works. A number of the existing programs provide initial training and then ongoing mail or conference calls to ensure that the TVR have access to the most current information and forms. EES, with guidance from VHA and VBA, has developed a standardized curriculum for the initial TVR training course. Networks interested in copies of the guide or in need of information should contact (Karen McCoy at EES Salt Lake City, Karen.Mccoy@lrn.va.gov, or Amy Hertz in 10H, Amy.Hertz@va.gov).

Q: Our VISN doesn't have many Indian veterans. Should this really be a priority for my Network?

A: Every Network should complete a thorough needs assessment. Each VISN should also provide information and outreach to AI/AN veterans when local partners are available to assist with this effort (e.g., Tribes, IHS, Urban programs or local intertribal organizations.) Some VISN have been exempt from further action because there are no partners available for follow up. Specifically, VISN 4, 5, 9 and 10 are exempt. Other Networks can be considered for exemption following the analysis of local needs and opportunities For the remaining Networks the level and type of activities and program established will depend on the level of need and interests of the VISN and partner organizations and available resources. However, VISN with a greater percentage of AI/AN veterans should work to implement a more robust program than those with a lower density of AI/AN veterans. (See Table I)

TABLE I – Concentration of AI/AN Veterans by VISN and State

TIER	DEFINTION	VISN	STATE DETAIL
Tier I	AI/AN as % of total veterans by state is greater than 1.0%	16	OK 5.4%
		18	NM 5.1%
			AZ 2.3%
		19	UT O.8%
			MT 3.8%
			WY 1.6%
			CO 0.9%
		20	AK 49.0%
			WA 1.3%
			OR 1.0%
			ID 1.0%
		23	SD 5.5%
			ND 3.3%
			MN 0.9%
Tier II	AI/AN as % of total veterans by state is greater than 0.7% but less than or equal to 1.0% AND those states not included in Tier I or II that have more than 4,500 AI/AN veterans	21 and 22	NV 1.0%
		15	KS 0.9%
		17	TX 11,303
		8	FL 7,323
		6	NC 0.9%
		2 and 3	NY 4,633
Tier III	AI/AN as % of Total veterans by state is less than or equal to 0.7%	1, 7, 11 and 12	
Tier IV Exempt	No local partners and few AI/AN veterans	4, 5, 9, 10	

Promising Practices

VISN 6 : Outreach. To address and meet the needs outlined in the MOU the Asheville VA Medical Center (AVAMC) has taken an aggressive approach to ease the process for Native American Veterans to enroll and receive treatment from the Department of Veterans Affairs. One key initiative established is a bi-weekly clinic where AVAMC staff travel to the Cherokee Indian Hospital Authority to provide benefits information to AI veterans and answer eligibility questions.

VISN 19 and 21: Traditional Healing. The Salt Lake City VAMC has established a traditional healing program that includes a healing garden, sweat lodge ceremonies, a weekly drum circle and access to traditional healers at the facility. The Menlo Park VAMC also has a well developed traditional healing program.

VISN 19: Tribal Veteran Representative Training. For the last several years, VISN 19 together with VBA has provided training to Tribal members to assist them in

becoming veteran tribal representatives. In FY 2005, the Salt Lake City EES office developed a standard national curriculum for TVR training. It should be ready for distribution throughout VA by mid-November 2005. (Contact Karen McCoy at EES or Amy Hertz in 10H for copies of the curriculum. Karen.Mccoy@lrn.va.gov Amy.Hertz@va.gov.)

VISN 23: Network Coordinator/Performance Standard. In FY 2004, the Network Director appointed a Native American Outreach Coordinator (NAAC) to work with Facility NAACs appointed at each of the 8 medical Centers. On monthly conference calls and at annual training, the group shares best practices, areas of expertise and training opportunities for outreach to the 23 Reservations and 5 significant urban Indian populations located within the Network's 5-state area. The coordinators established network-wide objectives in FY 2005 and FY 2006 to expand services and activities to support AI/AN veterans. These include:

- Establishing a Tribal Veteran Representative training program in each state (Minnesota, South and North Dakota completed in FY 2005; Iowa and Nebraska scheduled for FY 2006);
- Conducting regular visits to Indian communities, including benefit fairs, town halls and hosting information booths on each reservation or at each relevant gathering of the Tribes (such as a Pow Wow. At these events, staff not only provide benefit information and help to answer questions about eligibility, they also perform C&P Exams to facilitate the enrollment process.)
- Developing a behavioral health presence on each reservation (primarily through telemedicine). Contact C.B. Alexander for more information (c.b.alexander@med.va.gov)

VISN 23: Spiritual/Cultural Competency: Sweat Lodges have been in place at the Hot Springs and Fort Meade campuses of the VA Black Hills Health Care System and at the St. Cloud Medical Centers for many years. A Network-wide Traditional Healing Policy was instituted in FY 2005 to encourage the support of culturally competent spiritual advisement/support at each of the medical facilities/CBOCs in the Network. In cooperation with IHS and tribes throughout the Network, VISN 23's EES office produced a Cultural Competency: Plains Indians Enhanced DVD which includes not only a video, but also the ability to link with web resources and additional video that enhance the short initial presentation. Contact Janet Smith for more information (jan.smith@lrn.va.gov).

NATIONAL SUPPORT

The Office of the Deputy Under Secretary for Health for Health Policy Coordination (DUSH / HPC), 10H, is the principal office responsible for coordinating implementation of the MOU within VHA. The office works with the leadership and staff of VHA and IHS to identify priority actions and promote appropriate responses within VHA. The office coordinates the development of implementation plans and prepares progress report for the Under Secretary for Health, the Secretary and Deputy Secretary of Veterans Affairs, the White House and Congress. DUSH / HPC also provide this information to VACO and field leadership, staff and other constituents.

Coordination with the Indian Health Service

The DUSH / HPC works closely with the leadership of IHS to achieve smooth implementation of the MOU and ensure that initiatives are focused on the highest priority needs of both agencies. Three principal mechanisms are used to promote productive communication and maintain alignment between the agencies:

IHS / VHA Steering Committee. In December 2003 the Under Secretary for Health and the Director of IHS chartered the IHS / VHA Steering Committee. The committee is co-chaired by the DUSH / HPC and the Chief Medical Officer of IHS and is staffed through 10H and the Office of the Director (OD) at IHS. Committee members include VISN and Area Directors, facility directors from both agencies, chief officer equivalents from each agency and representatives from VBA, the Center for Minority Veterans and a Tribal official. The committee meets three times each year. As stated in the charge to the committee, it is responsible for reviewing and providing guidance on national initiatives; identifying new areas for collaboration and setting priorities for these new areas; encouraging and catalyzing additional collaborative projects; and supporting outreach and communication to the appropriate constituent groups. The committee recommended, and the USH and IHS Director approved, establishing two standing workgroups; Information Technology sharing, and Health Promotion / Disease Prevention (HPDP). It further directed the HPDP workgroup to focus initial collaborative efforts on diabetes prevention and the prevention of long term PTSD in Indian veterans returning from current conflict zones. The committee has also indicated that sharing of educational resources, patient safety, and effective outreach and communication are important areas for further collaborative efforts.

The Steering Committee (SC) met in April 2005 to review progress under the MOU, hear from veterans and Tribal leaders, and determine if changes were needed. The SC recommended that the MOU and the programs under it continue unchanged. However, the SC expects to see a greater emphasis on communication, outreach and the sharing of program and benefit information with veterans and Tribes including information on housing programs and support for homeless AI/AN veterans. In addition, the leadership of each organization has been asked to develop a joint policy for the coordination of health care for dual use veterans. Finally, the development of a new home health care demonstration for long term care elderly patients is expected over the next two years.

Headquarters Advisory Group. 10 H and staff from OD at IHS convene by phone each month to share information, report on the progress of workgroup activities, coordinate future Steering Committee and Director's meetings and discuss other priority projects and field implementation activities. The group also identifies outreach and communication opportunities and plans joint presentations. In FY 2006, the group will make continued progress on the national priorities identified by the Steering Committee (communication to veterans and Tribes, home health care, policy for shared patients, dissemination of benefits information, recruitment of AI/AN employees) and the important topics identified by the field leadership (Credentialing, Telemedicine.)

VISN and Area Meetings. To promote greater understanding of mutual needs and advance the implementation of the MOU at the regional level 10H, in partnership with the OD at IHS, has twice convened the VHA VISN Directors and IHS Area Directors. During the meetings, field leaders shared promising practices, discussed priority areas for action and provided input and feedback to the HQ staff of both agencies on topics where support at the national level is needed to advance progress. In FY2006, headquarters staff plans to bring together the points of contact within each VISN and Area to promote greater communication among these senior staff and to share ideas. VISN POC should look for information from 10H in early December 2005 about a meeting at the end of January 2006. If you are a VISN POC and would like to be sure to receive information about this planned meeting, send your name to Sherrie.Hans@va.gov in 10H.

Network Implementation

The Office of the DUSH / HPC supports Network implementation of the MOU through the annual strategic planning process and quarterly monitoring system. Each Network should have an implementation plan in place that was based on a local assessment of needs around the five objectives of the MOU. These plans consistently identified high priority needs for sharing and collaborations on a number of topics: telemedicine to improve access to services in rural locations; joint training and continuing education for health professionals; radiology or teleradiology; outreach to AI/AN veterans and assistance to them in enrolling for VA benefits; sharing of electronic health records systems; diabetes prevention; services for mental health care and PTSD; and sharing of laboratory services.

Over the past year tremendous progress has been made by the VISNs in implementing the objectives of the MOU. More than 150 activities or programs have been undertaken at the local level, as summarized in the following paragraphs and in Table II, page 35.

Communication: In the first three quarters of FY2005, VISNs reported more than 100 contacts with IHS, Tribal leaders or AI/AN veteran groups. Over half of these communication activities occurred directly with Tribes.

Sharing and Collaboration: The Networks reported more than 25 agreements to promote sharing and collaboration through June 2005. Projects included the sharing of space, information technology expertise, educational programming, joint purchasing, and contracting for laboratory or diagnostic services.

Access: As of June 2005, VISNs reported 20 programs that expand access to services for AI/AN veterans. For example, Network 19 reported providing more than 180 telepsychiatry patient contacts, 48 traditional healer consults, and the completion of a residential substance abuse treatment program by 8 patients. Other programs around the country include a dedicated AI coordinator to assist with nursing home placements, Tribal/reservation based CBOCs, telehealth home health care, telecardiology services, emergency room care agreements and reservation based housing for homeless AI/AN veterans.

Organizational Support: At the local level, organizational support frequently manifests as VHA sponsored health fairs, pow wow or homeless stand downs for AI/AN veterans, often held on or near a reservation. VISNs reported holding more than 35 such events through June 2005.

Health Promotion / Disease Prevention: Only two Networks reported that prevention oriented programs were in place: OIF/OEF readjustment outreach in VISN 18 and 20. However, a majority of the remaining networks indicated that discussions are taking place with IHS and Tribes to implement additional programs.

National Initiatives

National initiatives under the IHS / VHA MOU have arisen from the priorities identified by either the Steering Committee or by the Area and Network Directors during their meetings and planning processes. The national initiatives support the five objectives of the MOU. A number of the initiatives are aimed at improving the efficiency or effectiveness of the agencies. Other initiatives target issues that, if solved, would greatly ease the ability of the field to work collaboratively in a number of areas.

The DUSH / HPC provide coordination and guidance to IHS and VHA staff charged with responsibility for each of the issues outlined below. In addition, on a number of topics where no appropriate staff office has yet been identified or where extensive policy development needs to occur before implementation, 10H leads the initiative with input and assistance from other offices at VHA and IHS.

<u>Communications</u>

The Steering Committee identified communication, both to internal constituents and to external stakeholders, as a key national activity that would greatly enhance the ability of the two services to work together over time. The leadership and staff of the IHS / VHA Headquarters Advisory Group have taken on the responsibility for organizing the national communications efforts. The Steering Committee and other leaders engaged in

implementation of the MOU identified a need for 1) a standard statement that describes the work under the MOU, 2) a mechanism for exchanging information, materials and ideas and 3) active outreach to constituents. To meet the first two points, a Frequently Asked Questions guide was published in Q1 of FY2005 and the group has developed a web presence accessible to all of the partners. To enhance outreach VHA has initiated connections to tribal and national AI/AN organizations such as the National Indian Health Board and National American Indian Veterans, Inc. Briefings and presentations about the partnerships have been made at more than a dozen events around the country. The American veteran has also completed two news broadcasts that discuss work undertaken in support of the MOU.

Building Partnerships

- *Education Sharing.* IHS and VHA are both nationwide health delivery systems. As such, both have similar needs to provide ongoing education and training to staff, including continuing education for clinical staff to help them update and maintain their clinical skills. VHA has developed a sophisticated internal education and training system that delivers programming to remote staff. Similarly, IHS has developed internal expertise in organizing and presenting clinical training. Both organizations see value in creating savings through economies of scale and sharing of educational resources that would be beneficial to both organizations. In FY2005, EES has established an education sharing demonstration with the Nashville Area office. A website has been established at https://www.ees_learning.net. It lists available programs and provides a mechanism for IHS and Tribal health providers to receive continuing education credits for the training they complete. By the end of FY 2005 more than $260,000 worth of training (direct cost for development) has been made available to IHS.

- *Information Technology*. VHA and IHS have sound reasons to collaborate on their respective electronic health record activities as federal health care providers. Collaboration can promote efficient use of federal resources and create opportunities to better serve the constituents of both agencies, including the overlapping population of AI/AN veterans.

  VHA has implemented electronic health record functionality in the form of VistA/CPRS and VistA Imaging. IHS is in the initial phase of implementing the RPMS EHR (electronic health record), which to a significant degree is based on CPRS. Approximately 20 facilities have installed RPMS EHR to date and IHS is committed to implementing the system at all sites by 2008. IHS is interested in implementing VistA Imaging as a complement to RPMS EHR. Although RPMS is based on VistaA and is very similar to it, the differences between the two health information systems are long standing, tied to unique business practices and preclude IHS use of VistA without modification. During the past several years, efforts have been made to close the gaps between the two systems. Today, VHA is embarking on a VistA reengineering project to take advantage of new technology while IHS endeavors to catch up with current VistA releases and

participate in VHA's reengineering requirements identification process. IHS and VHA have developed a framework for working together which includes

- Adopting a common core of infrastructure and applications, with IHS and VHA building their own agency-specific functionality around the core;
- Supporting IHS's evaluation of the HealtheVet technology / architecture;
- Strengthening, standardizing and implementing institutional mechanism to support IHS adoption / continued use of VistA applications
- Supporting IHS re-use of specific VHA clinical IT products (including VistA Imaging, Master Patient Index, and current VistA clinical applications)
- Strengthening IT sharing.

(See the Joint Workplan Update under Appendix M)

Improving Access

- *Home Health Care and Geriatric Services*. In April 2005, the IHS/VHA Steering Committee received testimony from American Indian veterans and Tribal leaders indicating that there is a need to improve and strengthen geriatric services and extended care programs for American Indian and Alaskan Native (AI/AN) veterans. The work to be undertaken by the two agencies includes:

  - Developing an information resource for veterans and their caregivers that clearly describes VHA long term care options and outlines the services rendered, eligibility requirements, financial support and benefits provided, availability by location, and the process to apply for each service;

  - Identifying collaborative activities that would enhance the professional capacity in geriatrics and extended care at both organizations, such as; exploring ways to share educational resources, clinical guideline development and implementation, and joint in-service training programs;

  - Making recommendations for several pilot programs around the country to assist elderly AI/AN veterans to remain in their homes, consistent with VHA and IHS priorities.

- *Telemedicine*. Both VHA and IHS recognize the value of telehealth in increasing access to care and maintaining services in locations where it is difficult to recruit clinicians. The same infrastructure can also help improve or expand the reach of administrative and educational functions. The IHS and VHA are each using telehealth in their own respective VISNs and Areas. Notable examples of interagency collaboration already exist in Alaska, Wyoming, Utah, and South Dakota. There is interest in developing such collaborations further.

  Currently the underlying drivers for both VHA and IHS in pursuing telehealth collaborations are pragmatic and involve the following issues:

  - Meeting acute needs in providing clinical services
  - Targeting areas of growing healthcare demand

- Improving access to quality specialty services
- Preventing unnecessary duplication of services
- Saving on infrastructure development costs through sharing
- Setting standards on coding for shared staff workload reporting
- Expanding educational offerings to clinicians and staff

There are also common long-term interests regarding the development of ViRtual Centers of Excellence for telehealth care and the evaluation of telehealth on health system costs and clinical outcomes. However, a variety of barriers to collaboration persist. These include legal issues (privacy laws, cyber security regulations), administrative (provider credentialing, clinical coding, patient eligibility), technological (capacity, reliability, work flow disruption) and clinical concerns (staffing shortages, provider acceptance.) In April 2005, eighteen IHS staff attended the annual VHA telehealth coordination meeting for the first time. During the meeting, VHA agreed that IHS and Tribal representatives will join each VHA VISN-level telehealth coordination workgroup and two test sites for joint network development were identified; the Billings Area IHS and the Utah telehealth network (which includes Tribes.)

Health Promotion and Disease Prevention

Diabetes Prevention. VA teams have partnered with American Indian and Alaska Native (AI/AN) Health providers to develop and implement culturally appropriate, evidenced based physical activity and nutrition programs targeted at AI/AN veterans. Programs are intended to promote long term behavior change in diet and exercise to help prevent the development and progression of Diabetes in AI/AN veterans. Partner organizations contribute cultural expertise, knowledge of diabetes prevention strategies in Indian populations, and outreach capability to the initiative. Three sites have been selected for 2005: VA Greater Los Angeles Healthcare System, VA San Diego Health Care System, and the New Mexico VA Health Care System.

Behavioral Health. The current deployment in Iraq and Afghanistan (Operation Iraqi Freedom (OIF)/ Operation Enduring Freedom (OEF)) and the subsequent return of military personnel to Tribal communities can have an impact on the community as a whole. Most veterans returning from combat find that they require reintegration with and readjustment to their family, work and community life. This is a normal reaction to a military combat deployment and does not constitute a medical condition or disease. However, a number of veterans will go on to develop a mental health problem and be diagnosed with depression, anxiety, substance use disorder or PTSD.

IHS and VHA have an opportunity to prevent these new veterans from developing long-term PTSD by establishing programs to ease the readjustment process and identify those who may need ongoing care. At the same time, VHA and IHS can help community members develop skills to identify problems early, support veterans readjustment, help prevent the development of PTSD, and when PTSD does develop, to support veterans

recovery.

Program materials have been developed and are available to be shared with Tribes for local customization and use in their communities (See Appendix G). Staff in the Office of the DUSH/HPC is available to discuss the use of these tools. Staff members can be reached at 202-565-6363.

SAMSHA Toolkit. The federal Department of Health and Human Services' Substance Abuse and Mental Health Service Administration (SAMHSA) has prepared a number of evidence-based practice tool kits that address both community and clinically based services and interventions for prevention and treatment of mental illness and disorders. The resource kits include programs such as 1) illness management and recovery, 2) medication management approaches in psychiatry, 3) assertive community treatment, 4) family psychoeducation, 5) supported employment, 6) community based alcohol treatment and 7) co-occurring disorders – integrated dual diagnosis treatment. The tool kits contain such resources as information sheets for stakeholders, introductory videos, practice demonstration videos, workbooks and manuals for practitioners. These tools represent a considerable investment by SAMHSA on the research, development and evaluation of these interventions and programs. Funding has been made available to VHA field locations to 1) adopt and adapt one or more of the SAMSHA tools, 2) work in partnership with IHS or Tribal providers and 3) pilot test the modified tool with AI veterans.

Organizational Support

To better serve AI/AN veterans and enhance interactions between VHA and Tribes a number of policies and practices at VHA need to be updated. The first, was to standardize the practice of supporting the use of traditional healers and spiritual practices for AI/AN veteran patients. The Chaplain Service at VHA has developed a policy and it is included as Appendix M. The second issue is to raise the cultural competence of VHA clinicians and front line staff to ensure that the needs and perspective of AI/AN veterans are taken into account and addressed while the veteran is under VHA care. The need to improve cultural competency among VHA providers is not unique to AI/AN veterans, however. Patient Care Services has been charged to develop cultural competency curriculum for clinical providers. This training will address sensitivity to the needs of AI/AN veterans.

Finally, the IHS leadership and Tribal representatives have noted that VA has not yet developed a Tribal Consultation policy as required in EO 13175. Recognizing this, staff within the Office of the Secretary has developed a draft policy for consideration. Completion of the policy should provide clearer guidance to the field on when and how to undertake a consultative process with Tribes.

TABLE II
Examples of IHS / VHA Sharing and Collaboration Activities
FY2005

PROGRAM EXAMPLES	LOCATION	COMMENT
Access		
1. Telecardiology Services	SC, IHS at Rockhill	12 clients served to date
2. Patient diet counseling	NM, IHS Gallup	IHS provided counseling for VA
3. Home based care	AZ, LA	Telehealth enabled
4. Tribal staffed CBOC	OK, Choctaw Nation	1000 vets; save 130 mile drive
5. ER diagnostic / treatment	OK, Choctaw Nation	Saves 2 hour emergency trip
6. Health fair prevent screen	LA, Jena Band Choctaw	Enrolled vets w/ presumptive Dx
7. Mental Health Therapy	AZ, reservation based	2 group; 63 indiv consults Q2
8. Telepsychiatry	WY	96 patient contacts, Q2
9. Residential SA treatment	UT	Three patients completed
10. Primary Care	CA, United AI Involve.	76 AI vets ongoing since 2000
11. Co-management w/CPRS	SD/ND; Pine Ridge, Ft. Yates, Eagle Butte	IHS staff can view VA records for all shared patients
12. Homeless Housing	SD, Pine Ridge	Building dedicated June 2005
13. Vet Centers	AZ, SD, OK, AK	Hopi, Navajo, Pine Ridge, Rosebud, Tahlequah, AK Native Villages
Sharing & Collaboration		
1. Radiology and Pathology	KS, Haskell Nation	100-200 reads / month
2. Space Lease	WI, Ho-Chunk Nation	5,661 sq ft space leased
3. Tribal College affiliation	OK, Cherokee Nation	Training for student RN, opt, rad
4. Laboratory contract	TX	$3,361 revenue generated Q2
5. PTSD education training	AK	Prepare IHS for OIF/OEF vets
6. Mental Health Support	Red Lake, MN	Vet Centers and VISN 23 provided professional support to mental health providers
Organizational Support		
1. Shared FTE veteran coord.	NC, Cherokee Hospital	80 clients served FY2005
2. Credentialing Tribal staff	NC, Cherokee Hospital	Smooth referral, access CPRS
3. Share patient edu material	VISN 12, Bemidji IHS	
4. Tribal veteran rep training	VISN 23, 19, 18, 12	
5. Weekly talking circle	AZ	PTSD patients enrolled
6. Full Time AI Coordinator	AZ	Assist nursing home placement