National Indian Health Board

August 30, 2017

RADM Michael D. Weahkee
Acting Director
Indian Health Service
5600 Fishers Lane
Rockville, MD 20857
Attn: RPMS Consultation

Submitted via consultation@ihs.gov.

Re: National Indian Health Board Comments on RPMS

Dear RADM Weahkee:

On behalf of the National Indian Health Board (NIHB), and the 567 Tribal nations we serve, I write to submit written comments in response to the recent Indian Health Service (IHS) listening sessions related to the Resource and Patient Management System (RPMS).

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

Background

On June 26, 2017, IHS issued a Dear Tribal Leader Letter (DTLL) announcing that it would be holding listening sessions related to the RPMS to seek input and recommendations on how best to modernize and improve the IHS's electronic health record (EHR) system. In the DTLL and the listening sessions, IHS announced that the U.S. Department of Veterans Affairs (VA) has announced plans to modernize their EHR by shifting away from the Veterans Information System and Technical Architecture (VistA) and adopting the MHS GENESIS, which is used by the Department of Defense (DoD). IHS explained during its listening sessions that RPMS shares much of VistA's infrastructure and that IHS benefits from the work the VA does to maintain and update

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VistA, adapting VistA software to the RPMS. During the listening sessions, IHS announced that for the VA the transition will take 8 to 10 years and will cost between $19 and $35 billion. NIHB attended the IHS listening sessions and welcomes this opportunity to comment as IHS considers the future of its EHR system.

Separate Appropriations for IHS EHR Modernization

We applaud IHS for engaging in this conversation with Tribes. The EHR system utilized by IHS should be appropriate for the modern health environment. The VA's decision to discontinue VistA will have major and costly impacts on the Indian health system. These impacts will be felt regardless of whether the IHS decides to keep RPMS or move to commercial-off-the-shelf (COTS) software product.

IHS currently depends on the VA for software developments and updates critical to RPMS's continued functioning. If IHS decides to keep RPMS, it will have to expend significant resources to develop and update the system on its own or to contract to a company that can make the necessary software developments and updates.

Alternatively, if IHS discontinues RPMS in favor of a COTS software product, the transition will be extremely costly as well. In addition to the cost of the software, the IHS will also have to incur additional costs to ensure that any COTS software product is tailored to the Indian health system to allow for required reporting and interoperability with the software currently used by some Tribal facilities. In addition, there will be transition costs. Any transition to a new system must ensure that data that is currently housed within the RPMS system can be preserved and transferred. The preservation of existing data is critical to ensure continuity of patient care, as well as for use by public health authorities in analyzing and assessing patient care within the Indian health system. The costs associated with the preservation and transfer of this data are likely to be considerable.

The agency will also need separate, multi-year funding to help both IHS and Tribal facilities transition to the new software. Many smaller Tribal facilities that continue to use RPMS will not be able to bear the financial burden of transitioning to a new software once RPMS is discontinued. These facilities will need to train staff to work an entirely new system and will need to transfer patient files and data. Individualized, hands-on training will be needed to ensure that Tribal health programs are not harmed if IHS does decide to transition to a COTS software product. IHS needs to ensure that sufficient training and technical assistance accompanies any transition in software. Because Tribes will have to increase workforce to make a commercial off the shelf (COTS) application work, such positions need to be funded as part of this initiative as well.

Funding for IHS's EHR modernization should not under any circumstances affect IHS service delivery or the existing IHS budget. IHS is already severely underfunded, with IHS and Tribal facilities struggling to meet their patient's needs. The costs associated either approach will be substantial, and must not impact current IHS funding levels. As a result, IHS must seek a separate appropriation specifically for IHS EHR modernization. This separate appropriation should include not only the costs associated with either modernizing RPMS or purchasing new COTS software, but also support a multi-year transition period that includes training and technical assistance dollars, as well as funding for ongoing support of the software going forward. These costs cannot

come out of the IHS's current IT budget, but must come in a separate appropriation. This appropriation must include multiple years of committed funding if there is any chance for it to succeed.

We encourage the agency to seriously explore working with the VA and DoD on seeking this appropriation to ensure that the systems continue to operate together, and to increase the likelihood of achieving this result.

Interoperability

In considering modernization of the IHS EHR system, NIHB strongly urges the agency to prioritize interoperability. Currently, RPMS does not interact with the various COTS software programs used by many Tribes. This makes continuity of care and data collection difficult, disadvantaging patients and reducing information sharing within the Indian health system.

Currently, the RPMS houses substantial amounts of Indian health system data that is invaluable to IHS and Tribal health providers. As discussed above, if IHS decides to transition away from RPMS, it must ensure that this data is preserved and that it is transferred to the new system.

IHS should continue near-term efforts to develop EHR data interoperability, especially in support of quality initiatives required by CMS, as it seeks long-term interoperability in considering IHS EHR modernization. IHS should also ensure that any COTS software program is tailored to the unique needs of the Indian health system, including allowing for the reporting of Government Performance and Results Act (GPRA) data.

Tribal Consultation

We commend IHS for holding a series of listening sessions at the very beginning of its process of considering how to modernize its EHR system, and we look forward to the agency's upcoming Request for Information (RFI) on this topic. We encourage IHS to engage in extensive Tribal consultation regarding the future of RPMS and the IHS EHR system. IHS's decisions regarding its EHR system will have an enormous impact on the Indian health system, and IHS must ensure it is fulfilling its consultation obligations through regular and consistent communication with Tribes, Tribal health programs, and urban Indian health programs. Additionally, we encourage transparency as IHS considers whether to discontinue RPMS and, if it decides to do so, which COTS software program it will select. For instance, IHS should make cost estimates and projected timelines available as soon as it is able to do so. Full and informed Tribal participation is necessary at every stage of this process.

Conclusion

Thank you for this opportunity to provide comments and recommendations. We look forward to continuing to work with IHS as it explores options for modernizing its EHR system. Please contact NIHB's Director of Federal Relations, Devin Delrow, at ddelrow@nihb.org or 202-507-4072 if there are any questions or comments on the issues raised in these comments.

Sincerely,

Vinton Hawley
Chairman, National Indian Health Board