

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**INDIAN HEALTH SERVICE
HOSPITALS: MORE
MONITORING NEEDED TO
ENSURE QUALITY CARE**



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EXECUTIVE SUMMARY – INDIAN HEALTH SERVICE HOSPITALS: MORE MONITORING NEEDED TO ENSURE QUALITY CARE

OEI-06-14-00010

WHY WE DID THIS STUDY

We conducted this study and its companion, *Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care* (OEI-06-14-00011), in response to concerns about the care provided in Indian Health Service (IHS) hospitals. Reports of inadequate health care services for American Indians and Alaska Natives (AI/ANs) have concerned the Federal Government for almost a century. IHS is responsible for providing health services to the 567 federally recognized tribes of AI/ANs. As part of its service, IHS directly operates 28 acute-care hospitals. IHS requires its hospitals to be accredited by a nationally recognized organization (or certified by Medicare) and to comply with the Medicare Hospital Conditions of Participation (CoPs). OIG is committed to continued work to improve patient care provided in IHS hospitals. Upcoming OIG work includes an IHS management review and a medical review focusing on patient safety in IHS hospitals.

HOW WE DID THIS STUDY

We interviewed leadership staff at each IHS-operated hospital, the eight IHS Area Offices that oversee hospitals, and IHS headquarters regarding their processes for quality monitoring and oversight. Hospital interviews included the Chief Executive Officer (CEO) or Acting CEO, and Area Office interviews included the Area Director or Acting Director. Additional leadership staff, such as clinical directors and chief medical officers, were also present in most interviews. IHS headquarters interviews included the Chief Medical Officer, the Director of Field Operations, and the Director of the Hospital Consortium. We supplemented these interviews with document reviews and questionnaires. We also interviewed staff and reviewed select documents from the Centers for Medicare & Medicaid Services (CMS), which is the primary oversight agency for hospitals nationwide.

WHAT WE FOUND

IHS may be missing opportunities to identify and remediate quality problems in its hospitals because it performed limited oversight regarding quality care and compliance with the CoPs. IHS relies on its Area Offices to monitor hospitals. However, Area Office staff have few sources of information about hospital quality, and most limit reviews of that information to infrequent meetings of each hospital's Governing Board. Further, CoP compliance surveys are not conducted by CMS with the frequency needed to make them a useful tool. Staffing shortages in Area Offices also limit the clinical support and guidance that they are able to provide, and the most promising efforts to improve hospital quality lack dedicated funding. Additionally, hospitals struggle to implement data-driven quality improvement methods as a result of limited information technology knowledge, a lack of resources, and difficulties with the electronic health record systems.

WHAT WE RECOMMEND

We recommend that IHS (1) implement a quality-focused compliance program; (2) establish standards and expectations for Area Office/Governing Board oversight activities; (3) work to identify new—and more meaningful—hospital performance metrics; and (4) continue to invest in training for hospital administration and staff. Additionally, we recommend that CMS assist IHS in its oversight efforts by conducting more frequent surveys of non-accredited hospitals, informing IHS leadership when hospitals are cited with deficiencies, and continuing to provide technical assistance and training. The Office of the Secretary, IHS, and CMS provided a joint response to this report and its companion report. Collectively, these HHS agencies concurred with all recommendations in both reports.

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OBJECTIVE

To assess the Indian Health Service's (IHS) efforts to monitor and ensure that IHS hospitals provide quality care and comply with Medicare standards of care.

BACKGROUND

IHS is responsible for providing Federal health services to American Indians and Alaska Natives (AI/ANs). IHS's mission is to raise the "physical, mental, social, and spiritual health of AI/ANs to the highest level." In partnership with the tribes, IHS provides free primary and preventive health care services for approximately 2.2 million AI/ANs living in the United States. However, reports of health disparities and inadequate health care services for AI/ANs have been of concern to the Federal Government for almost a century.

In 2010, Senator Byron Dorgan, then-Chairman of the Senate Committee on Indian Affairs, released a report citing problems in some IHS facilities related to credentialing and licensing of providers, accountability of controlled substances, and management of funds. These problems were similar to those previously identified by the Office of Inspector General (OIG) and the U.S. Government Accountability Office (GAO).¹ Prior to that, in 1999, and again in 2004, the U.S. Commission on Civil Rights found significant health disparities for AI/ANs as a result of structural barriers (e.g., insufficient staffing, aging facilities) and financial barriers (e.g., insufficient resources), many of which were similar to problems identified almost a century ago. In 1928, a report requested by Federal oversight authorities regarding the conditions of AIs found that their health and living conditions were "bad," and that the lack of funding, personnel, and equipment "prevented the development of an adequate system of public health administration and medical relief work" for AIs.^{2, 3}

¹ U.S. Senate Committee on Indian Affairs, *In Critical Condition: The Urgent Need to Reform the Indian Health Service's Aberdeen Area*, December 28, 2010. Accessed at <http://www.indian.senate.gov/sites/default/files/upload/files/Chairman-s-Report-In-Critical-Condition-12-28-10.pdf> on February 12, 2015.

² The Institute for Government Research, *The Problem of Indian Administration*, February 21, 1928, ch. I. Accessed at http://www.alaskool.org/native_ed/research_reports/IndianAdmin/Indian_Admin_Problem_s.html on November 3, 2014.

³ U.S. Commission on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System*, September 2004, pp. 2-4. Accessed at <http://www.usccr.gov/pubs/nahealth/nabroken.pdf> on November 3, 2014.

Indian Health Services

IHS provides health care services to 567 federally recognized tribes primarily through outpatient clinics, but in some locations it also offers inpatient care and behavioral and community health services. Depending on agreements with the particular tribes, IHS either provides services directly to AI/ANs through IHS-operated facilities or provides financial support for the tribes to operate their own health care systems.⁴ Currently, just under half of IHS's \$1.8 billion appropriation to provide health care services is allocated to Federal operations serving tribes directly. The other half of the hospital and health clinics portion of the budget goes to the individual Indian tribes or tribal organizations that have contracts and/or compacts with IHS.⁵

IHS Area Offices

Located in Rockville, Maryland, IHS headquarters provides general direction, policy development, and support for each of the 12 Area Offices and their health care delivery sites, which may include hospitals, urgent care clinics, and/or other types of facilities. Area Offices oversee the delivery of health services and provide administrative and technical support to the federally operated hospitals and clinics for one or more of the 170 geographically defined service units.⁶ Each Area Office includes staff dedicated to common services, such as finance, administrative support, information technology (IT), public health programs, and environmental health.

IHS maintains its current policies, procedures, and operating standards in the Indian Health Manual (IHM). The IHM is the “preferred reference” for IHS staff regarding IHS-specific policy and procedural information.⁷

IHS Hospitals

IHS directly operates 28 acute-care hospitals in 8 States, many of which are in remote locations. (See Appendix A for a listing of IHS-operated hospitals and Figure 1 for a map of their locations.) These hospitals are

⁴ Pursuant to the Indian Self-Determination and Education Assistance Act, P.L. No. 93-638, IHS contracts and/or compacts with tribes or tribal organizations to deliver services.

⁵ Department of Health and Human Services (HHS), IHS, *Justification of Estimates for Appropriations Committees*, Fiscal Year (FY) 2016, p. 6, 55. Accessed at <http://www.ihs.gov/budgetformulation/includes/tehememes/newihstheme.documents/FY2016CongressionalJustification.pdf> on February 9, 2016. Total IHS appropriations in FY 2015 were \$4.6 billion. In addition to the \$1.8 billion appropriated for hospital and health clinic services, IHS supports programs such as dental services, public health, and purchased/referred care, among others.

⁶ A service unit is an administrative subunit of IHS Area, operated by IHS or a tribe, with responsibilities for providing IHS services within a particular geographic area.

⁷ IHS, *Indian Health Manual*, pt. 1; ch.1; section 1-1.2 (Indian Health Manual).

data systems and quality departments. Hospitals—public and private—began submitting quality data to the Centers for Medicare & Medicaid Services (CMS) in 2004 as part of a pay-for-reporting program.^{10, 11} In 2006, CMS began developing a plan to link hospital payments to quality—a data-driven concept known as Value-Based Purchasing—and added new requirements for reporting of hospital quality data.^{12, 13} In 2009, the Federal Government created an incentive program granting \$27 billion in funding for hospitals and other providers to adopt electronic health record (EHR) systems that were expected to reduce adverse drug events, decrease mortality rates, and lower health care costs.^{14, 15} (This incentive program is often referred to as “Meaningful Use.”) In 2010, the Affordable Care Act tied payment to quality by including a provision that rewards or penalizes providers on the basis of quality performance.¹⁶ In 2011, CMS launched Partnership for Patients, an initiative to improve the quality, safety, and affordability of health care by reducing preventable hospital-acquired conditions and readmissions.¹⁷ In January 2015, HHS announced specific measurable goals for participation in Value-Based Purchasing programs. HHS expected that by 2016, 85 percent of Medicare payments should be tied to programs such as the Hospital Value-Based Purchasing program and the Hospital Readmissions Reduction Programs. HHS expects 90 percent of payments to be tied to these programs by 2018.¹⁸

¹⁰ P.L. No. 108-173, Medicare Prescription Drug, Improvement, and Modernization Act of 2003 § 501(b).

¹¹ CMS, *Medicare Hospital Value-Based Purchasing Plan Development Issues Paper*, January 17, 2007. Accessed at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/Hospital_VBP_Plan_Issues_Paper.pdf on December 22, 2014.

¹² *Ibid.*

¹³ P.L. No. 109-171, Deficit Reduction Act of 2005 §§ 5001(a) and 5001(b).

¹⁴ See Titles IV and XIII of the American Recovery and Reinvestment Act of 2009. P.L. No. 111-5.

¹⁵ Office of the National Coordinator for Health Information Technology, *EHR Incentives & Certification*. Accessed at <http://www.healthit.gov/providers-professionals/ehr-incentives-certification> on March 3, 2015.

¹⁶ Patient Protection and Affordable Care Act of 2010 § 3001(a).

¹⁷ CMS, *Press release: Partnership for patients to improve and lower costs for Americans*, April 12, 2011. Accessed at <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2011-Press-Releases-Items/2011-04-12.html> on March 5, 2015.

¹⁸ HHS, News, *Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value*, January 26, 2015. Accessed at <http://www.hhs.gov/news/press/2015pres/01/20150126a.html> on January 26, 2015.

Quality Data Reported to Congress

Pursuant to the Government Performance and Results Act of 1993 (GPRA), IHS must report to Congress annually on the quality of health care provided to AI/ANs.¹⁹ In 2014, IHS reported more than 20 GPRA measures. These measures focus on overall health of the AI/AN population, reporting almost exclusively rates of diagnostic screenings and preventive care.²⁰

Medicare Conditions of Participation

IHS instructs its hospitals to be accredited by a nationally recognized organization (or certified by Medicare). Accrediting organizations used by IHS must support the reimbursement requirements established by Medicare and Medicaid, including Medicare's Conditions of Participation (CoPs).^{21, 22} The CoPs are a set of minimum quality and safety standards and include requirements such as establishing an effective governing body legally responsible for the conduct of the hospital, having an organized medical staff that is responsible for the quality of patient medical care, and maintaining a physical environment that avoids transmission of infections and communicable diseases.²³ Additionally, hospitals should have an effective quality assurance and performance improvement (QAPI) program.^{24, 25} Hospital leaders may customize QAPI programs to best suit their individual needs, but the programs should be data-driven and hospital-wide, and should result in specific interventions designed to

¹⁹ IHS, *Government Performance and Results Act Plus*. Accessed at <http://www.ihs.gov/cio/GPRAPlus/gpra-plus-reporting.asp> on December 7, 2015.

²⁰ IHS, *GPRA FY 14 through FY 16 Performance Measures Matrix*. Accessed at https://www.ihs.gov/crs/includes/themes/newihstheme/display_objects/documents/gpra/2016/2014-2016_Matrix.pdf on September 9, 2016.

²¹ IHS, Circular No. 97-01. Accessed at http://www.ihs.gov/ihs/index.cfm?module=dsp_ihm_circ_main&circ=ihm_circ_9701 on January 22, 2014.

²² Social Security Act §§ 1880(a) and 1865 (a)(1).

²³ 42 CFR §§ 482.1, 482.12, 482.22, 482.41 and 482.42.

²⁴ 42 CFR § 482.21.

²⁵ CMS, Survey & Certification (S&C) 03-16, *Interim Guidance for the Hospital Quality Assessment and Performance Improvement Condition of Participation*. Accessed at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter03-16.pdf> on March 18, 2015.

improve health outcomes for patients.^{26,27} (See Appendix B for a descriptive list of all CoPs.)

Hospital Surveys

CMS and accreditation organizations monitor IHS-operated hospitals' compliance with the CoPs through periodic onsite surveys.²⁸ Surveyors observe how hospitals provided care to patients, and assess whether that care met the needs of the patient and was in compliance with all requirements. To indicate noncompliance, surveyors cite hospitals with deficiencies that hospitals must correct in a timely manner to continue participating in Medicare. Accreditation organizations conduct full surveys of accredited hospitals approximately every 3 years, but there is no regulatory timeframe requirement for CMS-conducted surveys.²⁹ In addition to conducting these routine surveys, accreditation organizations and CMS conduct abbreviated surveys in response to complaints. These "complaint surveys" substantiate or dismiss third-party allegations of noncompliance or poor quality.³⁰

Related Work

This report expands on prior work by OIG in response to a congressional request. In August 2015, OIG issued a report—*OIG Site Visits to Indian Health Service Hospitals in the Billings, Montana Area (OEI-09-13-00280)*—that identified problems related to staffing and continuity of care at two sites in the Billings Area.

Companion Report. OIG is concurrently issuing a companion report, *Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care (OEI-06-14-00011)*. The companion report describes a range of interrelated challenges—such as low inpatient censuses (number of patients), access limitations, difficulty maintaining clinical competence, staffing instability, and outdated facilities—that affect IHS hospitals' ability to provide quality care and maintain compliance with the CoPs. (See a summary below of the challenges cited in the companion report.)

²⁶ 42 CFR § 482.21.

²⁷ CMS, S&C 12-32, *Patient Safety Initiative Pilot Phase – Revised Draft Surveyor Worksheets*. Accessed at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-12-32.pdf> on March 24, 2015.

²⁸ CMS, *State Operations Manual (SOM)*, ch. 1, Sec. 1018A.

²⁹ Each accrediting organization describes its standard on the application for deeming authority, which is approved by CMS. Survey frequency standards for non-accredited hospitals are not currently defined in Federal regulation.

³⁰ CMS, *SOM*, Chapter 5 §§ 5100.1, and 5200.

Staff-Reported Challenges Affecting IHS Hospitals

IHS hospitals report facing significant and longstanding challenges that restrict their ability to provide quality care and meet Federal requirements. These challenges, summarized below, underscore the importance of robust oversight.

Access limitations – Hospitals trying to meet the needs of a growing patient population are hampered by their small scopes of services and limited access to specialists.

Difficulty maintaining clinical competence – With many hospitals treating few inpatients with complex conditions, providers lack the practice and repetition to maintain necessary skill sets for some procedures.

Staffing instability – Difficulty recruiting and retaining staff has led to a dependence on ‘acting’ personnel and contracted providers, weakening both leadership stability and the continuity of care provided to patients.

Outdated buildings and equipment – Limited resources for maintaining or updating hospital structures and equipment has created service interruptions and concerns about patient safety.

Source: OIG summary of companion report, *Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care* (OEI-06-14-00011).

Upcoming Work. OIG is committed to continued work to improve patient care provided in IHS hospitals. Upcoming OIG work include an IHS management review and a medical review focusing on patient safety in IHS hospitals.

METHODOLOGY

This study describes IHS’s efforts to ensure that the 28 IHS-operated hospitals provide quality care and comply with Medicare standards of care. Report findings are based on multiple data sources, including telephone interviews, questionnaires, and document reviews. We spent numerous hours conducting in-depth telephone interviews with leadership staff at each IHS-operated hospital, the eight Area Offices that oversee the hospitals, and IHS headquarters. We verified staff reported issues when possible by reviewing documentation, such as internal management reports, contracts, meeting agendas, and survey deficiency reports. In addition, we interviewed staff and reviewed select documents from CMS. Information was collected between April and October 2014. (See Appendix C for a full description of the methodology.)

Limitations

Although we reviewed supporting documentation when possible, we often relied on the perspectives of staff in leadership positions and did not interview patients, midlevel or lower level staff, or tribal representatives to

gain their perspectives. Additionally, the findings in this report pertain only to the 28 IHS-operated hospitals and cannot be generalized to other IHS providers, including the 18 hospitals operated by tribal organizations.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Area Offices performed limited oversight of IHS hospital quality of care and compliance with the CoPs

Eight of the twelve Area Offices oversee the twenty-eight IHS hospitals, and these offices are charged with an important role in quality oversight. IHS has established Governing Boards for each of its hospitals.

Governing Board membership is composed of staff from the respective Area Offices, making them the primary parties responsible for the performance of the hospitals, including compliance with the CoPs and the quality of care provided to patients.³¹ However, Area Offices vary in the extent to which they monitor and oversee hospital performance.

Area Offices have few sources of information about hospital quality

Each of the eight Area Offices reported that they conduct activities to monitor quality, yet those efforts are minimal in some Areas. Even the Area Offices that are most engaged in monitoring activities acknowledged limitations in the comprehensiveness and usefulness of the information they collected.

A small number of complaints and patient harm reports are the primary source of information Area Offices use to detect quality problems. Five of the eight Area Offices stated that they are most likely to detect quality problems at hospitals through complaints by patients, patient families, or staff.³² However, according to hospital administrators, most patient complaints relate to customer service and wait times, rather than medical care. Further, most hospitals (20 of 28) receive fewer than 100 complaints per year for inpatient and outpatient visits combined, averaging about 1 complaint per 1,000 patient visits.

Patient harm is rarely recorded by staff in an IHS hospital's incident reporting system. According to a recent internal report by IHS, 4 hospitals reported no patient harm data during a 16-month reporting period and another 10 hospitals reported rates of fewer than 5 harm events per 1,000 "risk opportunities" each month.³³ Considering the quantity and

³¹ See 42 CFR § 482.12; See also CMS, *SOM*, App. A § 482.12.

³² The other three Area Offices said they usually detect problems through mock surveys, data trends, or peer reviews.

³³ A "risk opportunity" is the number of patient harm events to which an inpatient is considered susceptible. IHS limits its harm rate to a list of 10 hospital-acquired conditions, and some of these harm events are not applicable to every patient. For example, only patients who undergo surgery are at risk for surgical infections. On average, patients have approximately five risk opportunities per admission.

subject matter of complaints and patient harm reports, they are unlikely to provide hospital staff with the breadth of information needed to identify and diagnose systemic quality or compliance breakdowns.

Half of Area Offices do not routinely conduct mock surveys, which provide insight regarding hospital quality practices. Mock surveys typically include methods similar to those that CMS uses during certification surveys or that accrediting organizations use during accreditation surveys. These methods include direct observations, policy reviews, and medical record reviews. Although they are not required to do so, four of the eight Area Offices reported conducting mock surveys to assess hospital quality and compliance between accreditation or certification surveys. These mock surveys vary in frequency, but most hospitals in these four Areas receive such surveys annually. Three Area Directors described mock surveys as the best way to ensure that hospitals are meeting national standards of care.

Area Offices that reported that they did not conduct mock surveys stated that they lacked either appropriate staff or sufficient funding to perform this type of oversight. The Area Directors reported occasionally hiring consultants to fill that role, but stated that they primarily rely on hospitals to self-monitor. Consequently, these Area Offices must depend on the less frequent surveys conducted by accrediting organizations or CMS and/or meeting benchmarks with reported data metrics, such as CMS's Hospital Compare, to gauge whether hospitals are meeting national standards of care.

Data monitoring is both difficult and less useful for small IHS hospitals. Traditional metrics for monitoring quality—such as those found in CMS's Hospital Compare and in the Core Measures developed by the Joint Commission (TJC), an accrediting organization—are often not applicable to IHS hospitals. Too often, these metrics relate to procedures or services that are either not performed or are performed so infrequently that quality measures cannot be used for comparison to other hospitals. Inpatient censuses for small IHS hospitals can be as few as one or two patients per day, and the hospitals may not have sufficient opportunities to perform procedures that are commonly used for outcomes comparisons. For example, several hospitals do not perform surgery and therefore cannot provide rates of postsurgical infections. Treatment for other conditions may be in the scope of services offered at the hospital (e.g., treatment for heart failure or pressure ulcers), but these conditions may be so seldom seen that an outcomes comparison to other hospitals is not meaningful.

GPRA measures are widely reviewed by IHS hospital administrators and are the quality data that the Area Offices most frequently review, but these

measures emphasize health screening and prevention activities for the AI/AN population and are not specific to the services provided at the hospitals. GPRA measures include data regarding immunization rates, cancer screenings, and smoking cessation education, all of which hospitals may perform (see Table 1). However, these measures have little bearing on the most critical hospital-management issues, such as infection control practices or patient outcomes (e.g., mortality rates).

Table 1: Topics Covered by GPRA Performance Measures (FY 2014)

| Topics Covered by GPRA Performance Measures | |
|--|--|
| Clinical tests or screenings (8) | |
| <ul style="list-style-type: none"> Cholesterol testing for diabetic patients Mammography Depression screening Risk assessments for cardiovascular patients | <ul style="list-style-type: none"> Retinopathy assessment for diabetic patients Colorectal cancer screening Domestic violence screening HIV testing for pregnant women |
| Prevention activities (7) | |
| <ul style="list-style-type: none"> Access to dental services Use of topical fluoride for children Influenza vaccines for senior adults Breastfeeding rates | <ul style="list-style-type: none"> Use of dental sealants for children Childhood immunization rates Tobacco cessation interventions |
| Administration (3) | |
| <ul style="list-style-type: none"> Implementation of tribal recommendations Suicide surveillance reporting | <ul style="list-style-type: none"> Documentation of public health nursing activities |
| Patient outcomes (2) | |
| <ul style="list-style-type: none"> Glycemic control for diabetic patients | <ul style="list-style-type: none"> Blood pressure control for diabetic patients |
| Accreditation (2) | |
| <ul style="list-style-type: none"> Hospital accreditations | <ul style="list-style-type: none"> Youth Regional Treatment Center accreditations* |

Source: OIG summary of IHS's GPRA performance measures reported in FY 2014.

*Youth Regional Treatment Centers are tribally and federally operated centers that address substance abuse and co-occurring disorders among AI/AN youth.

Most Area Offices depend on infrequent Governing Board meetings to review quality metrics

All but one Area Office identified their respective Governing Board meetings as an important component of their quality oversight efforts. (The remaining Area Office began holding these meetings in January 2015, after our review.) OIG states in its guidance to Governing Boards that it views the quality-improvement function of Governing Boards as critical for minimizing the risk of patient harm. In addition, industry research suggests that Governing Board practices are strongly related to hospital quality performance.^{34, 35} In addition to providing opportunities

³⁴ HHS, OIG, et al., *Practical Guidance for Health Care Governing Boards on Compliance Oversight*. April 20, 2015. Accessed at <http://oig.hhs.gov/newsroom/news-releases/2015/guidance-release2015.asp> on April 20, 2015.

³⁵ Tsai, Thomas, et al., "Hospital Board and Management Practices are Strongly Related to Hospital Performance on Clinical Quality Metrics." *Health Affairs*, August 2015.

for reviews of financial statements and administrative responsibilities, Governing Board meetings give Area Offices an opportunity to inquire about hospitals' quality challenges and performance on various quality metrics. The nonprofit Institute for Healthcare Improvement recommends that Governing Boards review quality data weekly, or at a minimum, monthly.³⁶

In one Area Office, staff reported that the only time they routinely review hospital quality data—such as incident reports, peer reviews, or statistics about patient outcomes—is during their twice-yearly Governing Board meetings. Four other Area Offices reported reviewing the vast majority of quality data only at their Governing Board meetings, with the exception of a few items that they review more frequently. For example, one Area Office reviews incident reports and complaints as it receives them and conducts more frequent monitoring of its Special Diabetes Program, but leaves all other programmatic reviews until its Governing Board meetings.

Despite the importance of Governing Board meetings, they are infrequent.³⁷ Although IHS has not established a specific requirement for the frequency of meetings, the two Area Offices with the highest number of scheduled Governing Board meetings per year met on a quarterly basis. Four other Area Offices reported meeting two to three times per year, and one Area Office held only one Governing Board meeting each year.

Lack of routine surveys by CMS limits the information available to IHS regarding hospital quality

Administrators from four hospitals described accreditation or certification surveys as the most useful source of information to determine whether hospitals are following acceptable standards of care. Of the 28 IHS-operated hospitals, CMS was responsible for conducting CoP compliance surveys for 10.³⁸ (The other 18 hospitals were deemed compliant on the basis of their good standing with an approved accrediting organization.) CMS does not have a written requirement as to how often it must survey these non-accredited hospitals, but a staff member described an unofficial goal of conducting certification surveys of IHS hospitals at least once every 5 to 6 years. CMS met this modest benchmark for 9 of

³⁶ Institute for Healthcare Improvement, 5 Million Lives Campaign. *Getting Started Kit: Governance Leadership "Boards on Board" How-to Guide*. Cambridge, MA; 2008. Accessed at <http://www.ihl.org/resources/Pages/Tools/howtoGuideGovernanceLeadership.aspx> on April 3, 2015.

³⁷ In addition to holding full Governing Board meetings, some Boards hold separate meetings to address ad-hoc issues and/or to give formal approval for the credentialing of medical staff. These meetings were not included in our frequency analysis.

³⁸ CMS, *SOM*, Pub. 100-97, ch. 1, § 1018A.

the 10 hospitals that it surveyed. The remaining hospital had not been surveyed since 2005, which was 8 years prior to our review. By comparison, all of the 18 accredited hospitals were surveyed during the 3-year timeframe of our review (2011–2013). During the same timeframe, CMS recertified only two nonaccredited hospitals.

In an interview, CMS officials expressed concern that some IHS hospitals had incomplete or outdated knowledge of the CoPs and lacked expertise with methodologies for quality improvement. As a result, CMS decided to use its limited funds towards training and hands-on technical assistance, rather than increasing the number of surveys it conducted. As part of this effort, CMS staff went onsite to assist hospitals with significant problems and extended CMS’s CoPs training (originally designated for State survey agencies) to IHS staff. Administrators from all but 1 of the 28 hospitals reported receiving some kind of education or technical assistance from CMS or a CMS-funded Quality Improvement Organization (QIO) during the prior year.

Complaint surveys are another source of information about hospital compliance; however, delayed CMS investigations may limit their usefulness. Administrators from one hospital explained that when CMS finally came onsite to conduct a survey after a long interlude, it reviewed multiple complaints dating back as far as 5 years. CMS’s policy for investigating complaints allows for less serious complaints to be addressed during the next onsite survey.³⁹ However, according to these hospital administrators, the lag between the complaints and the CMS investigation made it impractical to identify the breakdowns and to make timely improvements.

Staff reductions limit the clinical support and CoPs guidance that Area Offices provide

Tribal contracting, Sequestration, reorganizations, and the difficulty of filling positions affected staffing in most Area Offices.⁴⁰ Five of the eight Area Directors described significant decreases in the number of staff positions during the past decade; two Area Offices reported losing over 50 percent of their staff positions in recent years. These losses were

³⁹ CMS, *SOM*, ch. 5 § 5075.9, “Maximum Time Frames Related to the Federal Onsite Investigation of Complaints/Incidents,” Updated 9-19-14. Accessed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c05.pdf> on February 9, 2015.

⁴⁰ Pursuant to the Indian Self-Determination and Education Assistance Act, P.L. No. 93-638, tribes may contract with IHS to provide health services directly to their members, taking significant portions of Area Office budgets with them.

further compounded by a high vacancy rate (13 percent) for remaining positions across the eight Area Offices.

Staffing reductions and vacancies led several Area Offices to shift services towards administrative matters and to conduct less community outreach and clinical consulting. One Area Office reported having only four staff members with clinical expertise remaining in the Area. As a result, the hospital clinical directors in this Area rely on each other to identify and solve problems with little support from the Area Office. They had previously consulted the Area Office for some clinical and other issues. Two other Area Offices reported no longer employing clinical consultants to manage the Area's nursing and quality assurance programs, which are important components of ensuring hospital quality.

From the hospitals' perspective, the lack of clinical support staff sometimes limits Area Offices' ability to assist hospitals. For example, administrators from two hospitals reported that lack of staff—particularly clinical consultants—and lack of funding are the reasons their Area Offices no longer conduct hospital program reviews or mock surveys.⁴¹ Administrators from another hospital described its Area Office as being “overwhelmed,” with too many facilities to oversee and not enough staff, and reported difficulties receiving timely assistance.

The Hospital Consortium provided a much needed focus on quality improvement, but uncertainties remain about its influence and funding

Prompted by quality concerns and requests for assistance with compliance with the CoPs, some Area Offices combined efforts to create a collaborative group dedicated to achieving and maintaining hospital quality standards of care. Organized at the national level circa 2012, this group—then known as the Hospital Consortium (the Consortium)—included representatives from each Area. During its first 2 years, the Consortium laid groundwork for future improvements, including facilitating training for hospital staff, collecting baseline quality metrics, and earmarking topics for research.

Despite these positive efforts, the ability of this group to improve quality is unclear. Consortium leaders reported that not all Areas are fully engaged in the Consortium activities and that IHS leadership has yet to find funding to hire a permanent Consortium director. One IHS official

⁴¹ Like mock surveys, program reviews evaluate program priorities, strengths, deficiencies, and unmet needs for specific functional areas. However, program reviews are typically conducted by Area Office consultants for a single programmatic topic. IHS, *Indian Health Manual*, pt. 3; ch. 8; section 3-8.2B.

explained that the financial cost of providing basic patient care leaves few resources to devote to other activities, such as the Consortium.

The Consortium's lack of dedicated funds may also affect the future of this group. Through interagency agreements connected to CMS's Partnership for Patients initiative, CMS provided over \$2.3 million in 2013 and 2014 to support the efforts of the Consortium. However, no subsequent funding agreements were made to continue this support in 2015. Although the Consortium was in place before CMS funding, it could not have completed the bulk of its work without CMS's support. The funding supported the cost of four staff to lead the Consortium in 2013 (\$450,000). It also allowed for several contracts, with the largest contracts (totaling \$700,000) dedicated to hospital performance assessments—evaluating current processes and providing onsite assistance. Another \$450,000 was dedicated to the development of Web-based training on quality-related topics and to travel costs for select staff to attend CMS training on the hospital CoPs. Additional contracts were let for conducting a needs assessment (\$400,000) and improving data analytic capacities (\$300,000). As the Consortium continues, leaders have identified new goals for standardization of Governing Board bylaws and credentialing, as well as exploring opportunities for annual accreditation surveys.

IHS hospitals struggle to implement data-driven quality improvement methods and to adapt to new technology

Although all IHS hospitals report having a QAPI program, underdeveloped programs and IT challenges in many hospitals result in difficulties meeting new and evolving expectations for quality. Current standards place a high emphasis on hospitals' use and reporting of quality statistics, which is dependent on accurate data collection and the ability to extract information from the relevant IT and EHR systems. An IHS official who oversees the Area Offices described hospital staff's lack of IT-related knowledge and training as one of the top barriers to quality and compliance in IHS hospitals.

Administrators from nearly half of hospitals reported significant challenges in collecting, analyzing, or reporting quality or patient outcomes data

Of the 28 hospitals, 12 reported difficulties collecting, analyzing, or reporting data related to quality or outcomes. These data challenges stem from staff shortages, lack of expertise, low inpatient censuses, and competing priorities. For example, although IHS expects hospitals to have

at least one staff member specialized in extracting information from EHRs, administrators from two hospitals reported extended periods (up to 10 years) without such a person. Other hospitals described the requirements for reporting data (to Area Offices and external groups) as “onerous” and expressed the need for more direction from the Area Offices on how to prepare the reports. Further, as described previously, smaller hospitals may not treat a sufficient number of patients with particular conditions or conduct enough of certain procedures to make meaningful comparisons to other hospitals.

Difficulties using EHR systems contribute to wait times and create potential for quality problems in some IHS hospitals

The adoption of EHR systems was intended to improve patient care in hospitals. However, administrators from nine hospitals reported that the current systems are cumbersome and outdated and have significantly increased patient wait times. For example, administrators from one hospital reported difficulties completing EHR documentation in real time because of a slow system and the lack of the ability to record information in examination rooms. These problems are particularly pronounced in the hospital’s emergency department where staff and providers must often move quickly from patient to patient. Hospital administrators reported that the lag in documentation combined with the urgency of patient care sometimes resulted in patient visits that were not recorded and the transfer of emergency patients without the electronic portion of the medical record. In another hospital, administrators explained that it does not use EHRs in the emergency department out of concern with not being able to use them effectively. Other concerns included frustration and delays related to the use of parallel systems, such as requiring multiple logins to access certain information (e.g., x-rays and outside referrals), and problems with the systems “freezing.”

Hospital Quality Assurance and Performance Improvement programs fall short on requirements to be data-driven and hospital-wide

Although CMS added the QAPI requirement to the hospital CoPs more than a decade ago (2003), several IHS staff members explained that hospital QAPI efforts are relatively new or have been recently enhanced to reflect the new emphasis. The addition of the QAPI requirement was an effort to bring about a data-driven, proactive approach to improving patient care.⁴² This requirement combines quality assurance, which is a retrospective effort to examine why a facility failed to comply with certain

⁴² CMS, S&C 03-16, *Interim Guidance for the Hospital Quality Assessment and Performance Improvement Condition of Participation*. (See footnote 26 for URL.)

standards, and performance improvement, which is a proactive and continuous effort to prevent problems by addressing underlying causes of systemic problems.⁴³ One Area Office reported that its hospitals began QAPI efforts only 2½ years ago. Another Area Office indicated that a basic QAPI infrastructure is only now being required of its hospitals. Administrators from a hospital within one of these Areas described its QAPI program as small and indicated that the hospital needs to dedicate more time to it. Other hospitals indicated that they have functioning QAPI programs, but struggle with certain required aspects, such as managing data and ensuring that the improvement efforts are hospital-wide.

The lack of QAPI-dedicated staff in Area Offices may affect hospitals' ability to instill a culture of continuous performance improvement. Although most hospital administrators reported having a dedicated quality manager on staff to identify and address quality problems, only four Area Offices reported having a dedicated staff member (i.e., a clinical consultant) to provide direction and assistance to hospital staff regarding QAPI. Several hospital administrators from the remaining Areas expressed a desire for more assistance and direction on QAPI compliance.

The projects selected for QAPI efforts are sometimes related to administrative or customer satisfaction, rather than being driven by patient-harm data, as required. When asked about current and recent performance improvement efforts, leadership staff from several hospitals reported administrative improvement efforts such as provider productivity, privileging, or billing processes, or physical improvement such as renovating buildings. Others identified efforts to improve customer satisfaction generally or as it related to long wait times, inadequate seating in the waiting room, a drab institutional appearance, or noise problems during evening hours. Additionally, administrators from three hospitals reported that they try to comply with the requirement that QAPI efforts be hospitalwide by requiring each clinical department to identify a project. In the absence of data to guide the selection of projects, staff may be introducing a great deal of subjectivity into what should be primarily a data-driven process.

⁴³ CMS, *QAPI Description and Background*. Accessed at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapidefinition.html> on October 27, 2014.

RECOMMENDATIONS

IHS staff told us—and our review of documentation supports—that IHS hospitals attempt to meet new revised requirements for quality while also struggling to meet patients’ basic care needs. A companion report—*Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care (OEI-06-14-00011)*—identifies longstanding challenges: ensuring access to needed care, maintaining clinical competence, recruiting and retaining essential staff, and keeping patients safe despite outdated buildings and equipment. These issues elevate the importance of IHS’s efforts to ensure a strong infrastructure for quality and proactive monitoring efforts. However, IHS has few sources of information on its hospitals’ performance and a limited capacity to provide clinical support. CMS surveys could be a valuable source of information to assist IHS in improving quality, but CMS does not conduct these surveys with the frequency needed for IHS to rely on them as a key management tool. Additionally, the lack of dedicated funding within IHS means there is a risk of curtailing the most promising efforts to improve hospital quality. As a result, IHS may be missing opportunities to identify and remediate quality problems in its hospitals.

We recommend that IHS:

Implement a quality-focused compliance program to support Federal requirements for health care programs

IHS should establish an agencywide compliance program that—in addition to including other elements of an effective compliance program—oversees the analysis of risk areas, investigation of reported concerns, and development of efforts to improve program quality. The program should be supported by a committee that is chaired by a compliance officer and includes members of IHS senior management and physician executives, as well as representatives from Area Offices and service units. This program should coordinate and support the compliance efforts of the Area Offices/Governing Boards and hospitals. The program should include mechanisms for staff at all levels to confidentially report concerns regarding quality and/or compliance and should ensure timely investigations of such reports. The committee should address quality care matters such as patient safety, peer review, and credentialing and privileging, and it should meet at least quarterly.

Establish standards and expectations for how Area Offices/ Governing Boards oversee and monitor hospitals and monitor adherence to those standards

Area Offices/Governing Boards should review and oversee matters related to quality and compliance with Federal requirements for health care programs. IHS should provide guidance to Area Offices/Governing Boards on both minimum standards and best practices for quality oversight. This should include minimum standards for the content and frequency of Governing Board meetings, the review of quality metrics, and the use of mock surveys and/or peer review processes—all of which were found to be inconsistent among IHS Areas. When IHS develops these standards, it should consult OIG for guidance on the role of Governing Boards. Additional guidance may be warranted for standards regarding intake of patient complaints and staff reporting of patient harm. IHS should incorporate such standards into the Indian Health Manual, periodically assess whether its expectations are being met, and it should hold Area Offices/Governing Boards accountable.

Continue to seek new and meaningful ways to monitor hospital quality through the use of outcomes and/or process measures

IHS should partner with Federal agencies that have expertise in developing health care quality indicators, such as the Agency for Healthcare Research and Quality, and strive to develop more suitable quality metrics for small rural hospitals. IHS should consider the use of a customized panel of quality metrics for each hospital to ensure that it observes the most meaningful measures for that hospital.

In addition, given hospital and Area Office focus on GPRA reporting, IHS should develop additional GPRA measures to monitor hospital performance. GPRA appears to be the most widely used tool for quality improvement in IHS, yet only one GPRA measure specifically addresses hospital performance. This measure, which is the percentage of hospitals that are accredited (or certified by Medicare), does not reflect serious and/or extended compliance deficiencies with the CoPs. New quality measures could include the number of survey deficiencies cited, number of serious reportable events, and/or numbers of patient harm indicators, such as unexpected mortality. Additional measures related to management could include measures of staff turnover and use of acting positions or percentage of providers who are contracted.

Continue to invest in training for hospital administration and staff, and assess the value and effectiveness of training efforts

IHS recently began a training initiative that includes developing a series of Web-based trainings and funding staff attendance at CMS-sponsored training on the hospital CoPs. Although these efforts appear to align with IHS's current needs, IHS should study the value and effectiveness of these efforts to ensure the best use of limited training resources. Further, IHS should continue to invest in training efforts and ensure that the content covers both quality improvement methodologies and training to correct specific deficits, such as difficulties in extracting and reporting data from the EHR system.

We recommend that CMS:

Assist IHS in its oversight efforts by conducting more frequent surveys of IHS hospitals, informing IHS leadership of deficiency citations, and continuing to provide technical assistance and training

CMS should elevate the priority of conducting CoP compliance surveys for IHS hospitals that are non-accredited—of which there are currently 10—to ensure that it surveys these hospitals at intervals similar to those used by accrediting organizations. When hospitals are cited with deficiencies, CMS should inform IHS leadership immediately to allow for early intervention. Further, for any IHS hospital with a recent history of serious compliance problems, CMS should consider giving the hospital heightened attention—for example, conducting surveys more frequently and investigating complaints quickly. Lastly, CMS should continue to provide technical assistance and training opportunities to IHS as opportunities arise, and should provide formal communication to IHS leadership regarding its perception of IHS training needs.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Office of the Secretary, IHS, and CMS provided a joint response to this report and its companion report. Collectively, these HHS agencies concurred with all recommendations in both reports. HHS also described efforts underway to address quality problems, especially concerns raised during a congressional hearing in February 2016 about the quality of care in the Great Plains Area and by CMS during certification surveys of several IHS hospitals. These efforts, detailed in the Agency comments in Appendix D, include:

- ***Departmentwide investment in IHS***—HHS created an Executive Council on Quality Care, currently led by the HHS Acting Deputy Secretary. This Council, which includes health quality experts from across HHS, is working with IHS to examine the quality of care at IHS-operated hospitals. HHS is currently targeting these efforts to respond to identified issues in the Great Plains Area. The Council’s work includes a mentorship program for administrators of select hospitals in the Great Plains Area, the development of a patient experience survey and data dashboards, new recruitment efforts using assistance from the National Health Service Corps, Health Resources and Services Administration, and the Peace Corps, and a deployment of the U.S. Public Health Service Commissioned Corps.
- ***Quality Framework***—IHS is developing a Quality Framework document that will establish a vision and course of action for improving the care provided by IHS facilities. IHS is assessing its policies and practices for quality and plans to add new policies for Governing Boards and hospital response to adverse events by the end of this calendar year. IHS also plans to establish a new Office of Quality in its headquarters that will focus on standardizing processes and procedures across the IHS system of care.
- ***Survey readiness and training initiatives***—IHS began a mock survey initiative to ensure that all IHS hospitals are assessed for compliance with the CoPs at regular intervals and using standardized protocols. IHS plans to centrally track performance data from these mock surveys and from accreditation or certification surveys. Additionally, IHS recently awarded a contract to TJC to assist hospitals in survey readiness, training, and education services. The first TJC training sessions will cover QAPI and the Emergency Medical Treatment and Labor Act (EMTALA) requirements. Additional training efforts, prompted by a Systems Improvement Agreement with CMS, will

address Governing Board practices and the Medicare CoP requirements more broadly. Further, IHS recently began holding quarterly webinars with Area Office and service unit leaders to provide technical assistance and to share experiences.

- ***Continuation and expansion of CMS technical assistance programs***—CMS will continue to support IHS hospital improvements through its Quality Improvement Network-Quality Improvement Organization (QIN-QIO) and Hospital Engagement Network (HEN) programs. The QIN-QIO for the Great Plains Area will provide QAPI support with emphasis on leadership, staffing, data analytics, clinical standards, and quality. Additionally, CMS and IHS are developing a task order for a single QIN-QIO to assist with quality improvement technical assistance in all IHS hospitals. IHS hospitals will also participate in a HEN, which is a learning collaborative dedicated to preventing patient harm in hospitals. This effort will continue as the HEN program transitions to the Hospital Improvement and Innovation Network (HIIN).

HHS, IHS, and CMS's recent efforts provide a strong foundational response to the issues identified in this report. Many of these activities, however, are currently localized to a single Area and it is unclear the extent to which these efforts will be applied to other Areas. We encourage IHS to ensure that the lessons learned in the Great Plains Area will also be used to benefit the whole of IHS. We wish to provide additional clarity regarding our recommendation to implement a compliance program. A compliance program would provide internal controls to govern IHS's ethical and business policies, and help create a culture that promotes prevention, detection, and resolution of unlawful or unethical conduct. It is worth noting, also, that the efforts described by HHS are extensive, and full implementation will likely take years to achieve. As such, we anticipate an extended timeframe for monitoring progress towards fulfillment of the recommendations.

APPENDIX A

The table below provides basic demographic information, including the locations, of IHS hospitals. We used publicly available “2010 Frontier and Remote Area” data from the U.S. Department of Agriculture to identify remote locations and population density for the appropriate ZIP Codes. “Remote areas” are at least 60 minutes from an urban area of 50,000 or more people. IHS provided the hospitals’ user populations and facility demographics for FY 2013. We identified hospitals’ respective surveying agency using both survey data provided by CMS and a review of information available on the TJC website.

Table A-1: IHS Hospitals by Area

| Hospital | City/State | Remote Area | Pop. Density | User Pop. | Avg. Daily Census* | Age of Facility | Survey Agency |
|--|-----------------|-------------|--------------|-----------|--------------------|-----------------|---------------|
| Great Plains (formerly known as Aberdeen) Area Office | | | | | | | |
| Standing Rock/Fort Yates Hospital | Ft. Yates, ND | - | 8.6 | 9,040 | 0.1 | 48 | CMS |
| Quentin N Burdick Memorial Hospital | Belcourt, ND | Remote | 45.5 | 13,799 | 7.0 | 46 | TJC |
| Cheyenne River Hospital | Eagle Butte, SD | Remote | 2.3 | 8,457 | 2.1 | 3 | CMS |
| Pine Ridge Hospital | Pine Ridge, SD | Remote | 6.7 | 21,989 | 12.0 | 21 | CMS |
| Rapid City Indian Hospital | Rapid City, SD | - | 103.5 | 14,819 | 0.9 | 76 | CMS |
| Rosebud Hospital | Rosebud, SD | Remote | 8.9 | 12,482 | 6.8 | 24 | CMS |
| Winnebago Hospital | Winnebago, NE | - | 24.4 | 5,213 | 2.2 | 10 | TJC** |
| Albuquerque Area Office | | | | | | | |
| Mescalero Service Unit | Mescalero, NM | Remote | 5.0 | 4,705 | 2.0 | 46 | TJC |
| Acoma-Cononcito-Laguna Service Unit | Acoma, NM | - | 3.3 | 11,035 | 2.8 | 35 | TJC |
| Santa Fe Service Unit | Santa Fe, NM | - | 69.9 | 14,766 | 1.5 | 35 | TJC |
| Zuni Comprehensive Health Center | Zuni, NM | Remote | 16.3 | 11,973 | 6.4 | 40 | TJC |
| Bemidji Area Office | | | | | | | |
| Cass Lake Hospital | Cass Lake, MN | Remote | 18.1 | 10,589 | 0.7 | 77 | CMS |
| Red Lake Hospital | Red Lake, MN | Remote | 45.9 | 8,046 | 2.8 | 33 | TJC |
| Billings Area Office | | | | | | | |
| Blackfeet Community Hospital | Browning, MT | Remote | 7.0 | 11,571 | 11.0 | 77 | CMS |
| Crow/Northern Cheyenne Hospital | Crow Agency, MT | - | 4.2 | 13,342 | 4.6 | 19 | CMS |
| Fort Belknap Hospital | Harlem, MT | Remote | 3.5 | 4,662 | 0.1 | 16 | CMS |

Continued on next page.

Table A-1: IHS Hospitals by Area (Continued)

| Hospital | City/State | Remote Area | Pop. Density | User Pop. | Avg. Daily Census* | Age of Facility | Survey Agency |
|----------------------------------|----------------|-------------|--------------|-----------|--------------------|-----------------|---------------|
| Navajo Area Office | | | | | | | |
| Chinle Comprehensive Health Care | Chinle, AZ | Remote | 9.6 | 35,027 | 19.0 | 33 | TJC |
| Gallup Indian Medical Center | Gallup, NM | Remote | 34.5 | 43,275 | 41.7 | 53 | TJC |
| Northern Navajo Medical Center | Shiprock, NM | - | 8.3 | 53,915 | 5.8 | 20 | TJC |
| Crownpoint Health Care Facility | Crownpoint, NM | Remote | 5.2 | 19,787 | 1.5 | 26 | CMS |
| Oklahoma Area Office | | | | | | | |
| Claremore Indian Hospital | Claremore, OK | - | 196.5 | 100,801 | 6.8 | 37 | TJC |
| Lawton Indian Hospital | Lawton, OK | - | 109.3 | 22,782 | 6.6 | 47 | TJC |
| Phoenix Area Office | | | | | | | |
| Parker Indian Hospital | Parker, AZ | - | 16.6 | 9,275 | 4.6 | 13 | TJC |
| Hopi Health Care Center | Polacca, AZ | Remote | 10.7 | 6,545 | 19.0 | 14 | TJC |
| Phoenix Indian Medical Center | Phoenix, AZ | - | 3232.3 | 68,838 | 34.0 | 44 | TJC |
| San Carlos Hospital | San Carlos, AZ | Remote | 2.7 | 12,323 | 0.7 | 52 | TJC |
| Whiteriver Hospital | Whiteriver, AZ | Remote | 39.5 | 16,428 | 14.0 | 35 | TJC |
| Tucson Area Office | | | | | | | |
| Sells Indian Hospital | Sells, AZ | - | 1.9 | 20,215 | 4.4 | 54 | TJC |

*The average daily census includes inpatients only.

**Winnebago Hospital lost accreditation and reverted to CMS certification during our evaluation.

Sources: OIG compiled this table using information from the IHS website and the TJC website; Medicare provider data from the Certification and Survey Provider Enhanced Reporting; and interviews, surveys, and documents collected during this evaluation.

APPENDIX B

Table B-1: Hospital Conditions of Participation

| Condition | Regulation | Description |
|---|------------|---|
| Administrative Functions | | |
| Compliance with Federal, State, and Local Laws | § 482.11 | A hospital must comply with applicable federal laws on patient health and safety and state and local laws on hospital and personnel licensing. |
| Governing Body | § 482.12 | A hospital must have a legally responsible governing body or persons charged with the responsibilities of a governing body. |
| Patients' Rights | § 482.13 | A hospital must protect and promote patients' rights. |
| Basic Hospital Functions | | |
| Quality Assessment and Performance Improvement Program (QAPI) | § 482.21 | A hospital must have an effective, hospitalwide quality assurance program. |
| Medical Staff | § 482.22 | A hospital must have an organized medical staff that abides by bylaws approved by the governing body and is responsible for the quality of patient medical care. |
| Nursing Services | § 482.23 | An organized nursing service must provide 24-hour nursing services that are supervised or furnished by registered nurses. |
| Medical Record Services | § 482.24 | A hospital must have a medical record service that has administrative responsibility for medical records. |
| Pharmaceutical Services | § 482.25 | The hospital must have pharmaceutical services that meet patient needs. |
| Radiologic Services | § 482.26 | The hospital must maintain, or have available, diagnostic radiologic services. Therapeutic services provided must meet professionally approved standards for safety and personnel qualifications. |
| Laboratory Services | § 482.27 | The hospital must maintain, or have available, adequate laboratory services. |
| Food and Dietetic Services | § 482.28 | Dietary services must be organized, directed, and staffed by qualified personnel. Contracted services must meet certain requirements. |
| Utilization Review | § 482.30 | Utilization review plans must provide for review of the services that a hospital and its medical staff provide to Medicare and Medicaid patients. |

Continued on next page.

Table B-1: Hospital Conditions of Participation (Continued)

| Condition | Regulation | Description |
|------------------------------------|------------|---|
| Physical Environment | § 482.41 | Hospital construction, arrangements, and maintenance must ensure patient safety and provide diagnostic and treatment facilities and special hospital services appropriate to community needs. |
| Infection Control | § 482.42 | A hospital's sanitary environment must avoid sources and transmission of infections and communicable diseases. It must have an active program to prevent, control, and investigate infections and communicable diseases. |
| Discharge Planning | § 482.43 | A hospital must have a discharge planning process applicable to all patients. Policies and procedures must be in writing. |
| Organ, Tissue, and Eye Procurement | § 482.45 | The hospital must have and implement written protocols on procurement and have adequate organ transplant policies. |
| Surgical Services | § 482.51 | Surgical services must be well organized and provided in accordance with acceptable standards of practice. Outpatient services must be consistent with inpatient care quality in accordance with the complexity of services offered. |
| Optional Services | | |
| Anesthesia Services | § 482.52 | Anesthesia services must be well organized and directed by a qualified doctor of medicine or osteopathy. The service is responsible for all anesthesia administered. |
| Outpatient Services | § 482.54 | Outpatient services must meet patient needs consistent with acceptable standards of practice. |
| Emergency Services | § 482.55 | If emergency services are provided they must be organized under the direction of a qualified member of the medical staff and have adequate medical and nursing personnel qualified in emergency care to meet the needs anticipated by the facility. |
| Rehabilitation Services | § 482.56 | Rehabilitation, physical therapy, occupational therapy, audiology, or speech pathology services must be organized and staffed to ensure the health and safety of patients. |
| Respiratory Services | § 482.57 | Respiratory services must meet patient needs in accordance with acceptable standards of practice. |
| Nuclear Medicine Services | § 482.53 | Nuclear medicine services must meet the needs of the patients in accordance with acceptable standards of practice. |

Sources: 42 CFR §§ 482.11-482.57 CMS, SOM, Pub. No. 100-07, App. A.

APPENDIX C

METHODOLOGY

This study describes CMS's and IHS's efforts to ensure that IHS hospitals provide quality care and comply with Medicare standards of care. Report findings are based on multiple data sources collected between April and October 2014.

Telephone Interviews

We conducted in-depth, semistructured telephone interviews with IHS leadership staff from federally operated hospitals, headquarters, and Area Offices. We also interviewed staff from CMS.

IHS Hospital Interviews. We interviewed hospital CEOs from the 28 IHS-operated hospitals. The CEOs often opted to include additional members of their leadership team in the interviews (e.g., clinical directors, directors of nursing, and quality managers). Interview questions focused on hospitals' ability to provide necessary care; challenges affecting quality care and compliance; improvement efforts; and assistance received from Area Offices, IHS headquarters, CMS, and accrediting organizations.

IHS Area Office Interviews. We interviewed the eight Area Directors responsible for overseeing federally run hospitals. Area Directors often opted to include additional members of their leadership team in the interview. We asked about the Area Offices' functions, hospital oversight activities, and collaboration with CMS and accrediting organizations.

IHS Headquarters Interviews. We interviewed a range of headquarters and specialized field staff including:

- Chief Medical Officer (CMO) – We interviewed the CMO to discuss IHS's role in guidance, monitoring, and efforts to improve hospital quality and compliance with the CoPs for inpatient care.
- Director of Field Operations (DFO) – We interviewed the DFO to better understand the relationship of Area Offices with both the hospitals and headquarters.
- Director of the Hospital Consortium – We interviewed the Director of the Hospital Consortium, a cross-Area workgroup, to learn about the Consortium's efforts to improve hospital quality and promote CoPs compliance.

CMS Interview. We interviewed leadership staff in CMS's Consortium for Quality Improvement and Survey & Certification Operations. We asked about CMS's role in overseeing IHS hospitals and their experiences working with them.

Questionnaires

IHS Hospital Questionnaires. For each of the 28 hospitals, we administered questionnaires regarding the hospital's average daily censuses, vacancies, referrals, and grievances during 2013.

IHS Area Office Questionnaires. We administered questionnaires to the eight Area Offices. We asked questions about consultant programs, procedural information regarding how the Area Office staff reviews quality information, and perceptions about which challenges most affected hospitals' ability to provide quality care and maintain compliance.

Document Reviews

Based on interview and questionnaire responses, we requested documents to validate information shared by IHS staff.

IHS Hospital Surveys. Using survey data stored in the Automated Survey Processing Environment (ASPEN) and Accrediting Organization System for Storing User Recorded Experiences (ASSURE), we reviewed survey frequencies and deficiency citations from before January 1, 2014, for each of the 28 hospitals. We also requested full survey reports from CMS and, when applicable, the accrediting organization, as well as an IHS-contracted report entitled *Accreditation Survey Analysis* that included an analysis of IHS hospital accreditation and certification surveys conducted from September 30, 2005, to July 15, 2013.

Area Office Questionnaires and Documents. From each Area Office, we received documents from Governing Board meetings (e.g., agenda, list of attendees), quality-related reports or dashboards (e.g., incident reports, infection control reports), and reports from mock surveys conducted during FYs 2013–2014. (Mock surveys simulate certification and accreditation surveys.)

IHS Headquarters Documents. From IHS headquarters, we received several management-related documents including the Federal Managers Financial Integrity Act (FMFIA) Deficiency Analysis, and final reports of the Area Office reviews conducted in response to Senator Dorgan's 2010 report. Additionally, we received the proposed charter for the Hospital Consortium; interagency agreements relating to the Partnership for Patients initiative; and, contracts, deliverables, and related budget information regarding the Quality Improvement Organization (QIO) Special Innovation Project.

APPENDIX D

AGENCY COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

SEP 12 2016

TO: Daniel R. Levinson
Inspector General
Department of Health and Human Services

FROM: Mary K. Wakefield, *Mary Wakefield*
Acting Deputy Secretary
Department of Health and Human Services

Mary Smith, *Mary Smith*
Principal Deputy Director
Indian Health Service

Andy Slavitt, *Andy Slavitt*
Acting Administrator
Centers for Medicare and Medicaid Services

SUBJECT: HHS Comments on OIG Draft Reports: *IHS Hospitals: More Monitoring Needed to Ensure Quality Care*, OEI 06 14 00010 and *Indian Health Service Hospitals (IHS): Longstanding Challenges Warrant Focused Attention to Support Quality Care*, OEI-06-14-00011

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the Office of the Inspector General's draft reports *IHS Hospitals: More Monitoring Needed to Ensure Quality Care*, OEI 06 14 00010 and *Indian Health Service Hospitals (IHS): Longstanding Challenges Warrant Focused Attention to Support Quality Care*, OEI-06-14-00011.

HHS, through the Indian Health Service (IHS), strives to provide access to quality health care for the over 2 million American Indian and Alaska Native patients it serves. As part of this commitment, in July 2016, IHS unveiled the first-ever Quality Framework to outline key priorities and objectives that focus on strengthening the underlying foundation of the direct service health facilities within the IHS system of care. This Framework builds on existing initiatives and programs to drive improvements in service delivery. This Quality Framework sets forth a Quality Vision that IHS will provide patient-centered, timely, effective, safe, and reliable health care of the highest quality.

IHS Hospitals: More Monitoring Needed to Ensure Quality Care, OEI 06 14 00010

OIG Recommendation

OIG recommends that IHS implements a quality-focused compliance program to support Federal requirements for health care programs

IHS Response

IHS concurs with this recommendation. IHS is strongly committed to a quality-focused compliance program for all American Indians and Alaska Natives served through IHS hospitals. Earlier this year, we strengthened and refocused our resources within the IHS as part of an aggressive strategy to improve the overall quality of care in the Great Plains Area and across the country. IHS is working to instill a culture of quality care, leadership, and accountability across the agency. We are committed to improving the health status of American Indian and Alaska Native families and communities.

To ensure that dependable, quality care is delivered consistently across IHS facilities, in February 2016, Secretary Burwell created the Executive Council on Quality Care and asked Acting Deputy Secretary Wakefield to lead it. This council includes senior executives from across HHS and draws on expertise from across the Department. We have some of HHS's top managers, clinicians, and program experts taking a fresh look at long-standing obstacles, like challenges to delivering quality of care, and addressing key operations issues. The council provides the structure to ensure that we are leveraging all the resources we can on behalf of tribal communities and the patients we serve.

In conjunction with the work of this Council, IHS, since March 2016, is taking a very close look at the quality of care delivered through direct-service hospitals at IHS facilities across the Great Plains Area as well as throughout Indian Country. We want to affirm and support facilities that are delivering quality care and work closely with facilities that need improvement. It is important that IHS leadership from Headquarters to Area Offices to our Service Units work closely with both tribal leadership and direct service hospitals in a transparent way that encourages open information exchange about improvement opportunities. We know from decades of experience across the health care continuum that problems that are not acknowledged and fixed put patients at risk. For the past 20 years, health care systems across the nation have been embracing new models of improvement, and we are working to embrace those models through the assets of IHS and other HHS operating divisions.

Systems Improvement Agreements

In April 2016, IHS and CMS signed Systems Improvement Agreements (SIA) for both Rosebud Hospital and Pine Ridge Hospital. The agreements are designed to improve services at the hospitals to fully meet safety and quality of care standards, allowing time needed to address and overcome systemic barriers to quality. Both agreements cover a 12-month period, and during this time, IHS will continue billing Medicare and Medicaid for services provided to Medicare and Medicaid beneficiaries at these hospitals. IHS is fully committed to accomplishing the terms of the SIAs and ensuring system-wide compliance with quality health care standards. Employees

and managers alike will be held accountable for their performance to fulfill the terms of the SIAs. Moreover, IHS is using what is learned from the implementation of these SIAs to inform related work at other direct service hospitals so that the entire system of hospitals, where appropriate, can benefit.

System-Wide Mock Survey Initiative

In May 2016, IHS began a system-wide mock survey initiative at all 26 of its hospitals to assess compliance with the CMS Conditions of Participation and readiness for re-accreditation. The new mock survey initiative is a unified effort to reinforce standardization of processes and to achieve consistent quality care. We began in the Great Plains Area with assessments and, when appropriate, interventions through the provision of on-site assistance to hospital staff. Although some direct service hospitals currently conduct self-assessments, IHS is standardizing and improving this process so that direct-service hospitals receive a consistent assessment within the next few months and performance data is centrally tracked, not just at individual facilities but across all facilities. As a result, this standardized approach and data collection will ultimately facilitate the exchange of best practices across the system of service units.

Through this and a number of other targeted strategies, IHS will move from being reactive to proactive in identifying and addressing performance issues early. Our first efforts were piloted May 10, 2016, at the Rosebud Hospital, and we will continue to do quality surveys at all direct service hospitals, excluding those that have been surveyed in the past year or are scheduled to be formally surveyed through other mechanisms during this timeframe. When our survey teams identify problems, we will work swiftly to address these local problems and work to put systems changes in place to resolve the problems.

Hospital Engagement Network

We also are infusing substantial quality expertise into informing and improving care quality in direct service facilities. In partnership with CMS, we have launched a Hospital Engagement Network (HEN) to provide evidence-based efforts in quality improvement. As announced on May 13, 2016, this HEN is now available to all IHS direct service facilities and focuses on quality improvement methods intended to reduce avoidable readmissions and hospital acquired conditions (e.g. central line blood infections, pressure ulcers, falls, etc.). Hospitals in the network share successful practices and lessons learned to accelerate learning and change.

Quality Improvement Organization

Additionally, we are bringing in targeted quality improvement assistance through CMS' Quality Improvement Organization (QIO) infrastructure. Among other support and training functions, QIOs assist with root cause analysis of identified problems, assist with the development of improvement plans, establish baseline data, and monitor data to ensure improvement plans are successful and sustained over time. Also through Secretary Burwell's Executive Council on Quality Care, HHS is deploying quality experts, as needed, from throughout the Department to consult with and help our IHS direct service hospitals that are currently out of compliance with the CMS Conditions of Participation and to monitor progress as the facilities come into compliance.

Quarterly Technical Assistance Webinars

For the first time, IHS has begun to conduct quarterly meetings with Area Office and Service Unit leaders to provide technical assistance, share learning and experiences, and solicit feedback. The first series of webinars was held in June 2016, and several sessions were conducted across several IHS areas. The June 2016 webinars focused on sharing best practices and updates from the CMS survey results in the Great Plains Area hospitals.

IHS Quality Framework

In July 2016, IHS released a comprehensive draft IHS Quality Framework¹ and is currently seeking input on the framework from both employees and tribal partners. The draft Framework supports high quality patient-centered, timely, effective, safe, and reliable health care. The Framework proposes strengthening IHS organizational capacity to improve quality of care and systems, meeting and maintaining accreditation for IHS government-operated facilities, standardizing key processes and policies aimed at improving the patient experience, and continuing to cultivate an environment that delivers safe, high quality care. The Framework describes the vision, goals, and priorities to develop, implement, and sustain an effective quality program that improves patient experience and outcomes, strengthens organizational capacity, and ensures the delivery of reliable, high quality health care for IHS direct service facilities.

The Framework was developed by assessing current IHS quality policies, practices, and programs, incorporating standards from national experts, and including best practices from across the IHS system of care. The Framework is a living document with an initial focus on strengthening the underlying quality foundation of the federally-operated facilities within the IHS system of care that builds upon existing initiatives and programs.

The five priorities of the Framework are:

- 1) Strengthen Organizational Capacity to Improve Quality of Care and Systems
- 2) Meet and Maintain Accreditation for IHS Direct Service Facilities
- 3) Align Service Delivery Processes to Improve Patient Experience
- 4) Ensure Patient Safety
- 5) Improve Processes and Strengthen Communications for Early Identification of Risks

IHS is also committed to sharing best practices, models, and policies with Tribes and Urban Indian programs and strengthening partnerships with Tribes, local communities, and regional health care systems. Tribal consultation on the framework is designed to ensure transparency and open communications with Tribal partners. The Framework will be reviewed and updated annually.

The Framework includes numerous objectives to strengthen IHS' quality foundation. For example, the establishment of an Office of Quality in IHS headquarters that reports to the IHS Director and works closely with Area Offices and Service Units to standardize processes and procedures across the IHS system of care.

¹ https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/2016_Letters/56010-1_Enclosure_IHSQualityFramework_DRAFT.pdf

Hospital Accreditation Contract Awarded

Also, in July 2016, IHS awarded a one-year contract to The Joint Commission for accreditation, training, and education services² to strengthen quality and patient safety. Through this contract IHS is proactively ensuring that all federally-operated IHS hospitals meet the standards required for Medicare participation and are prepared for CMS surveys. IHS will also provide training on the Medicare Conditions of Participation required by CMS and expand its capacity to support quality improvement work through this contract. Training sessions by The Joint Commission will be available through real time modes of delivery to all IHS hospital administrators, providers, and staff. On-site training will begin in September 2016 at four IHS hospitals, and will be broadcast remotely to all federal IHS hospitals.

OIG Recommendation

OIG recommends that IHS establish standards and expectations for how Area Offices/Governing Boards oversee and monitor hospitals, and monitor adherence to those standards

IHS Response

IHS concurs with this recommendation. IHS continually strives for quality health care services through federal programs and services, which are accredited by The Joint Commission, or, as an alternative through certification by CMS for meeting Medicare Hospital Quality Standards, often referred to as Conditions of Participation. We focus on quality of care standards in large part through the work of the Governing Boards responsible for the operations of each of our health care facilities.

Standard Governing Board Policy

IHS recognizes the critical role that Governing Boards play in ensuring that IHS Hospitals provide quality care to our patients. IHS Area Offices are key to IHS hospital oversight. Under the IHS Quality Framework, which was released in July 2016, planned activities include the development of a standard governing body policy for all IHS facilities and Area Offices by the end of calendar year 2016. This activity will provide consistency in meeting accreditation standards and support the overall readiness initiatives to sustain provider certification by CMS. In addition, the OIG guidance on the role of Governing Boards will be very helpful in IHS fully accomplishing this recommendation.

Governing Board Training in the Great Plains

In furtherance of requirements of the SIAs with CMS, in August 2016, IHS commenced Governing Board training for all Service Units in the Great Plains Area. These trainings emphasize quality and safety as critical and significant components of Governing Board meetings/agendas, in addition to a review of fundamental Governing Board structure and operations. An emphasis on strengthening Area Office leadership competencies in governance will be a focus of training and accountability for 2017.

² <https://www.ihs.gov/newsroom/pressreleases/2016pressreleases/ihs-awards-contract-for-hospital-surveys-education-and-training/>

OIG Recommendation

OIG recommends that IHS continue to seek new and meaningful ways to monitor hospital quality through the use of outcomes and/or process measures

IHS Response

IHS concurs with this recommendation. IHS takes seriously its responsibility for high quality care for American Indian and Alaska Native patients. To this end, IHS continues to seek new and meaningful ways to monitor hospital quality through the use of outcomes and/or process measures. IHS initiated and is maintaining high quality care through a number of strategies that include: conducting internal mock surveys that will assist in monitoring IHS progress to improve hospital quality; participation in HEN 2.0 to address patient safety indicators as defined by the CMS Partnership for Patients; and increasing capture of reportable events in the IHS-developed legacy system called WebCidents (patient, visitor, and occupational safety reporting database) for review and response at multiple levels of the organization. Specific to increasing reporting in WebCidents, IHS, through its Quality Consortium, is developing an Adverse Event Prevention and Response policy that will reduce barriers to reporting based on national best practice in patient safety. This policy is currently under agency review.

OIG Recommendation

OIG recommends that IHS continue to invest in training for hospital administration and staff, and assess the value and effectiveness of training efforts

IHS Response

IHS concurs with this recommendation. As part of the professional development of individuals in key leadership positions, IHS is committed to investing in training for hospital administration and staff and also to determine the value and effectiveness of training efforts.

Hospital Senior Leadership under SIAs

IHS is committed to ensuring strong leadership at IHS direct-service hospitals. In furtherance of this priority, under the SIAs with Pine Ridge and Rosebud Hospitals, IHS will implement immediate, short-term and long-term plans to ensure qualified hospital leadership and management that is sustainable over time. Pursuant to the SIAs, IHS is in the process of exploring alternatives for possibly contracting with a hospital management firm for the leadership at both hospitals or providing a coach for permanent federal staff in senior leadership at both hospitals, among other options. There is a plan to extend what is learned under the SIAs to share with other IHS direct-service hospitals.

Joint Commission Contract

In July 2016, IHS announced a one-year contract to The Joint Commission for accreditation services for IHS federal-government-operated medical facilities and training and education services to strengthen quality and patient safety. Training and education will benefit IHS

facilities in Arizona, Minnesota, Montana, Nebraska, New Mexico, North Dakota, Oklahoma, and South Dakota.

Like other hospitals in the private and public sectors, IHS hospitals are surveyed, or inspected, by independent experts so IHS can identify and correct any issues that could adversely impact patients as well as improve baseline quality of care. IHS hospitals will benefit from this new contract that will proactively ensure that all federally-operated IHS hospitals meet the standards required for CMS certification and are prepared for CMS surveys that assess hospital compliance in meeting Medicare program requirements. This contract underscores the IHS commitment to enhancing patient safety and ensuring high quality care for our patients. IHS is working with our tribal partners and with independent hospital quality experts to ensure that uniform processes for identifying any potential issues are in place, consistent with best practices in hospital administration.

With this contract, IHS is also responding to requirements of the SIAs between IHS and CMS for Rosebud and Pine Ridge Hospitals in South Dakota. These hospitals are two of those covered by this contract. IHS will provide training on the CMS Conditions of Participation for the Medicare and Medicaid programs and expand its capacity to support quality improvement work through this contract, as required by the agreements.

Joint Commission Training Sessions

IHS is committed to invest in training for hospital administration and staff throughout the agency to ensure maximum value, efficiency, and effectiveness of care for all American Indian and Alaskan Natives served by IHS. Training sessions by The Joint Commission will be available through real time modes of delivery to all IHS hospital administrators, providers, and staff. On-site training will begin in September 2016 at four IHS hospitals and will be broadcast remotely to all federal IHS hospitals. Training in September 2016 will cover the Emergency Medical Treatment and Labor Act (EMTALA) requirements and Quality Assurance and Performance Improvement (QAPI). An additional training day at each of the four hospitals is scheduled for the training teams to apply the knowledge gained the previous day, to perform "tracers" on actual patient cases, and identify whether deficient practices actually occurred. IHS is working to strengthen its orientation as a learning organization and is committed to accomplishing and sustaining knowledge in the most practical, relevant, and useful manner available.

OIG Recommendation

OIG recommends that CMS assist IHS in its oversight efforts by conducting more frequent surveys of IHS hospitals, informing IHS leadership of deficiency citations, and continuing to provide technical assistance and training.

CMS Response

CMS concurs with this recommendation. CMS is serious about its responsibility to provide objective, onsite assessments of the quality and safety in health care facilities, properly identify any deficiencies, and require that timely corrections are made. All Medicare-certified hospitals, including IHS hospitals, are required to meet basic health and safety provisions found in the

Medicare Conditions of Participation. Hospitals are required to undergo recertification surveys, which are unannounced onsite reviews of a facility's compliance with all of the Medicare Conditions of Participation. Between recertification surveys, hospitals may also receive a more focused onsite review following complaint allegations related to quality of care. As such, CMS will conduct recertification surveys of unaccredited IHS hospitals every three years rather than the current standard of every five years for recertification of unaccredited hospitals. CMS will continue to perform complaint investigations based on the complaint triage priority. Furthermore, CMS will continue to inform IHS leadership immediately when IHS hospitals are cited with deficiencies to allow for early intervention, and will continue to give any IHS hospitals with recent history of serious compliance problems heightened attention through our established enforcement and compliance processes.

CMS will continue to provide technical assistance and training to IHS hospitals as part of its general efforts through the Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) to support all hospitals in improving quality of care and ensuring safety. For example, CMS will provide Quality Assurance and Performance Improvement (QAPI) support from the Great Plains QIN-QIO targeted to critical quality improvement issues for three IHS hospitals in the Great Plains service area. CMS is also working with IHS to develop a separate Task Order which will be awarded to a single QIN-QIO for dedicated quality improvement technical assistance to all IHS hospitals. The role of the QIN-QIO will be to solidify the foundational processes that will lead to high quality healthcare in the areas of leadership, staffing, data analytics, clinical standards of care, and quality.

In addition, CMS is providing technical assistance specifically on the reduction of hospital-acquired conditions and preventable readmissions through a Hospital Engagement Network (HEN) and will continue to do so as HENs transition to Hospital Improvement and Innovation Networks (HIINs) in awards anticipated by the end of the 2016 fiscal year³. Similar to HENs, the HIINs will work at the national, regional, state, or hospital system level to develop learning collaboratives for hospitals so that they can implement the changes and innovations necessary to achieve the safety and care transitions goals of the Partnership for Patients, a nationwide public-private collaboration to keep patients from being harmed while in the hospital and heal without complication once they are discharged. As part of the HINN's efforts, quality improvement experts will conduct site visits at IHS hospitals and IHS hospitals will be able to access training and technical assistance on making patient care safer.

³https://www.fbo.gov/?s=opportunity&mode=form&id=19085c2b489ce1a47e4c3235dc87d159&tab=core&_cview=0

Indian Health Service Hospitals (IHS): Longstanding Challenges Warrant Focused Attention to Support Quality Care, OEI-06-14-00011

OIG Recommendation

OIG recommends that as part of the Office of the Secretary's newly formed executive council, the Office of the Secretary lead an examination of the quality of care delivered in IHS hospitals and use the findings to identify and implement innovative strategies to mitigate IHS's longstanding challenges.

OS Response

HHS concurs with this recommendation. HHS is committed to strengthening and sustaining the quality of care delivered to American Indian and Alaskan Native populations through IHS direct service hospitals. As part of this commitment, HHS developed a five prong strategy that includes 1) surfacing problems, 2) immediately strengthening service delivery, 3) strengthening IHS Area management, 4) infusing top quality expertise into IHS hospitals, and 5) convening expert panels to address longstanding challenges. To advance this goal, in February 2016, Secretary Burwell created the Executive Council on Quality Care to augment IHS' efforts to ensure that sustained, quality care is being delivered consistently across IHS service units. Additionally, HHS' Acting Deputy Secretary charged the Executive Council to develop a work plan to facilitate a smooth transition of this targeted effort into the next Administration. The Executive Council has been harnessing expertise from across HHS to assess and address longstanding challenges in IHS through multiple innovative strategies that target key areas. The aim of the Council is to support the achievement of both immediate and long-term sustained improvements in the delivery of quality care, primarily through building the workforce and leverage quality improvement expertise. The vehicles for accomplishing this aim include:

Quality Workgroup of the Executive Council

Representatives from across HHS agencies convene biweekly and assist in support of specific work to develop the IHS Quality Framework. Several members of this workgroup also participate and lend their experience to the work of developing a patient experience survey and improvement program which is essential to delivery of patient centered care and one of the priorities of the Quality Framework. Other working group members are working with IHS to develop the plans for managing accreditation surveys and data dashboards.

Commissioned Corps Deployments

To address the immediate need in the Great Plains Area, beginning in February 2016, the Surgeon General deployed Commissioned Corps Officers to the Great Plains Area to provide needed clinical care and address quality needs. These officers of the U.S. Public Health Service include nurses, pharmacists, quality assurance experts, nurse leaders focused on outpatient and urgent care, and medical officers.

To strengthen and sustain quality of care, in the spring of 2016 the Surgeon General implemented a strategy so that, going forward, IHS will have first priority for placement of new

Commissioned Corps officers. New officers with skills needed by IHS will be placed at IHS facilities and offices. Additionally, the Surgeon General is further targeting Commissioned Corps Officers by expediting the commissioning of applicants who accept clinical and leadership positions at one of the three Great Plains Area facilities, in order to meet this critical staffing need.

Expanded Partnerships with the National Health Service Corps

To further leverage HHS workforce programs designed to meet the needs of underserved communities are being examined and leveraged in support of access to health care providers for American Indian and Alaska Native populations. In the immediate term, the National Health Service Corps (NHSC) identified 80 loan repayment recipients that currently need a new service site. These clinicians are being encouraged to consider positions at IHS sites. There are 682 eligible sites within the IHS system where NHSC clinicians may serve. Currently, 414 NHSC clinicians are working in IHS, Tribal, and Urban sites. In the long term, the NHSC program will include consideration of placement at IHS facilities of clinicians needing new practice sites.

Additional internal HHS partnership strategies have been initiated and include a partnership between IHS and the Health Resources and Services Administration (HRSA) to host Virtual Job Fairs to promote employment opportunities at IHS service sites. In February, March and April 2016, HRSA and IHS hosted IHS-specific Virtual Job Fairs that included over 900 participants of which, as of August 2016, a total of 41 participants applied for positions. These Virtual Job Fairs are for clinicians and students interested in applying for NHSC and IHS loan repayment and scholarship opportunities. These fairs have been a strategy that HRSA has been using for the last four years to connect clinicians and students with job vacancies at NHSC sites without having to travel, which is time consuming and costly. HRSA and IHS will sustain this partnership going forward.

NHSC is working to increase the number of self-identified American Indian and Alaskan Native participants in its program, and IHS is working with NHSC to explore additional NHSC program changes that would boost recruitment to IHS sites (for example, the Student Loan Repayment Program) to help achieve long term impact on the IHS workforce. As of September 2015, there were 188 NHSC participants self-identified as American Indian and Alaskan Native (77 primary care, 86 mental health, 25 oral health), as well as 27 NURSE Corps participants.

Innovative Partnerships with other U.S. Government Agencies

Through the Executive Council, additional innovative strategies are being implemented to help mitigate IHS's longstanding challenges around provider recruitment by reaching out to other U.S. Government Agencies. For example, the Council has facilitated a new partnership between IHS and the Peace Corps, a like-minded agency in many ways given the related missions. Both organizations are service-oriented and provide cultural immersion opportunities for motivated individuals hoping to make a difference by working side-by-side with local leaders in their communities.

The Peace Corps has a health initiative, the Global Health Service Partnership (GHSP), under which physicians and nurses, often at the beginning or near the end of their careers, are deployed for one year to international sites (primarily in Africa). Each year, more than 60 GHSP

physicians and nurses return from their service abroad, and the Peace Corps has offered to provide these health care providers with information about IHS career opportunities, along with the more than 200 individuals who originally applied to participate in the program, but were not selected (largely due to limitations in the number of positions in the program). Since many of these providers are driven toward impactful career opportunities and providing high quality health care through cultural immersion, IHS service can be a good next step for them in their careers. And since this is a program with an annual cohort, this is also an opportunity for recurring IHS recruitment outreach.

In addition, the Peace Corps will share information about IHS career opportunities with its network of volunteer alumni, with whom it actively maintains a long-term relationship. Many of these individuals may have pursued health careers in the years following their volunteer service. Lastly, the Peace Corps has recently started their new Emerging Leaders Project: a 12-month leadership development program for returned Peace Corps volunteers that places them in targeted positions in organizations that share the core values of the Peace Corps. HHS and IHS see this as a potential partnership opportunity with the Peace Corps to recruit from a pipeline of future health care leaders while they are in the early-to-mid careers. These motivated individuals could help to lead quality improvement initiatives for IHS and drive positive change across the system.

HHS will continue to look at additional partnerships with other U.S. Government Agencies to increase recruitment opportunities to enhance the IHS workforce.

Quality Improvement Organizations and Hospital Engagement Network

CMS has markedly increased its technical assistance to the Great Plains Area and is strengthening technical assistance across all IHS direct service hospitals. CMS is continuing to provide technical assistance and training to IHS hospitals as part of its general efforts through the Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) to support all hospitals in improving quality of care and supporting the delivery of safe Care. Additionally, to target specific expertise to IHS hospitals, CMS is also working with IHS to develop a separate Task Order which will be awarded to a single QIN-QIO for dedicated quality improvement technical assistance to all IHS hospitals. This Task Order will be awarded in early Fall 2016. The role of the QIN-QIO will be to solidify the foundational processes that will lead to high quality healthcare in the areas of leadership, staffing, data analytics, clinical standards of care, and quality.

In the interim, CMS arranged for the Premier Hospital Engagement Network (HEN) serving the Great Plains Area to work with IHS hospitals to reduce hospital acquired conditions and avoidable readmissions (this arrangement will continue as HENs transition to Hospital Improvement and Innovation Networks (HIINs) in awards anticipated by the end of fiscal year 2016). CMS also arranged for the Great Plains QIO, the existing QIO serving the Great Plains Area states, to work with the three Great Plains Area hospitals until the IHS-specific QIO begins its work.

Hospital Mentoring Teams

Specific to the Great Plains Area, since June 2016, the Quality Workgroup of the Executive Council established mentoring teams of quality experts across HHS to work closely with the CEO of each of the Great Plains Area hospitals to address a broad range of quality of care issues. The mentors have visited their hospital and met with staff. They conduct weekly calls with hospital CEOs, review mock survey findings, and assist in developing workplans in response to findings along with helping connect hospital leaders with other resources. Across all direct service hospitals, HHS Quality Experts are working to strengthen and sustain quality care by developing new strategies. For example, for the first time, IHS has begun to conduct quarterly meetings with Area Office and Service Unit leaders to provide technical assistance, share learning and experiences, and solicit feedback. The first series of webinars was held in June 2016, and several sessions were conducted across several IHS areas. The June 2016 webinars focused on sharing best practices and updates from the CMS survey results in the Great Plains Area hospitals.

OIG Recommendation

Conduct a needs assessment culminating in an agency wide strategic plan with actionable initiatives and target dates

IHS Response

IHS concurs with this recommendation. IHS is committed to the implementation of an agency-wide strategic plan with actionable initiatives and target dates that meets the agencies most critical needs. The IHIS Quality Framework was developed in response to needs identified by the Quality Consortium and by CMS and accreditation surveys across the agency. The Framework addresses the strategic needs of IHS related to quality improvement, standardization of processes, and compliance with accreditation and certification standards. Activities that support the objectives and priorities of the Framework have been identified. An implementation plan for the Framework, with actionable initiatives and target dates, is under development. Once the implementation plan is completed, it will be continuously monitored and updated. IHS is dedicated to learning from results of internal and external surveys and maintaining continual readiness and sustained improvements in quality of care to American Indian and Alaskan Native patients. HHS is committed to supporting IHS in achieving this goal.

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Office of Inspector General

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