United States Government Accountability Office

Report to Congressional Requesters

January 2017

INDIAN HEALTH SERVICE

Actions Needed to Improve Oversight of Quality of Care

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Why GAO Did This Study

IHS is charged with providing health care to American Indian/Alaska Native (AI/AN) people who are members or descendants of 567 tribes. AI/AN people born today have a life expectancy that is 4.4 years lower than all races in the United States, and they continue to die at higher rates than other Americans from preventable causes. Concerns about the quality of care provided to AI/ANs in IHS facilities have been identified recently by federal officials and tribal members. GAO was asked to review how IHS oversees the quality of care provided in its facilities.

This report examines IHS's oversight of the quality of care provided in its federally operated facilities. GAO reviewed policies and guidance related to quality of care in federally operated facilities and interviewed IHS officials at the headquarters level and all nine area offices with federally operated facilities. GAO also examined documents from governance meetings between area office and facility staff.

What GAO Recommends

GAO recommends that the Secretary of the Department of Health and Human Services direct the Director of IHS to (1) as it implements its quality framework, ensure that agency-wide standards for the quality of care provided in its federally operated facilities are developed, that facility performance in meeting these standards is monitored over time, and that enhancements are made to its adverse event reporting system, and (2) develop contingency and succession plans for the replacement of key personnel.

HHS concurred with GAO's recommendations.

What GAO Found

The Indian Health Service's (IHS) oversight of the quality of care provided in its federally operated facilities has been limited and inconsistent. While some oversight functions are performed at the headquarters level, the agency has delegated primary responsibility for the oversight of care to nine area offices. Area officials stated that the oversight they provide has included, for example, holding periodic meetings with facility staff, reviewing available quality performance data and reviewing adverse events. However, GAO found that this oversight was limited and inconsistent across IHS facilities, due in part to a lack of agency-wide quality of care standards. Specifically, GAO found:

- variation in the frequency of governing board meetings and the extent to which quality was a standing agenda item at these meetings;

- limited and inconsistent reporting of quality data across IHS areas and facilities; and

- inconsistent reporting of adverse events at federally operated facilities.

These inconsistencies are also exacerbated by significant turnover in area leadership. Officials from four of the nine area offices in our review reported that they each had at least three area directors in the past five years. According to IHS officials, the agency has not defined contingency or succession plans for the replacement of key personnel, including area directors. IHS's lack of agency-wide quality of care standards and lack of contingency and succession plans for key personnel are inconsistent with federal internal control standards. These standards suggest that agencies should establish and review performance standards and then monitor data to assess the quality of performance over time, and define contingency and succession plans for the replacement of key personnel to help IHS continue achieving its objectives. As a result, IHS officials cannot ensure that facilities are providing quality health care.

Recognizing the challenges it faces with overseeing and providing quality health care in its facilities, IHS finalized the development of a quality framework in November 2016 that outlines, at a high level, IHS's plan to develop, implement, and sustain a quality program intended to improve patient experience and ensure the delivery of reliably high quality health care. For example, the framework directs IHS to develop a quality office that will be responsible for identifying resource needs, structures, processes, and supports for an effective and sustainable quality assessment and performance improvement system. More specifically, the framework directs IHS to develop a process for monitoring select performance measures, such as measures of clinical care, patient access, and financial performance, for periodic review by leadership. The framework also explains that IHS will enhance its current patient safety reporting systems to encourage consistent use by staff. If effectively implemented, the quality framework could address the limited and inconsistent oversight of the quality of care provided in federally operated IHS facilities. As of November 2016, IHS officials stated that the agency has not yet selected quality performance measures but has plans to do so.

Contents

Abbreviations

AAAHC	Accreditation Association for Ambulatory Health Care
AI/AN	American Indian and Alaska Native
BCMA	bar code medication administration
CEO	chief executive officer
CMS	Centers for Medicare & Medicaid Services
GPRA	Government Performance and Results Act of 1993
HHS	Department of Health and Human Services
HIIN	Hospital Improvement and Innovation Network
IHS	Indian Health Service
OPM	Office of Personnel Management
PMAP	Performance Management Appraisal Program
PRC	Purchased/Referred Care
QIO	Quality Improvement Organization
RPMS	Resource and Patient Management System
SIA	systems improvement agreement

January 9, 2017

The Honorable John Barrasso, M.D.
United States Senate

The Honorable Jon Tester
United States Senate

The Indian Health Service (IHS), an agency within the Department of Health and Human Services (HHS), is charged with providing health care services to the approximately 2.2 million American Indian and Alaska Native (AI/AN) people who are members or descendants of 567 federally recognized tribes. IHS's mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. IHS provides health care services directly through a system of federally operated IHS facilities—hospitals, health clinics, and health stations operated by IHS—and also funds services provided in facilities operated by tribes or others.[1] In fiscal year 2016, IHS allocated about $1.9 billion for health services provided by federally and tribally operated hospitals, health centers, and health stations.[2] Federally operated IHS facilities, which received over 5 million outpatient visits and nearly 19 thousand inpatient admissions in 2014, provide mostly primary and emergency care, as well as some ancillary and specialty services. These

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[1]In addition to federally operated IHS facilities, some federally recognized tribes choose to operate their own health care facilities and receive IHS funding. Other operators include 34 non-profit 501 (c)(3) programs nationwide, through which AI/AN people may receive care in certain urban areas funded through grants and contracts from IHS under Title V of the Indian Health Care Improvement Act, as amended, Pub. L. No. 94-437, 90 Stat. 1400 (1976).

[2]The total enacted appropriation for IHS for fiscal year 2016 was $4.8 billion, of which approximately 60 percent was allocated to tribes to deliver clinical and preventive services. It also included $523 million for facilities maintenance and construction. Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, 1298 Stat. 2242, 2564-68 (2015).

facilities are located in nine federally designated geographic areas overseen by IHS area offices.[3]

AI/AN people born today have a life expectancy that is 4.4 years less than all races in the United States and die at higher rates than other Americans from many preventable causes, including diabetes mellitus, suicide, chronic liver disease and cirrhosis, and chronic lower respiratory diseases. Such health concerns underscore the importance of quality health care for AI/AN people. However, the quality of care provided to AI/ANs in IHS facilities has been questioned recently by the Centers for Medicare & Medicaid Services (CMS), the HHS Office of Inspector General (OIG), Congress, and tribal members.[4] In 2015 and 2016, CMS cited four facilities in the Great Plains area that were out of compliance with the minimum standards required to participate in the Medicare and Medicaid programs. During surveys of these facilities, CMS officials found serious deficiencies in the quality of care provided—including the hand-washing of surgical instruments, the failure to provide patients with appropriate medical screening examinations, and the failure to take infection control measures with a patient with a history of untreated tuberculosis.[5] In addition, during a 2016 Senate hearing about substandard quality of care at IHS facilities, tribal members testified about

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[3]Ancillary services include laboratory, diagnostic imaging, and pharmacy services. Specialty care includes services provided by cardiologists, surgeons, and other physician specialists. The nine areas are Albuquerque, Bemidji, Billings, Great Plains, Nashville, Navajo, Oklahoma City, Phoenix, and Portland. In three additional areas—Alaska, California and Tucson—all IHS facilities are tribally operated under the Indian Self-Determination and Education Assistance Act, as amended. This report covers oversight of quality of care only in federally operated IHS facilities.

[4]See, for example, Department of Health and Human Services Office of Inspector General, *Indian Health Service Hospitals: More Monitoring Needed to Ensure Quality of Care*. OEI-06-14-00010. Washington, D.C., Oct. 2016, and Department of Health and Human Services Office of Inspector General, *Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care*. OEI-06-14-00011. Washington, D.C., Oct. 2016.

[5]Two of these facilities have entered into systems improvement agreements (SIA) with CMS in order to address the long-term, systemic issues at these facilities, and they continue to participate in the Medicare and Medicaid programs. In 2015, one hospital was terminated by the Medicare program. In 2016, another hospital was cited by CMS for deficiencies in its emergency department, and according to HHS, these deficiencies were subsequently corrected.

patients being sent home from facilities without being seen, misdiagnoses resulting in patient deaths, and incorrectly prescribed medications.[6]

You asked us to examine how IHS ensures quality of care at its facilities.[7] This report examines IHS's oversight of the quality of care provided in its federally operated facilities.

To examine IHS's oversight of the quality of care provided in its federally operated facilities, we reviewed the Indian Health Manual, IHS guidance, prior GAO reports, and HHS management and employee performance documents, including executive performance agreements and HHS Performance Management Appraisal Program (PMAP) documents. We also collected information about IHS succession planning and turnover in leadership positions. We assessed the reliability of the leadership turnover data, which we obtained from the nine area offices, by conducting follow-up interviews with area officials and checking for completeness. We determined that these data were sufficiently reliable for the purposes of our reporting objective. We also reviewed documentation of area governing board meetings and facility reviews, including meeting agendas and minutes. We interviewed officials from IHS Headquarters and senior officials at all nine area offices that have oversight responsibilities for federally operated IHS facilities about how the agency has designed processes that enable it to ensure oversight of high quality health care to AI/AN people on a consistent basis. In addition, we visited two federally operated facilities in one IHS area and asked staff about how they monitor the quality of care in their facility and any specific measures or information that IHS uses to monitor the quality of care. We compared IHS oversight practices against relevant standards for internal control in the federal government.[8]

We conducted this performance audit from March 2016 through January 2017 in accordance with generally accepted government auditing

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[6]*Reexamining the Substandard Quality of Indian Health Care in the Great Plains: Oversight Hearing Before the S. Comm. on Indian Affairs*, 114th Cong. (2016).

[7]This review was conducted in response to a 2014 request from Senators Jon Tester and John Barrasso—then Chairman and Vice Chairman, Senate Indian Affairs Committee—to review how IHS ensures quality of care at its facilities.

[8]Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved. See GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: September 2014).

standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our finding and conclusions based on our audit objective.

Background

IHS was established within the Public Health Service in 1955 to provide health services to members of AI/AN tribes primarily in rural areas on or near reservations. IHS provides these services directly through a network of hospitals, clinics, and health stations operated by IHS, and it also funds services provided at tribally operated IHS facilities.[9] The federally operated system comprises 26 hospitals, 56 health centers, and 32 health stations in 33 states and received over 5 million outpatient visits and approximately 19,000 admissions in 2014. (See table 1.)

Table 1: Numbers of Federally Operated and Tribally Operated Indian Health Service Facilities, as of July 2016

Facilities	Hospitals	Health Centers	Alaska Village Clinics	Health Stations
Federal	26	56	NA	32
Tribal	19	287	163	79

Source: Indian Health Service | GAO-17-181

[9]When health care services at federally operated or tribally operated IHS facilities are not available care may be obtained in certain circumstances from external providers and paid for through IHS's Purchased/Referred Care (PRC) program. IHS also provides funding to nonprofit, urban Native American organizations through the Urban Indian Health program to provide health care services to AI/AN people living in urban areas.

Under the Indian Self-Determination and Education Assistance Act, as amended, federally recognized Indian tribes can enter into self-determination contracts or self-governance compacts with the Director of IHS to take over the administration of IHS programs for Indians previously administered by IHS on their behalf. Self-governance compacts allow tribes to consolidate and assume administration of all programs, functions, services, activities, and competitive grants administered throughout IHS, or portions thereof, that are carried out for the benefit of Indians because of their status as Indians. In contrast, self-determination contracts allow tribes to assume administration of a program, programs, or portions thereof. See 25 U.S.C. §§ 450f(a) (self-determination contracts) and 458aaa-3 (self-governance compacts). In 2016, AI/AN tribes administered over one-half of IHS resources through 19 hospitals, 287 health centers, 79 health stations, 163 Alaska village clinics, and 34 urban health programs.

Federally operated IHS hospitals range in size from 4 to 133 beds and are open 24 hours a day for emergency care needs. Health centers offer a range of care, including primary care services and at least some ancillary services, such as pharmacy, laboratory, and X-ray services, and they are open for at least 40 hours a week. Health stations offer only primary care services on a regularly scheduled basis and are open fewer than 40 hours a week.

IHS oversees its health care facilities through a decentralized system of area offices, which are led by area directors and located in 12 geographic areas. (See fig. 1 for a U.S. map showing the IHS patient population by area). Nine of these 12 IHS areas have federally operated IHS facilities—Albuquerque, Bemidji, Billings, Great Plains, Nashville, Navajo, Oklahoma City, Phoenix, and Portland.[10]

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[10] The Alaska, California, and Tucson areas do not have any federally operated IHS facilities.

Figure 1: Indian Health Service Patient Population by Area, Calendar Year 2014
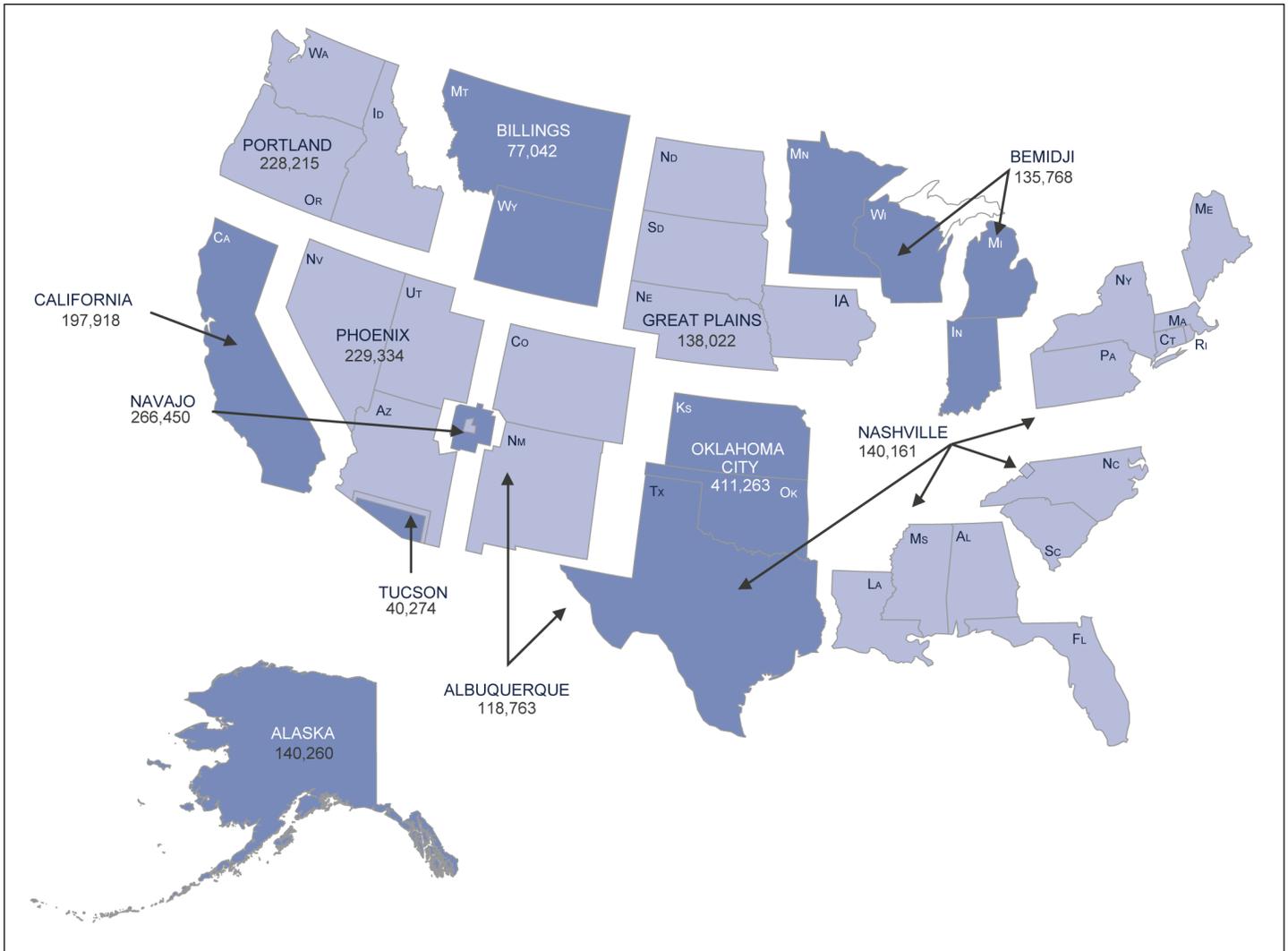
Source: Indian Health Service; Map Resources (map). | GAO-17-181

Note: The Albuquerque, Nashville, and Oklahoma City area offices oversee facilities in Texas. The Alaska, California, and Tucson areas do not have any federally operated IHS facilities.

According to IHS, the headquarters office is responsible for setting health care policy, ensuring the delivery of quality comprehensive health services, and advocating for the health needs and concerns of AI/AN people. The IHS area offices are responsible for distributing funds to the facilities in their areas, monitoring their operation, and providing guidance and technical assistance. (See fig. 2).

Figure 2: Health Care Responsibilities of Indian Health Service (IHS) Headquarters, Area Offices, and Federally Operated Facilities

IHS Headquarters
- Setting agency-wide health care policy
- Ensuring delivery of quality comprehensive services
- Advocating for health needs of AI/AN people

Area Offices
- Distributing funds to facilities
- Monitoring facility operations
- Providing guidance and technical assistance to facilities

Facilities
- Providing care to patients
- Providing other services, such as health and nutrition education and public health nursing
- Monitoring facility operations

Source: GAO. | GAO-17-181

According to IHS, its mission to raise the physical, mental, social, and spiritual health of AI/AN people to the highest level cascades through every organizational level and individual in the agency.[11] This cascading method of accountability is often used by health care organizations with a decentralized management structure and is recommended by the Office of Personnel Management (OPM) for agencies with clear organizational goals and objectives.[12] In addition, in 2009 IHS developed four agency-wide priorities that serve as a strategic framework for improvement within the agency. One of these four priorities is to improve the quality of and access to care. In 2016, IHS established the following revised agency-

[11]According to the Indian Health Manual, written performance elements are derived from the IHS Director's performance plan and are cascaded, as appropriate, to all employees. In developing the performance plan, rating officials are required to review and consider the IHS objectives and any other important goals and measures. The manual states that "the cascaded goals will impact organizational activity as well as individual performance expectations."

[12]According to OPM, expectations cascading to all employees must be: (1) aligned with organizational goals; (2) clear, specific, and understandable; (3) reasonable and attainable; (4) measurable, observable, or verifiable, and results oriented; (5) communicated in a timely fashion; and, (6) key in fostering continual improvement in productivity.

wide priorities: assess care, improve delivery of services, address behavioral health issues, strengthen management, bring health care quality expertise to IHS, and engage local resources.

IHS's Oversight of the Quality of Care Provided in Its Facilities Has Been Limited and Inconsistent, but IHS Has Drafted New Oversight Initiatives

IHS's Oversight of the Quality of Care Provided in Its Facilities Has Been Limited and Inconsistent

IHS's oversight of the quality of care provided in its federally operated facilities has been limited and inconsistent. While some oversight functions are performed at the headquarters level, the agency has delegated primary responsibility for the oversight of the quality of care to the area offices. Area officials told us that the oversight they provide has generally included (1) holding periodic meetings with facility staff, such as governing board and other meetings; (2) reviewing available quality performance data; (3) reviewing data on adverse events occurring in their facilities; (4) monitoring compliance with facility certification and accreditation requirements; and (5) appraising employee performance.[13] However, our review found that this oversight was limited and inconsistent across IHS areas and facilities, in part due to a lack of agency-wide quality performance standards and significant leadership turnover in some offices.

- **Meeting with facility staff.** Officials from all nine of the area offices that oversee federally operated IHS facilities told us that they monitor the quality of care provided by facilities through periodic meetings with facility staff—including governing board meetings and other meetings. However, according to area office officials, the frequency of these

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[13]Adverse events are incidents that pose a risk of injury to a patient as the result of a medical intervention or the lack of an appropriate intervention, such as a missed or delayed diagnosis.

meetings varies widely by area. In general, these meetings are used to discuss a range of issues, such as quality of care, equipment problems, staff vacancies, and provider credentialing. For example, documentation of a governing board meeting with facility staff in the Phoenix area shows that board members and staff discussed a problem with the facility's wireless internet connection, which was negatively affecting their bar code medication administration (BCMA) system.[14] A board member noted that these connectivity issues caused a patient safety risk, but another board member noted that they had a short-term resolution in place and area office officials were working with the wireless carrier to resolve the problem over the long-term. Area offices vary, however, as to whether, or to what extent, these meetings focus on the quality of care. For example, officials from one area office stated that their governing board meetings include a standardized agenda that includes quality of care items, and that facilities are required to submit data reports that include information on quality issues such as rates of hospital acquired infections, patient complaints, and provider productivity. In contrast, officials from another area office told us that there are no standing agenda items for the discussion of quality of care, and that facility staff set the meeting agendas based on issues they want to discuss. Furthermore, the frequency of governing board meetings with facility staff varied widely among the area offices, ranging from quarterly to annually.

- **Reviewing available quality performance data.** According to IHS officials, clinical quality performance data are generally collected and reported consistently to IHS's area and headquarters offices in response to requirements in the Government Performance and Results Act of 1993 (GPRA), but other data used to oversee the quality of care provided in facilities are not reported or reviewed consistently across IHS. Officials from all nine area offices in our review stated that they periodically review reports showing facility progress in meeting 24 annual GPRA clinical performance measure targets. These performance measures focus on health screening and prevention activities, such as cancer screening, immunization rates, and tobacco cessation activities, and do not include broader

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[14]A BCMA system generally consists of a barcode reader, a portable or desktop computer with wireless connection, a computer server, and software. When a nurse gives medication to a patient in a health care setting, the nurse can scan a barcode on the patient's wristband to make sure that the patient is the correct patient. The nurse can then scan the barcode on the medicine to verify that it is the correct medicine at the correct dose and time and is being administered by the correct route.

measures of quality, such as whether patients are receiving proper diagnoses and medications, and the extent to which facility staff properly perform infection control activities. Area officials reported that they review other quality performance data, such as the percentage of medication orders reviewed for therapeutic duplication, the number of mislabeled laboratory specimens, and patient satisfaction, but these data are not consistently obtained or reviewed by all area offices because IHS has not required that they be reviewed or reported. In addition, staff from the two facilities in our review told us that limitations of IHS's electronic health record system—the Resource and Patient Management System (RPMS)—also contribute to variation in the quality performance data that are collected and reported to area offices. For example, staff told us that certain data elements, such as patient diagnoses, are difficult to extract from RPMS. Officials from facilities and area offices said that pulling these data may require special modifications to RPMS. Officials said that modifying RPMS requires knowledge of computer programming and can be costly, so some facility staff may manually enter and extract certain data. Officials from several areas also told us that some facilities have hired contractors or purchased software to assist them in monitoring their data. One such software package—QlikView— provides facility staff with multiple data reporting options. Staff from one facility said that, from an information technology standpoint, they face "massively complicated issues" when the lack of a standardized user interface leads to individual facilities across IHS customizing RPMS for their own needs. IHS officials told us that they are working on improving RPMS, in part, by developing software to stabilize the system; however, we have not assessed these efforts.

- **Monitoring adverse events**. Officials from all nine area offices told us that their oversight of the quality of care includes monitoring adverse events that occur at IHS facilities, such as medication errors or patient falls, and taking steps to prevent future adverse events. While all IHS facilities have the means to report and monitor adverse events through an IHS-wide web-based reporting tool—WebCident— officials told us reporting adverse events through WebCident has been inconsistent. Officials from one area office stated that adverse events are not always reported through WebCident, and therefore the appropriate staff are often not notified when adverse events occur, including those resulting in patient harm. These officials stated that this creates a lost opportunity to address the deficiency and improve, as well as to hold individuals accountable. Officials from IHS headquarters reported that they plan to enhance this reporting system

to encourage consistent use by facility staff, or replace it with a new system after January 2017.

- **Monitoring compliance with facility certification and accreditation requirements.** Officials from all nine area offices in our review told us that they monitor the ongoing compliance with certification and accreditation requirements of the facilities in their area—such as through mock surveys and other interim monitoring—to help ensure that they maintain their certification by CMS to participate in the Medicare and Medicaid programs, as well as their accreditation by accrediting bodies such as The Joint Commission and the Accreditation Association for Ambulatory Health Care (AAAHC).[15] For example, documentation of a mock survey of a facility in the Phoenix area states that the facility emergency department was improperly storing contaminated medical instruments. In addition, documentation of a mock survey of a facility in the Albuquerque area states that the surveyors found defective lead aprons, as well as a high-voltage power line sitting on the floor instead of behind a wall, and exposed electrical wiring blocking the door and wrapped around a door handle—which the surveyors concluded could be a serious hazard. These findings underscore the need for such surveys, but the frequency with which these mock surveys have been conducted varies by area. Officials from one area office told us that they have conducted mock accreditation surveys of facilities in their area annually for the past 15 years. Officials from other area offices stated that they have recently begun performing such mock surveys.[16] IHS officials told us that in May 2016, IHS began a system-wide mock survey initiative at all 26 federally operated hospitals to assess compliance with the CMS Conditions of Participation and readiness for reaccreditation.[17] Surveys conducted by CMS and accrediting bodies are relatively infrequent, however, and this infrequency highlights the importance of interim monitoring. For instance, area office staff told us that The Joint Commission conducts site visits

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[15]Mock surveys assess facility compliance with accreditation or certification standards and include surveyors who observe and interview staff and review patient records to help identify issues related to patient safety and quality.

[16]IHS policy states that facilities must meet requirements of a nationally recognized accrediting or certifying body.

[17]IHS officials reported that they developed a corrective action plan process in November 2016 to catalog survey findings and track remediation efforts. Additionally, in July 2016, IHS awarded a one-year contract to The Joint Commission for accreditation, training and education services to strengthen quality and patient safety.

every 3 years, and, while CMS attempts to conduct site visits every 3 to 4 years, staff of one facility we visited stated that CMS had not surveyed the facility in 10 years.[18]

- **Appraising employee performance.** According to IHS, area directors are held accountable for achieving agency-wide goals and specific performance objectives through an appraisal process that also enables these goals and objectives to cascade down to chief executive officers (CEO) at individual facilities and to all agency employees. Area directors sign performance agreements documenting their accountability. The fiscal year 2016 performance requirements included a provision on ensuring that all IHS operated health care facilities achieve and maintain accreditation or certification by a national health care organization in fiscal year 2016. The performance requirements also included a provision on quality care that requires documentation of the implementation of "at least two activities to improve wait times and access to quality health care for patients that are based on enhanced implementation of current quality initiatives or new quality initiatives and that have measurable goals, measures and outcomes," as well as improvements resulting from these efforts. However, area officials can choose activities to satisfy this requirement from a list of suggestions—such as improving customer service and expanding clinic hours—without directly addressing the quality of care in their facilities.
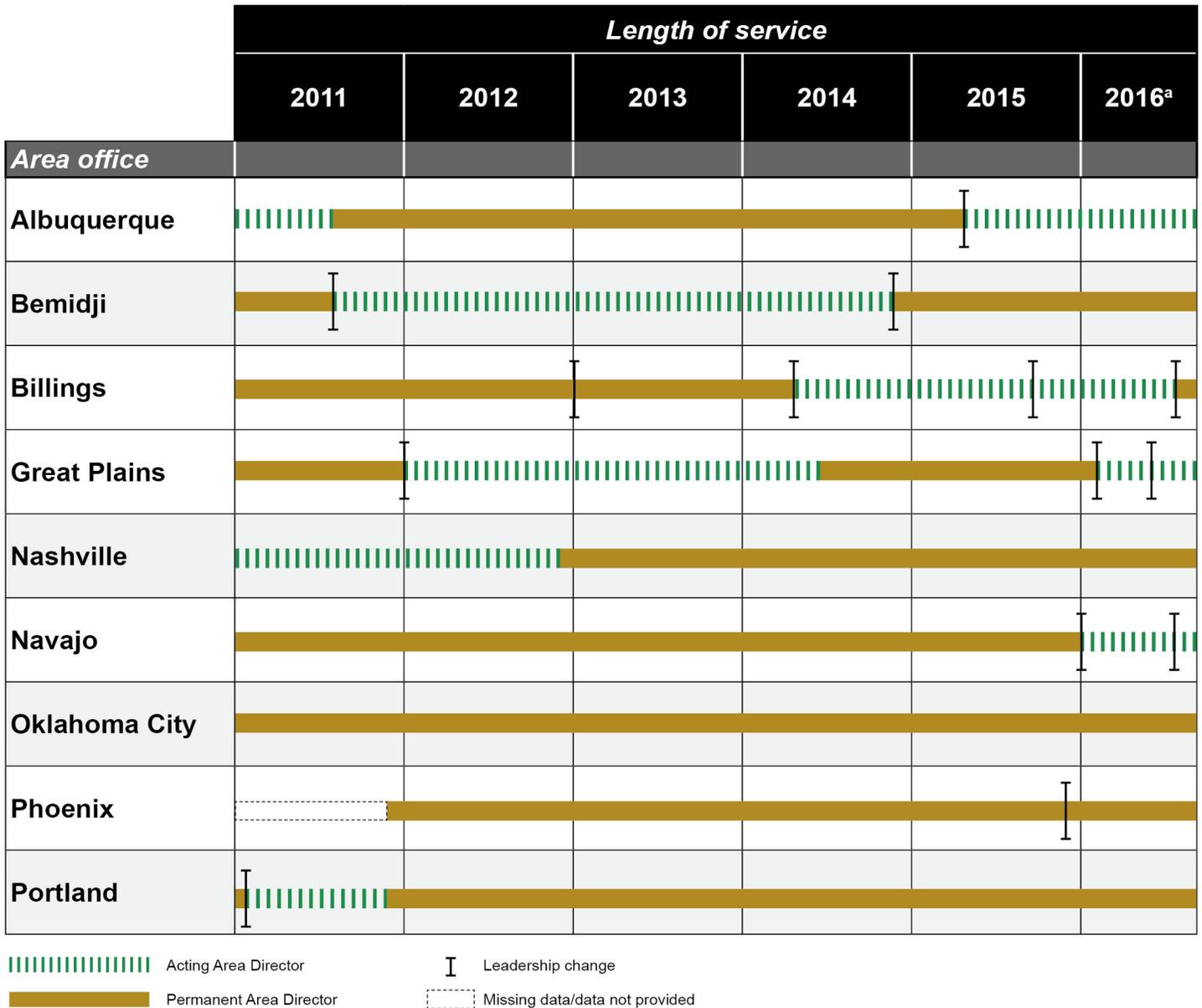
These inconsistencies are exacerbated by significant turnover in area leadership. Officials from four of the nine area offices in our review reported that they had at least three area directors in the past 5 years, and officials from three area offices reported that they had at least three chief medical officers.[19] (See fig. 3 and 4).

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[18]In addition, one area has facilities accredited by Det Norske Veritas (DNV), which conducts site visits annually.

[19] In addition, area offices reported 19 federally operated facilities that had 4 or more CEOs in the past 5 years. One area reported that one of its hospitals had 10 CEOs and 6 clinical directors in the past 5 years.

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Figure 3: Reported Indian Health Service (IHS) Area Director Turnover, January 2011 through July 2016

Length of service						
2011	**2012**	**2013**	**2014**	**2015**	**2016**[a]

Area office						
Albuquerque						
Bemidji						
Billings						
Great Plains						
Nashville						
Navajo						
Oklahoma City						
Phoenix						
Portland						

|||||| Acting Area Director

━━━ Permanent Area Director
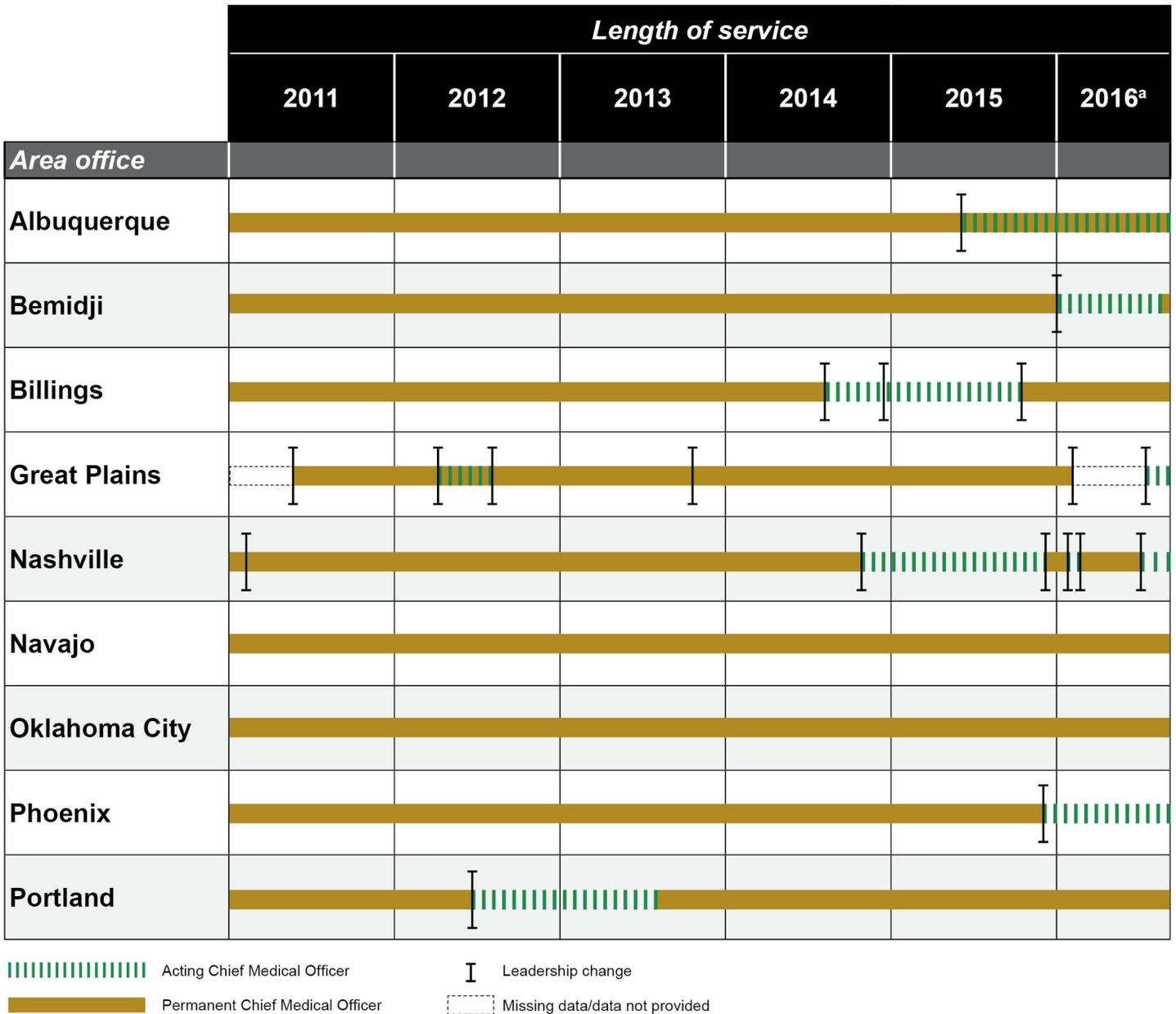
I Leadership change

⌐¬ Missing data/data not provided

Source: GAO analysis of IHS data. | GAO-17-181

Note: This figure reflects the number of positions held for a designated time period. One individual could be counted multiple times if that individual held both acting and permanent positions for different non-adjacent time periods. In four areas—Albuquerque, Great Plains, Nashville, and Portland—an acting director transitioned to a permanent position. In these situations, we counted this as one area director.

[a]Area officials reported information through July 2016.

Figure 4: Reported Indian Health Service (IHS) Area Chief Medical Officer Turnover, January 2011 through July 2016

Area office	Length of service					
	2011	**2012**	**2013**	**2014**	**2015**	**2016**[a]
Albuquerque						
Bemidji						
Billings						
Great Plains						
Nashville						
Navajo						
Oklahoma City						
Phoenix						
Portland						

||||| Acting Chief Medical Officer   I Leadership change

▬ Permanent Chief Medical Officer   ⌐ ⌐ Missing data/data not provided

Source: GAO analysis of IHS data. | GAO-17-181

Note: This figure reflects the number of positions held for a designated time period. One individual could be counted multiple times if that individual held both acting and permanent positions for different non-adjacent time periods. In two areas—Bemidji and Portland—an acting chief medical officer transitioned to a permanent position. In these situations, we counted this as one chief medical officer. The Great Plains area office reported that an acting chief medical officer filled in from April

2012 to August 2012 while the permanent chief medical officer was on medical leave. The Great Plains area office reported having a total of four chief medical officers from July 2011 through July 2016.

[a]Area officials reported information through July 2016.

Officials stated that inconsistent area office and facility leadership is detrimental to the oversight of facility operations and the supervision of personnel. For example, officials from multiple area offices told us that frequent leadership turnover can lead to instability in oversight initiatives if these initiatives are started but not completed. In addition, an area office's review of a facility in the Navajo area documented that the majority of facility staff interviewed felt that there were too many people in acting leadership positions, that acting leaders were afraid to commit to decisions, and that the leaders needed additional supervisory training. In addition, the facility staff interviewed stated that those in acting leadership positions had their own work to contend with and were not always responsive to the responsibilities of the leadership position. According to IHS officials, the agency has not defined contingency or succession plans for the replacement of key personnel, including area directors. See appendix I for additional information on leadership turnover within IHS.

IHS's limited and inconsistent agency-wide oversight of the quality of care in its federally operated facilities, as well as its lack of contingency and succession plans for key personnel, is inconsistent with federal internal control standards. These standards suggest that agencies should establish and review performance standards and then monitor data to assess the quality of performance over time, and that agencies should define contingency and succession plans for key roles to help continue achieving objectives.[20] As a result of IHS's lack of consistent agency-wide quality performance standards, as well as the significant turnover in area leadership, IHS officials cannot ensure that facilities are providing quality health care to their patients, and therefore that the agency is making steps toward fulfilling its mission to raise the physical, mental, social, and spiritual health of AI/AN people to the highest level.

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[20]According to federal internal control standards, effective monitoring assesses the quality of performance over time and promptly resolves the findings of audits and other reviews. Monitoring includes evaluations that may take the form of self-assessments and includes policies and procedures for ensuring that any audit and review findings and recommendations are brought to the attention of management and are resolved promptly. In addition, an effective control environment defines contingency and succession plans for key roles to help the entity continue achieving its objectives. Succession plans address the entity's need to replace competent personnel over the long term, whereas contingency plans address the entity's need to respond to sudden personnel changes that could compromise the internal control system. See GAO-14-704G.

IHS Developed a Quality Framework, but Has Just Begun to Implement Planned Changes

Recognizing some of the challenges it faces with overseeing and providing quality health care in its facilities, IHS finalized the development of a quality framework in November 2016 that outlines, at a high level, IHS's vision, goals, and priorities to develop, implement, and sustain an effective quality program that is intended to improve patient experience and ensure the delivery of reliably high quality health care for IHS direct service facilities.[21] According to IHS, the priorities of the framework are to (1) strengthen organizational capacity to improve quality of care and systems, (2) meet and maintain accreditation for federally operated facilities, (3) align service delivery processes to improve patient experience, (4) ensure patient safety, and (5) improve transparency and communication regarding patient safety and quality to IHS stakeholders. While this framework is focused on initiatives related to improving the quality of care provided in its facilities—such as increasing staff training and technical assistance on achieving compliance with quality and safety standards, promoting a culture of patient safety, and developing a patient perception survey process—elements of the framework also describe IHS plans to improve oversight. For example, the framework directs IHS to establish a quality office that will be responsible for assessing area office and facility functions, staffing, and critical quality assurance activities. This quality office is to be developed as part of an overall realignment of offices in IHS, and according to the framework, the office will be responsible for identifying resource needs, structures, processes, and supports for an effective and sustainable quality assessment and performance improvement system. More specifically, the framework directs IHS to develop a process for monitoring performance measures, such as measures of clinical care, patient access, and financial performance, for periodic review by leadership. In addition, IHS's quality framework states that the agency will implement annual mock accreditation surveys for all federally operated facilities and develop a standardized governing board structure to improve planning and oversight

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[21]IHS officials reported that they plan to review and update the quality framework annually. See *Indian Health Service Quality Framework, 2016-2017*, Nov. 2016. IHS also developed a quality framework implementation plan with estimated completion dates for certain items in the framework. See *Indian Health Service Quality Framework Implementation Plan*, Nov. 2016.

processes.[22] The framework says that "transparency and accountability will be fostered through regular and frequent (i.e., monthly or quarterly) communications" between offices. The framework also explains that IHS will enhance its adverse event reporting system to encourage consistent use by facility staff, or replace it with a new system after January 2017.[23]

If effectively implemented, the quality framework could address the limited and inconsistent oversight of the quality of care provided in federally operated IHS facilities. However, as of November 2016, the quality office had not yet been formed, and officials told us the agency's plan for realigning offices was out for tribal review and comment. In addition, IHS officials stated that the agency has not yet selected quality performance measures but has plans to do so.[24] Furthermore, the quality framework states that IHS will support enhanced efforts to recruit and retain highly qualified executives. While IHS officials reported that they are implementing strategies to recruit and retain staff, the quality framework does not specifically mention contingency or succession plans for key personnel.

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[22]According to IHS, the annual mock survey initiative began in the Great Plains area with surveys and, when appropriate, interventions through the provision of on-site assistance to hospital staff. In addition, although some direct service hospitals currently conduct their own mock surveys, IHS reported that it is standardizing and improving this process so that federally operated hospitals receive a consistent assessment and that performance data are centrally tracked. In July 2016, IHS awarded a one-year contract to The Joint Commission for accreditation, training, and education services to strengthen quality and patient safety.

[23]In addition to the improvement and oversight initiatives included in IHS's quality framework, IHS is engaging in other quality improvement efforts. For example, IHS officials reported that the agency is working collaboratively with CMS to bring in targeted quality improvement assistance through CMS's 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. Additionally, CMS now includes federally operated IHS hospitals in the nationwide Hospital Improvement and Innovation Networks (HIINs) contract for public and private sector hospitals to reduce adverse events by 20 percent and hospital readmissions by 12 percent. On November 10, 2016, CMS and IHS announced that CMS recently awarded $347 million to 16 national, regional, or state hospital associations and health system organizations to serve as HIINs.

[24]IHS officials told us that IHS plans to build upon the GPRA measures and other measures currently in use to establish consistent quality standards across IHS.

Conclusions

American Indians and Alaska Natives die at higher rates than other Americans from many causes—such as lower respiratory infections and complications from diabetes—that can be mitigated through access to quality health care services, and concerns continue to be raised about the quality of care provided in federally operated IHS facilities, including misdiagnoses, incorrectly prescribed medications, and unsafe facility conditions. Despite IHS's mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level, IHS's oversight of the quality of care in its federally operated facilities has been limited and inconsistent. In addition, several of the area offices in our review experienced frequent leadership turnover with no contingency or succession plans.

While IHS has recognized the need for quality improvement and has drafted a quality framework to improve the oversight of the quality of care provided, it has not yet developed quality performance standards. Until IHS develops agency-wide standards for the quality of care provided in its federally operated facilities, systematically monitors facility performance in meeting these standards at all facilities, and develops contingency and succession plans for key personnel to address its significant leadership turnover, it cannot ensure that it is consistently providing quality medical care to the AI/AN population served in its facilities.

Recommendations

To help ensure that quality care is provided to AI/AN people, the Secretary of HHS should direct the Director of IHS to take the following two actions:

1. As part of the implementation of its quality framework, ensure that agency-wide standards for the quality of care provided in its federally operated facilities are developed, that facility performance in meeting these standards is systematically monitored over time, and that enhancements are made to its adverse event reporting system.

2. Develop contingency and succession plans for the replacement of key personnel, including area directors.

Agency Comments and our Evaluation

We provided a draft of this report to HHS for its review and comment. HHS provided written comments, which are reproduced in appendix II. HHS concurred with both of our recommendations.

In its comments, HHS elaborated on steps that IHS has started taking to improve its oversight of the quality of care provided in its federally

operated facilities, which we describe in our report. Specifically, HHS described the development of IHS's quality framework and quality office, plans to develop agency-wide quality measures, the standardization of governing board by-laws, plans to enhance or replace its adverse event reporting system, and its annual mock survey initiative. In its comments, HHS also described IHS's corrective action plan process related to the mock survey initiative, and we added this information to our report. HHS also provided information on steps that IHS is taking to improve the quality of care in its federally operated facilities, including steps taken toward the automation and systemization of provider credentialing.

Regarding our second recommendation to develop contingency and succession plans for the replacement of key personnel, including area directors, HHS stated that IHS has already begun to address this recommendation. For instance, HHS reported that on December 2, 2016, IHS distributed succession planning instructions and descriptions of the competencies associated with each position in IHS headquarters, area offices, and facilities to all headquarters office directors and area directors. In addition, HHS reported that IHS has contingency plans in place to ensure continuity of operations in emergency situations. However, as explained in our report, standards for internal control in the federal government state that the agency should have contingency plans in place to respond to sudden personnel changes, which would include non-emergency situations as well.

HHS also provided technical comments, which we incorporated where appropriate.

We are sending a copy of this report to the Secretary of the Department of Health and Human Services. The report will be available at no charge on GAO's website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or kingk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page

of this report. GAO staff who made key contributions to this report are listed in appendix III.

Kathleen M. King
Director, Health Care

Appendix I: Information on Leadership Turnover at IHS Area Offices and Facilities

Officials from some area offices in our review reported significant turnover of staff in area office leadership positions. Officials from four of the nine area offices in our review reported that they had at least three area directors in the past 5 years, and three area offices reported that they had at least three chief medical officers. See table 2.

Table 2: Reported Indian Health Service (IHS) Area Office Leadership, January 2011 through July 2016

	Area Director Position		Chief Medical Officer Position	
	Number of area directors	**Number of these area directors in "acting" status**	**Number of chief medical officers**	**Number of these chief medical officers in "acting" status**
Albuquerque	2	1	2	1
Bemidji	3	1	2	0
Billings	5	2	4	2
Great Plains	4	2	4	2
Nashville	1	0	6	3
Navajo	3	2	1	0
Oklahoma City	1	0	1	0
Phoenix	2	0	2	1
Portland	2	0	2	0

Source: GAO Analysis of IHS facility data. | GAO-17-181

Note: This table reflects the number of positions held for a designated time period. One individual could be counted multiple times if that individual held both acting and permanent positions for different non-adjacent time periods. In four areas—Albuquerque, Great Plains, Nashville, and Portland—an acting director transitioned to a permanent position. In these situations, we counted this as one area director. In two areas—Bemidji and Portland—an acting chief medical officer transitioned to a permanent position. In these situations, we counted this as one chief medical officer.

In addition, area offices reported 19 federally operated facilities that had 4 or more chief executive officers (CEO) in the past 5 years. One area reported that one of its hospitals had 10 CEOs and 6 clinical directors in the past 5 years. See table 3.

Table 3: Reported Indian Health Service (IHS) Facility Leadership, January 2011 through July 2016

Facility Name	Chief Executive Officer Position		Clinical Director Position	
	Number of chief executive officers (CEO)	Number of these CEOs in "acting" status	Number of clinical directors	Number of these clinical directors in "acting" status
Albuquerque				
Albuquerque Dental Clinic	1	0	3	1
Albuquerque Service Unit[a]	5	2	3	2
Acoma-Canoncito-Laguna Service Unit	5	3	6	3
New Sunrise Regional Treatment Center	6	3	4	2
Jicarilla Service Unit	1	0	1	0
Mescalero Service Unit	1	0	3	2
Santa Fe Service Unit	2	1	1	0
Ute Mountain Ute Health Center	2	1	1	0
Taos Service Unit	6	3	3	1
Zuni Service Unit	1	0	2	0
Bemidji				
Cass Lake Hospital	3	1	1	0
Red Lake Hospital	8	5	1	0
White Earth Health Center	10	6	6	3
Billings				
Fort Belknap Service Unit	3	1	9	8
Crow Service Unit	5	2	4	1
Blackfeet Service Unit	5	2	1	0
Wind River Service Unit	3	1	5	0
Northern Cheyenne Service Unit	1	0	5	3
Fort Peck Service Unit	1	0	5	3
Great Plains				
Sisseton Service Unit	5	3	4	3
Rosebud Service Unit	7	5	5	3
Cheyenne River Service Unit	2	0	4	2
Wagner Service Unit	1	0	1	0
Ft. Thompson Service Unit	3	2	1	0
Belcourt Service Unit	2	1	2	*
Standing Rock Service Unit (Ft. Yates)	5	2	4	1
McLaughlin Health Center[b]	4	2	*	*

	Chief Executive Officer Position		Clinical Director Position	
Facility Name	**Number of chief executive officers (CEO)**	**Number of these CEOs in "acting" status**	**Number of clinical directors**	**Number of these clinical directors in "acting" status**
Lower Brule Service Unit	4	1	2	0
Rapid City Service Unit	4	3	3	1
Kyle Health Center[c]	1	0	1	0
Omaha/Winnebago Hospital	10	8	7	5
Wanblee Health Center[d]	1	0	2	1
Youth Regional Treatment Center	1	0	5	2
Pine Ridge Service Unit	3	0	1	0
Nashville				
Micmac Service Unit[a]	1	0	2	0
Catawba Service Unit[a]	1	0	1	0
Mashpee Service Unit	1	0	4	2
Navajo				
Gallup Indian Medical Center	2	0	2	0
Crownpoint Healthcare Facility	1	0	*	0
Northern Navajo Medical Center	1	0	3	0
Chinle Comprehensive Health Care Facility	1	0	2	0
Kayenta Health Center	3	0	1	0
Oklahoma City				
Claremore Indian Hospital	1	0	7	5
Lawton Indian Hospital	3	1	4	1
Pawnee Indian Health Center	1	0	1	0
Wewoka Indian Health Center	2	0	1	0
Clinton Indian Health Center	4	2	4	2
Haskell Indian Health Center	8	5	5	3
Phoenix				
Phoenix Indian Medical Center	5	2	2	1
Colorado River Service Unit	3	2	3	2
Hopi Health Care Center	2	0	1	0
Fort Yuma Service Unit	2	1	4	1
Schurz Service Unit	2	1	1	0
Whiteriver Service Unit	1	0	6	3
Uintah & Ouray Service Unit	4	1	2	0
Desert Visions Regional Treatment Center	2	0	1	0

	Chief Executive Officer Position		Clinical Director Position	
Facility Name	**Number of chief executive officers (CEO)**	**Number of these CEOs in "acting" status**	**Number of clinical directors**	**Number of these clinical directors in "acting" status**
Portland				
Colville Service Unit	3	1	4	2
Wellpinit Service Unit	3	1	2	0
Yakama Service Unit	2	1	2	0
Western Oregon Service Unit	2	0	1	0
Warm Springs Service Unit	1	0	2	0
Fort Hall Service Unit	1	0	3	2

Source: GAO Analysis of IHS facility data. | GAO-17-181

Note: * indicates missing or incomplete information. This figure reflects the number of positions held for a designated time period. One individual could be counted multiple times if that individual held both acting and permanent positions for different non-adjacent time periods. At facilities in 5 areas—Albuquerque, Great Plains, Nashville, Oklahoma City, and Portland—an acting CEO transitioned to a permanent position. In these situations, we counted this as one CEO. At facilities in two areas—Albuquerque and Bemidji—an acting clinical director transitioned to a permanent position. In these situations, we counted this as one clinical director.

[a]The Albuquerque Service Unit, Micmac Service Unit, and the Catawba Service Unit each reported vacancies in the clinical director position during this 5-year time period.

[b]The McLaughlin Health Center is part of the Standing Rock service unit. The Fort Yates Hospital has a Chief Executive Officer. The McLaughlin Health Center has a Health Systems Administrator.

[c]The Kyle Health Center is part of the Pine Ridge service unit. The Pine Ridge Hospital has a Chief Executive Officer. The Kyle Health Center has a Health Systems Administrator.

[d]The Wanblee Health Center is part of the Pine Ridge service unit. The Pine Ridge Hospital has a Chief Executive Officer. The Wanblee Health Center has a Health Systems Administrator.

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

DEC 1 4 2016

Kathleen M. King
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. King:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*INDIAN HEALTH SERVICE: Actions Needed to Improve Oversight of Quality of Care*" (GAO-17-181).

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

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN
SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT
REPORT ENTITLED: INDIAN HEALTH SERVICE: ACTIONS NEEDED TO IMPROVE
OVERSIGHT OF QUALITY OF CARE (GAO-17-181)**

The U.S. Department of Health and Human Services (HHS) appreciates the opportunity from the
Government Accountability Office (GAO) to review and comment on this draft report.

GAO Recommendations

To help ensure that quality care is provided to American Indian and Alaska Native (AI/AN)
people, the Secretary of HHS should direct the Director of the Indian Health Service (IHS) to
take the following two actions:

1. As part of the implementation of its quality framework, ensure that agency-wide
    standards for the quality of care provided in its federally operated facilities are
    developed, that facility performance in meeting these standards is systematically
    monitored over time, and that enhancements are made to its adverse event reporting
    system.
2. Develop contingency and succession plans for the replacement of key personnel,
    including area directors.

HHS Response – Recommendation 1:

HHS concurs with GAO's recommendation and work is already underway to address the quality
concerns outlined in the report. In early summer 2016, the Principal Deputy Director of IHS
charged senior IHS leaders with developing an organizational approach to guide the Agency's
strategic vision for quality and patient safety. This work culminated in the development of the
IHS Quality Framework and Implementation Plan, released in November 2016. The Quality
Framework (QF) was developed by assessing current IHS quality policies, practices, and
programs, incorporating standards from national experts, consulting with tribal leaders and
including best practices from across the IHS system of care, as well as leveraging resources
across HHS through the Executive Council on Quality Care. Quality priorities outlined in the
Framework are:

- Strengthen Organizational Capacity to Improve Quality of Care and Systems;
- Meet and Maintain Accreditation for IHS Direct Service Facilities;
- Align Service Delivery Processes to Improve Patient Experience;
- Ensure Patient Safety; and
- Improve Transparency and Communication Regarding Patient Safety and Quality to IHS
  Stakeholders.

We believe that when fully implemented, the QF will provide the strategic infrastructure to
achieve IHS's mission "to raise the physical, mental, social, and spiritual health of AI/AN to the
highest level."

Develop Agency-wide Standards for the Quality of Care in Federally Operated Facilities

Agency-level Quality Leadership

1

<u>**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN
SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT
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OVERSIGHT OF QUALITY OF CARE (GAO-17-181)**</u>

Establishing a strategic and organized approach to the management and oversight of quality at
the Agency-level, in close coordination and collaboration with the Area Offices and Service
Units, is critical to assuring the delivery of safe and high quality care at the Area Office and
Service Unit levels. The implementation of the QF provides the roadmap for the Agency
regarding clinical quality and patient safety. A key priority of the QF is the establishment of an
Office of Quality Health Care within the Office of the Director at IHS Headquarters (HQ). The
new Office of Quality Health Care, proposed as part of the realignment of the IHS HQ, is
responsible for implementing the QF and other quality and patient safety functions, including
setting Agency-wide standards for care and service and assuring Agency-wide adherence to these
standards. The Office of Quality Health Care will be under the oversight of a newly appointed
Associate Director for Quality. We have been actively recruiting for the Associate Deputy
Director of Quality position, and IHS expects to have the position filled by early 2017. A Senior
Quality Officer position was posted in December 2016, and is expected to be filled in early 2017
as well. To assure immediate implementation of the QF, the IHS Principal Deputy Director has
charged a Steering Committee, comprised of senior level quality and patient safety professionals
from IHS and other HHS agencies to oversee the execution of the QF initiatives.

Active engagement among Area Office leadership, IHS HQ leadership, and HQ quality staff is
essential to assuring timely communication and problem-solving. Beginning in November 2016,
weekly meetings were initiated with the Area Directors, the Area Chief Medical Officers, and
HQ staff to provide a forum for discussion of issues related to the QF. These meetings are a
venue to identify opportunities for performance improvement in the areas of patient safety and
care quality. These weekly meetings ensure Area-level engagement in quality, safety, and
operational matters.

Quality of Care Standards/National Accreditation/Certification

Assuring a high quality and safe care environment requires a multi-level and cascading approach,
which includes the certification and/or accreditation by national oversight entities, including the
Centers for Medicare & Medicaid Services (CMS) and other accrediting bodies, as well as the
development and deployment of Agency-wide standards of care and practice.

Achieving accreditation and/or certification by a nationally recognized entity provides a
benchmark that is universally recognized as a measure of quality and safety. IHS's current
standards are to meet all CMS Conditions of Participation. Additionally, many of the IHS service
units have adopted Joint Commission accreditation standards for quality and safety. Under the
QF plan, adoption of one set of standards will be the goal across all hospitals. To achieve this
goal, since June 2016, IHS has taken the following actions to facilitate accreditation/certification
of all IHS direct service facilities:

- Awarded a one-year contract for $700,000 to The Joint Commission Resources for technical
  assistance, training, and education services focused on facilitating compliance with CMS
  CoPs for IHS federally operated medical facilities in the Great Plains Area.

2

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN
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OVERSIGHT OF QUALITY OF CARE (GAO-17-181)**

- Established a formal partnership with the CMS through a contract awarded in October 2016
  to support best health care practices and other operational improvements for IHS federally
  operated hospitals that participate in the Medicare program. HealthInsight, a current Quality
  Innovation Network – Quality Improvement Organization (QIN-QIO) under CMS contract,
  is partnering with IHS hospitals focused on continuously improving the quality of care for
  the Medicare patients they serve. The overarching goals for the QIN-QIO are to support,
  build, and redesign, if needed, IHS hospital operating infrastructure in order to provide high
  quality health care services to Medicare beneficiaries. This work focuses on leadership, staff
  development, data acquisition and analytics, clinical standards of care, and quality of care
  related to the Medicare program.

- In May 2016, implemented a requirement to conduct annual mock surveys at all Service
  Units to assure continual accreditation/certification readiness. Oversight of this program
  rests jointly with the Area Offices and Agency Headquarters.
    o A meta-analysis of the first set of annual IHS mock survey findings has been
      completed. This analysis identified system-wide opportunities for standardizing select
      policies and facilitates tracking of individual Service Unit performance and Agency-
      wide compliance over time.

- Developed a "Corrective Action Plan" (CAP) process in November 2016 that each Service
  Unit will use to catalog all survey findings as well as to track remediation efforts. The CAP
  includes specific and rigorous timelines for the development and implementation of
  remediation activities. The CAPs are reviewed and tracked by the Area Office leadership as
  well as by the HQ Office of Quality Health Care (when established) for progress toward
  resolution of survey findings.

Agency-Wide Quality and Patient Safety Standards

Attainment of national accreditation or certification requires an organizational infrastructure of
policies, procedures, and performance standards at the system-level as well as the Service Unit
level. Within IHS, there are hospitals and ambulatory care facilities that demonstrate best
practices, deliver high quality and safe care, and achieve positive patient outcomes. However, as
the GAO report indicates, variation exists between and among Service Units and Area Offices.
To assure consistent delivery of high quality care, IHS must assure that each of the Service Units
operates with adherence to national accreditation and certification standards. IHS has identified
care processes and policies for which standardization will improve the quality and safety of care
and work is currently underway.

- *Standardizing Governing Board Bylaws* - As noted in the GAO report, Governing Board
  practices vary among IHS Area Offices. To address this issue, the QF Steering Committee
  conducted a comprehensive assessment of all Area and Service Unit Governing Board
  bylaws and is developing a standardized bylaws template to be used by all Service Unit
  Governing Boards. The standard bylaws will include: minimum membership of the
  Governing Board consisting of Area Office leadership while allowing for optional

3

<u>GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN
SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT
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OVERSIGHT OF QUALITY OF CARE (GAO-17-181)</u>

membership of Service Unit leaders; minimum frequency of meetings set at two annual
meetings; and, required agenda items for all Governing Board meetings including Quality,
Safety, and Operations. Service Unit Governing Boards may customize through additions to
the bylaws template to meet Service Unit-specific conditions or circumstances; however,
these proposed changes must be explicitly approved by the Area Office. The deployment of
the Agency-wide standardized Governing Board bylaws will be complete by the end of
January 2017.

- *Credentialing Practices* - An Agency-wide assessment of credentialing practices at the Area
  Offices revealed variation in this important quality process. In an effort to transform IHS
  credentialing into an automated, paperless, accessible, and efficient business process, IHS
  has secured a contractor to assist in identifying an appropriate commercial off-the-shelf
  (COTS) product to automate and systematize credentialing across the IHS system. The
  credentialing analysis final reports were received and a leadership briefing occurred on
  December 12, 2016. An Acquisition Plan, IT Business Case, and Scope of Work are under
  development for the implementation phase. IHS HQ will procure the system centrally and
  implement the new system across nine direct service Areas.

Systemically Monitor Facility Performance in Meeting Standards

IHS has several performance measurement programs in place; including, Government
Performance and Results Act of 1993 (GPRA). In addition, some Area Offices and Service
Units have mature and comprehensive programs to monitor clinical quality and patient safety
using an array of structure, process and outcome measures and including the use of business
intelligence tools for data analytics. However, this level of performance monitoring does not
extend to all Service Units and Area Offices. To address this variability in performance
monitoring, the QF Steering Committee has charged a team to establish a core set of
performance metrics to be collected throughout the Agency. This work will be done as part of
the collaboration with CMS's Quality Improvement Organization/Quality Innovation Network.
The QF team also is designing and will launch a pilot project to assess the use of electronic data
dashboards to guide care and monitor performance in Emergency Departments across the
Agency. This pilot program will be implemented in early 2017.

Enhance the Adverse Event Reporting System

Identifying and understanding untoward events and harm that occur in the health care setting
requires a systematic approach. Figure 1 below provides a framework for patient safety event
reporting.

4

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN
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REPORT ENTITLED: INDIAN HEALTH SERVICE: ACTIONS NEEDED TO IMPROVE
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Figure 1
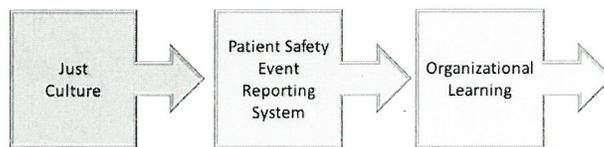
All three elements of this framework: a Just Culture, an accessible reporting system with data
analytics capacity, and an organizational commitment to learn from patient safety events must be
present to manage quality and safety effectively. IHS, through implementation of the QF, has
launched several initiatives designed to support the implementation of this patient safety
framework.

Just Culture Training - The foundation of an organization's approach to patient safety is a just
culture – an environment in which staff are encouraged to report errors and other safety events
without fear of retribution or retaliation and where data are used to drive improvement. In an
effort to move the Agency toward a just culture, a pilot just culture training program was
developed and launched on December 1, 2016. Training will be deployed through the Agency in
2017 as part of the QF and patient safety training initiatives. The topics addressed in this
training program include, but are not limited to, the principles of a just culture, the types of
patient safety events to report, supervisory guidelines for response to errors and lapses, and
intersection with federal personnel regulations.

Adverse Event Reporting System - A multidisciplinary working group is actively exploring the
feasibility of significantly upgrading WebCident (the IHS occupational and patient safety
reporting system) or replacing the system with a commercial product to improve the user
experience of reporting, facilitate the analysis of reported events, and strengthen accountability
related to adverse events. Additionally, IHS is working to change its culture of accountability
such that reporting of near misses or adverse events will increase and identifying risk before
events occur will be encouraged.

Organizational Learning - Data collected in the patient safety event reporting system must be
analyzed and disseminated to the organization to drive improvement. As noted above, the
standardized Governing Board bylaws will include explicit requirements to have the Service Unit
patient safety event reporting system data be reported regularly to the Governing Board. In
addition, starting in January 2017, the QF Steering Committee will convene monthly conference
calls with the Area Office and Service Unit quality and patient safety professionals. Information
gleaned from the Area Office and Service Unit quality and safety performance measurement
activities (including patient safety event reports) will be shared and discussed with the goal of
sharing best practices and improvement strategies.

HHS Response – Recommendation 2:

5

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN
SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT
REPORT ENTITLED: INDIAN HEALTH SERVICE: ACTIONS NEEDED TO IMPROVE
OVERSIGHT OF QUALITY OF CARE (GAO-17-181)**

HHS concurs with GAO's recommendation and work is already underway to address this
recommendation:

Succession Planning

IHS leadership has engaged in discussions with HQ and Area leadership on the importance of
succession planning. On December 2, 2016, succession planning instructions and a template
were distributed to all HQ Office Directors and Area Directors for the purpose of identifying the
key leadership positions and the competencies associated with each position in HQ, the Area
Offices and the Service Units within their Area. After the positions and competencies have been
determined, the next step is to identify employees who possess or have the potential to develop
the competencies to qualify for the position in the immediate, short, and long-term. This step
can be accomplished by conducting a skills gap analysis to assess an employee's current
competencies against those needed for the leadership position. This will aid in identifying and
establishing a training and development plan for each employee and also forecast a timeframe on
when the employee could qualify and/or be ready to assume the leadership position. This
succession planning is expected to be completed by January 2017.

Contingency Planning

IHS has a policy in place that addresses contingency planning in emergency situations to ensure
the continuity of operations. Indian Health Service Circular No. 2002-02, Continuity of
Operations Planning Program outlines the succession of IHS officials in an emergency as
follows:

Operational Washington, D.C., HQ. The Deputy Director, IHS, shall succeed the Director, IHS,
unless the President designates another officer of the government.

Non-operational Washington, D.C., HQ. The Deputy Director for Field Operations (if stationed
outside the Washington, D.C., metropolitan area) will succeed the Director, IHS, in the event
IHS HQ offices in the Washington, D.C., metropolitan area become non-operational. If the
Deputy Director for Field Operations is not stationed outside the Washington, D.C., metropolitan
area, the Director, IHS, will designate an order of succession from among the IHS Area
Directors.

A.   Succession to IHS Officials.

    1. The Deputy Director for Management Operations, Deputy Director for Field
       Operations, and HQ Office Directors will each have a minimum of three
       successors. At least one of the three shall be from permanent duty stations located
       outside of the Washington, D.C. area. This may require offices in the Washington,
       D.C. area to make arrangements to have IHS offices outside of the Washington, D.C.
       area, assume IHS responsibilities in a major emergency.

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<u>**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN
SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT
REPORT ENTITLED: INDIAN HEALTH SERVICE: ACTIONS NEEDED TO IMPROVE
OVERSIGHT OF QUALITY OF CARE (GAO-17-181)**</u>

2. The IHS Area Directors will each have a minimum of three successors; one of whom
   shall be from permanent duty stations located outside the Area Office. This may
   require the Area Directors to make arrangements to have IHS offices outside of the
   Area Office assume Area responsibilities in a major emergency.

3. Succession will take place only when there is an emergency or when the principal is
   unavailable or a higher authority directs the succession. Conflict of authority will be
   avoided by the use of all possible means of communication within the line of
   succession. Tenure will continue until the successor is relieved by the principal,
   someone higher in the order of succession, or by orders from higher authority.

4. Principals are responsible for providing both general orientation and specific
   operational information that a successor will need in an emergency.

<u>Listing of Successors</u>. All IHS managers for whom emergency succession is required are
responsible for the preparation and maintenance of a list of their successors. HQ Office
Directors, Area Directors, Chief Executive Officers, and other key officials will ensure that their
emergency planners file current copies of authenticated successor lists with the organization's
Directives and Delegations Control Officers.

For the purposes of key leadership contingency planning, IHS plans to develop guidance
requiring that for all key leadership positions at HQ and at each Area Office, that "successions"
be identified for top-level positions (HQ Senior Staff and Office Directors; Area Directors,
Deputy Area Directors, Area Chief Medical Officers, Area Executive Officers, etc.) and identify
two to three people as "backups" for each top-level position and indicate how ready
(competencies/knowledge, skills, abilities) each person is to assume the acting role of the
position.

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Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Kristi Peterson, Assistant Director; Kelly DeMots; Krister Friday; Keith Haddock; Lisa Rogers; Patricia Roy; Jennifer Whitworth; and Emily Wilson made key contributions to this report.