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ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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WASHINGTON, DC 20515–6115
Majority (202) 225–2927
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August 4, 2016

Ms. Mary L. Smith
Principal Deputy Director
Indian Health Service
5600 Fishers Lane
Rockville, MD 20857

Dear Principal Deputy Director Smith:

I am writing regarding the series of recent problems leading to substandard care in the Great Plains Area of the Indian Health Service (IHS). According to the Centers for Medicare and Medicaid Services (CMS), problems at IHS hospitals have been so severe that they have resulted in multiple patient deaths.[1] In addition, CMS has terminated or has considered terminating four hospitals' participation in Medicare and Medicaid due to issues in their compliance with various Medicare Conditions of Participation (CoPs) and Emergency Medical Treatment and Labor Act (EMTALA) requirements.[2]

In July 2015, CMS terminated the Winnebago IHS Hospital's participation in Medicare and Medicaid.[3] Noncompliance with EMTALA requirements and CoPs at the Winnebago IHS Hospital was found to have caused "immediate jeopardy" to patients, indicating that the deficiencies found placed patients at risk of injury, harm, impairment or death as well as resulted

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[1] NBC News, *Care at Native American Health Facilities Called 'Horrifying and Unacceptable' in Senate Hearing* (Feb. 3, 2016) (www.nbcnews.com/health/health-care/care-native-american-health-facilities-called-horrifying-unacceptable-senate-hearing-n510826)

[2] Committee on Indian Affairs, Written Statement of Andy Slavitt, Acting Administrator, Centers for Medicare & Medicaid Services, *Hearing on Reexamining the Substandard Quality of Indian Health Care in the Great Plains*, 114th Cong. (Feb. 3, 2016).

[3] *Id.*

in the death of one man and harm to at least nine other people.[4] Additionally, CMS noted that the Winnebago ER has rooms without access to defibrillators, nurses that cannot access basic drugs, and personnel without knowledge of how to call a Code Blue, among other issues.[5] Despite termination of its Medicare contract, the hospital remains open and continues to serve IHS beneficiaries.

The Rosebud IHS Hospital has faced termination.[6] While the Rosebud IHS Hospital has not had its participation in Medicare terminated, an inspection of the facility's Emergency Room, led CMS to declare an "immediate jeopardy" situation.[7] These failures, which forced the Rosebud Hospital Emergency Room to temporarily close on December 5,[8] included broken sterilization equipment, a lack of infection control measures for a patient with a history of untreated tuberculosis, an unattended delivery of a baby in a bathroom, and a patient having a heart attack who did not receive treatment until 90 minutes after arriving.[9] In addition to these violations, the facility is facing a shortage of staff. While the IHS Area Director indicated that the Rosebud Hospital needs 22 doctors, they currently have funding to pay for only 11 doctors and have just two full-time doctors employed by the hospital.[10]

The PHS Indian Hospital at Pine Ridge also faced termination.[11] Similar incidents were found in a CMS inspection of that facility. In Pine Ridge, specific violations included hospital

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[4] Sioux City Journal, *Officials say Winnebago hospital will operate without federal funding* (July 24, 2015) (siouxcityjournal.com/news/officials-say-winnebago-hospital-will-operate-without-federal-funding/article_5f283bb1-c660-5848-a710-40fbc551796c.html)

[5] Committee on Indian Affairs, Oral Statement of Victoria Kitcheyan, Treasurer for the Tribal Council for the Winnebago Tribe of Nebraska, *Hearing on Reexamining the Substandard Quality of Indian Health Care in the Great Plains*, 114th Cong. (Feb. 3, 2016).

[6] *Id.*

[7] Associated Press, *AP NewsBreak: Documents detail serious issues found by federal inspectors at two hospitals in South Dakota that provide care to Native Americans* (Jan. 28, 2016) (www.usnews.com/news/us/articles/2016-01-28/ap-newsbreak-reports-detail-issues-at-reservation-hospitals).

[8] Indian Health Service, *Rosebud Hospital Limits Urgent Care Hours* (Dec. 17, 2015) (www.ihs.gov/newsroom/index.cfm/pressreleases/2015pressreleases/rosebud-hospital-limits-urgent-care-hours/).

[9] *See* note 7.

[10] Committee on Indian Affairs, Oral Statement of Charles Headdress, Rocky Mountain Region representative to the National Indian Health Board's Board of Directors, *Hearing on Reexamining the Substandard Quality of Indian Health Care in the Great Plains*, 114th Cong. (Feb. 3, 2016).

[11] *Id.*

staff copying information from old patient charts into current patient records, hospital staff without credentials, and a dishware sanitation machine that was broken for three years.[12]

The PHS Indian Hospital at Rapid City – Sioux San also faced termination.[13] A CMS inspection of that facility found that Sioux San was not in compliance with all EMTALA requirements and that the deficiencies constituted an "immediate jeopardy" situation.[14] CMS found that the hospital's emergency department could not determine whether an emergency medical condition existed due to inadequate medical screening examinations.[15]

In order to address these issues, the Department of Health and Human Services (HHS) and IHS have taken several steps aimed at improving the care provided by IHS in the Great Plains Area and at the hospitals in question. Secretary Sylvia Burwell, has announced the formation of an executive council on care quality which will be headed by Acting Deputy Secretary Mary Wakefield and will include leaders from a variety of HHS agencies.[16] The council will bring leaders together to create a rapid-response process that will facilitate the deployment of resources throughout HHS when urgent improvement is needed at an IHS facility.[17] Additionally, Secretary Burwell has established a new Deputy Director, Quality Health Care, to oversee and focus on quality improvement, and has hired former IHS Phoenix Area Director, Dorothy Dupree, to serve in this position.[18] Other initiatives aimed at addressing the issues faced by IHS facilities include additional provider training, developing better reporting and decision-making through the use of data-analytics, and using a single accrediting body to guarantee comparable standards throughout IHS service areas.[19]

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[12] *See* note 7.

[13] Letter from Captain Linda Bedker for Steven Chickering, Associate Regional Administrator, Western Consortium Division of Survey & Certification, to Rick Sorensen, Administrator, PHS Indian Hospital at Rapid City – Sioux San (May 23, 2016) (www.indianz.com/News/2016/05/23/cmssiouxsan052316.pdf).

[14] *Id.*

[15] Modern Healthcare, *IHS hospital in South Dakota threatened with funds cutoff* (May 24, 2016) (www.modernhealthcare.com/article/20160524/NEWS/160529967).

[16] Committee on Indian Affairs, Oral Statement of Mary Wakefield, Acting Deputy Secretary, Department of Health and Human Services, *Hearing on Reexamining the Substandard Quality of Indian Health Care in the Great Plains*, 114th Cong. (Feb. 3, 2016).

[17] *Id.*

[18] Letter from Robert G. McSwain, Principal Deputy Director, Indian Health Service, to Tribal Leaders (Dec. 14, 2015) (www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/2015_Letters/54891-1_DTLL_Deputy_Director_Quality.pdf).

[19] Associated Press, *AP NewsBreak: Feds outline reforms for reservation hospitals* (Feb. 3, 2016) (bigstory.ap.org/article/a0659098cd83435d92d10b8be97f06d4/ap-newsbreak-feds-outline-reforms-reservation-hospitals).

I seek further information regarding these issues, including how IHS intends to respond and whether resources are adequate to respond. I respectfully request a briefing as soon as possible from the appropriate IHS staff with Democratic committee staff. To assist the committee's inquiry, please be prepared to cover the following questions:

1. What caused the failures that led inspectors to classify area hospitals as "immediate jeopardy" situations? What specific reasons led to staff utilizing unsafe practices such as copying information between patient charts and delays in repairs of sanitation equipment? Please provide copies of any reports related to these issues.

2. How did the closure of the Rosebud Emergency Room affect access to health care for tribal members? When the emergency rooms was closed, what steps were taken by the IHS to ensure adequate access to care is available in the affected community?

3. What specific steps have been or are being taken to remedy the situation at these hospitals and ensure safe care for patients? What specific resources are needed to get hospitals up to CMS standards?

4. What steps are being taken to enable the Winnebago IHS Hospital to once again participate in CMS programs?

5. What specific capabilities will the new initiatives put in place by HHS and IHS have to address the needs of the Great Plains Area? For example, what resources will be available to the executive council on quality as they create a rapid-response plan?

6. What has proven effective in recruiting and retaining staff in the communities served by the IHS?

7. What methods have been tested to facilitate adequate access to care and quality of care? For example, have you utilized telehealth visits? Have such innovative methods been successful?

8. How is IHS improving access to specialty care?

9. What is the average per capita spending in an IHS-operated hospitals? How does this compare to the average per capita spending at hospitals throughout the nation?

10. Does the IHS have adequate resources to provide quality health care services in all IHS-operated health facilities? If not, what funding level would ensure quality services could be provided across the IHS system?

If you have any questions, please contact Waverly Gordon of the Democratic Committee staff at (202) 225-5056.

Sincerely,

Frank Pallone, Jr.

Frank Pallone, Jr.
Ranking Member