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BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS

OVERSIGHT/LEGISLATIVE
FIELD HEARING ON
IMPROVING ACCOUNTABILITY AND QUALITY OF CARE AT THE INDIAN HEALTH
SERVICE THROUGH S. 2953
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INTRODUCTION

Good morning. Chairman Barrasso and Members of the Committee, thank you for the invitation to join you today here in Rapid City, South Dakota and to testify on S. 2953, the IHS Accountability Act of 2016. We would like to start by thanking you and Senator Thune for your leadership on the Committee and for elevating the importance of delivering quality care through the Indian Health Service. This Committee, IHS, and HHS share a common goal of providing consistent, quality health care to the American Indian and Alaska Native communities we serve. The Administration has concerns with some provisions in S. 2953 as drafted and looks forward to working with the Committee to improve the bill as it moves through the legislative process.

Earlier this year, we strengthened and refocused our resources within the Department as part of an aggressive strategy to improve the overall quality of care in the Great Plains Area, and across the country. HHS and IHS are working to instill a culture of quality care and accountability across the agency. We are committed to hearing directly from you and the communities we serve

to focus sharply on how to best improve access to quality health care and most importantly improve the health status of American Indian and Alaska Native families and communities.

To be clear, the acute problems we are seeing right now are largely tied to chronic, longstanding issues, often spanning decades. Recognizing that, the focus of our work this year is to move aggressively to develop both systemic changes even while we're addressing immediate, short-term needs. We have significant efforts underway on both fronts.

With new leadership at IHS, we are not accepting business as usual. IHS's Principal Deputy Director, Mary Smith, has made it crystal clear that change is the new status quo at IHS. And the leadership at HHS is reinforcing and amplifying that message. Under her leadership, IHS is changing the way it approaches long-standing challenges. IHS is working to reengineer its human resources, create an organizational structure that supports sustained improvement and accountability, and is focused on strengthening its financial management infrastructure.

To ensure that dependable, quality care is delivered consistently across IHS facilities, three months ago, 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 thus 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 workforce supply, housing, challenges to delivering quality of care, and addressing key operations issues.

The council ensures that we are leveraging all the resources we can on behalf of American Indian families and communities.

Through the work of this Council, in tandem with IHS, for the past two months, we have been engaging our work through a five-prong strategy to address these challenges—many of the same obstacles like sufficient workforce, personnel issues, and care quality, that your legislation seeks

to address. With this strategy, IHS and the Department are working to (1) surface existing problems so that we can work to resolve them; (2) improve service delivery; (3) strengthen IHS Area management; (4) infuse quality expertise; and (5) engage with local resources.

Surfacing Problems

First, we are assessing and surfacing problems so that we can work to resolve them. We are 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 across 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 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 even more patients at risk. For the past 20 years, health care systems across the nation have been embracing new models of improvement, and it is that orientation that we are working to further strengthen with in IHS through the assets of IHS and other divisions in HHS. For example, IHS is beginning a system-wide mock survey initiative at all 27 of its hospitals to assess compliance with CMS Conditions of Participation and readiness for re-accreditation. These mock surveys will be conducted by survey teams from outside each respective Area to reduce potential bias. The new mock survey initiative is being coordinated through the IHS Quality Consortium as a unified effort to reinforce standardization of processes. We are beginning 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 all Direct Service hospitals receive an assessment within the next three months and performance data tracked, not just at individual facilities but across all facilities.

Through this and 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. Additionally, best practices that are identified will be shared across IHS facilities.

Another example of surfacing and addressing problems is IHS' enhanced drug testing interim policy. This policy was released on June 6th and focuses on drug testing based on reasonable suspicion, and expands the HHS drug testing policy that already applies to IHS employees. The interim policy provides guidance to supervisors and managers on drug testing based on a reasonable suspicion of drug use. This effort was informed by tribal leaders' calls for additional IHS administrative actions in this area.

Improve Service Delivery

Second, we are working to improve service delivery by focusing on workforce and clinical support infrastructure.

Workforce

The IHS continues to face significant workforce challenges with a chronic shortage of health care providers. While we have immediate steps to address some local shortages and are in the

process of adding more, such as telemedicine, these longstanding challenges require building up and expanding the training and deployment pipelines and full use of innovative approaches to delivering care. In the near-term, with Secretary Burwell, Deputy Secretary Wakefield, and the U.S. Surgeon General's support, over two dozen Commissioned Corps clinicians have been deployed for temporary placements into the Great Plains hospitals with CMS findings. In addition, NIH has been helping IHS deploy strategies it has used to recruit nurses into its clinical program. These include providing new recruitment language and accessing web-based resumes of South Dakota nurses for the IHS, as well as using new web-based places to advertise. IHS is also revising position descriptions and deploying more comprehensive recruitment plans around key positions, in an effort to recruit a greater number of qualified candidates. IHS is also deploying Title 38 pay increases for high-demand clinicians and has established eligibility for payment of relocation expenses for GS-12 and lower graded clinical positions. However, even with these and a number of other strategies that have been deployed during the past two months or that are in development right now, there is still much more work that needs to be done to attract and retain an adequate health care workforce. Some of these changes will require legislative action. In addition, we are working with OPM, OMB, and other affected agencies to explore ways to enhance our current flexibilities. We are also combining efforts that leverage collaboration between tribal, public, and private academic institutions.

One of the most challenging areas to support is the availability of emergency services, particularly in the Great Plains Area. Because of this, on May 17, 2016, IHS initiated a new strategy through a contract award to provide both emergency department staffing and operations support and management services at three hospitals: Rosebud Hospital and Pine Ridge Hospital in South Dakota and Omaha Winnebago Hospital in Nebraska. This will provide health care in

these hospital emergency rooms while IHS reviews the administrative and clinical operations of its facilities across the region to develop long-term solutions. IHS's leadership both in the hospitals and at headquarters have direct oversight of this contractor and is responsible for holding this contractor accountable for providing consistent quality health care. However, because this is a new approach to Emergency Department staffing and management combined, a team of clinicians and attorneys, as well as the CEOs of the facilities, are tracking this initiative weekly to ensure that performance expectations are met.

As part of a longer term strategy, we are reexamining the scholarship and loan repayments program to make sure that we are maximizing their impact and we are introducing other new strategies as well. We are working with the Peace Corps' Global Health Services program that fields clinicians to areas of critical workforce needs and most immediately, we are building communication channels about service to Indian Country to 60 returning volunteers. By the end of this month for example, 60 returning volunteers will be learning about opportunities to work in direct service IHS hospitals even as we are engaging other longer term communication strategies with the broader Global Health Services program. Additionally, the U.S. Public Health Service Commissioned Corps has prioritized new officers to IHS with a particular focus on the Great Plains Area.

On a related front, on June 1st, IHS proposed to expand its community health aide program and is slated to engage consultation with tribal leaders over the next months on this expanded effort.

This important proposed change would bring more health workers directly into American Indian and Alaska Native communities.

Infrastructure

In addition to addressing workforce challenges, the IHS is trying to lessen the loads on our emergency departments by establishing alternative avenues of care, such as urgent care clinics and telehealth services. IHS is working aggressively to reopen the Rosebud Emergency Department as soon as it is safe for the patients. In the meantime, in order to fill the temporary gap, the IHS has re-purposed existing ambulatory care space into an Urgent Care clinic staffed with emergency department and ambulatory providers. Given the types of illnesses that individuals present with to the Rosebud Emergency Department, the Urgent Care clinic can manage the majority of these non-emergent care needs.

Specialty services like behavioral health, cardiology, and diabetes care can be difficult to find in rural areas. IHS will also be using telehealth contracts to bring specialty services into the communities where individuals live so they do not need to travel. IHS issued a Telemedicine Request for Proposal on May 5, 2016. Proposals were originally due June 6, 2016; however, at the request of prospective bidders for more time to prepare comprehensive proposals, IHS extended the deadline to respond by 30 days.

Strengthening Area Management

Third, we are working to strengthen area management. While we support the workforce at each hospital, we are also taking a broader view to strengthen Great Plains Area management through the temporary deployment of high-quality managers from within other areas of IHS as well as deploying HHS experts to both IHS headquarters and the field to assist with finance, contracting, and management functions. IHS also established a Human Resources (HR) Steering Committee, which provides oversight and guidance on the implementation of system-wide HR improvements in IHS.

As part of these efforts, Rear Admiral Kevin Meeks spent three months leading the Area Office. Captain Christopher Buchanan joined the Great Plains Area leadership team in May and is serving as the Acting Director of the Great Plains Area Office. Captain Buchanan has extensive expertise working with complex health systems which are IHS directly-operated facilities as well as tribally-managed programs assumed under the authority of the Indian Self-Determination and Education Assistance Act. In the longer term, the IHS is actively looking to find the best possible candidate for the Great Plains Area Director position. We revised technical qualification requirements for the position description in order to attract a broader pool of well qualified candidates. We have also implemented a stronger search committee process for recruiting highly qualified managers and executives. This committee is charged with candidate outreach, assessment, and vetting. IHS is also more widely advertising vacancies through federal, state, and non-profit partners, and is actively seeking additional venues to help attract a broad and diverse applicant pool. Additionally, going forward, we have expanded tribal participation in filling vacant Area Director positions and members of a tribe from each area will, for the first time, play a role in these search committees at the outset of the hiring process on these key positions.

Finally, IHS recently announced conducting a 90-day consultation with Tribal leaders to discuss the organization and operation of the Great Plains Area Office, to, in partnership with the Tribes, identify new approaches to better support patients and tribal community health in the Area.

Infusing Quality Expertise

Fourth, we 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 we announced on

May 13, 2016, the Premier 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. The HEN will prioritize working with the three Great Plains Area hospitals and is currently working with each hospital to schedule onsite meetings.

Additionally, we are bringing in targeted quality improvement assistance through CMS' . Quality Improvement Organization (QIO) infrastructure (QIO). Among other support and training functions, QIOs assist with root cause analysis of identified problems, assists with the development of improvement plans, establish baseline data, and monitor data to ensure improvement plans are successful and improvements are 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 CMS Conditions of Participation and to monitor progress as the facilities come into compliance.

Engaging Local Resources

And fifth, we aim to engage more robustly with local resources. We know that, in addition to our strong partnerships with Tribes and their leadership, local academic and health systems organizations can be valuable sources of expertise and partnership. We intend to strengthen our relationships with local and regional health care systems, local colleges and universities and tribal colleges, direct service hospital leadership and tribal leadership to build stronger academic pipelines and health care connections to ensure we are working collaboratively and effectively to produce health related workers and health care services.

We also recognize that the health of communities is tied to the economic health of communities. Rates of unemployment and poverty matter. Consequently we are committed to advancing the success of small businesses in tribal communities. The Department's Office of Small and Disadvantaged Business Utilization, in collaboration with the U.S. Small Business Administration, is working to coordinate meetings with tribal leaders and small businesses owned by Native Americans, Indian Tribes, and the Native American community at large. Our team plans to have these meetings in or near the 12 Indian Health Service Area Offices and the events will focus on how to effectively pursue contract opportunities with HHS, IHS, and other Federal Agencies.

STRENGTHENING IHS

We have been working to address challenges using new approaches on our end. First, we appreciate the authority we already have to use the pay flexibilities under chapter 74 of title 38. We are working with OPM, OMB, and other affected agencies to explore ways to enhance our current authorities to provide more tools to recruit and retain high quality staff.

Second, we are seeking tax treatment, similar to the treatment provided to recipients of National Health Service Corps (NHSC) and Armed Forces Health Professions scholarships. Currently, IHS loan repayment/scholarship awards are taxable, reducing their value. In contrast, participants in the NHSC scholarship program and Armed Forces Health Professions may exclude scholarship amounts used for qualifying expenses from income, and participants in the NHSC loan program may exclude any loan amounts repaid on their behalf from income. We recommend adopting the Administration's Fiscal Year 2017 Budget proposal which would

conform the tax treatment of IHS repayments/scholarships to the tax treatment for NHSC and Armed Forces Health Professions repayments/scholarships.

Third, the Indian Health Care Improvement Act requires employees who receive IHS scholarships or loan repayments to provide clinical services on a full-time basis. However, the Affordable Care Act permits certain NHSC loan repayment and scholarship recipients to satisfy their service obligations through half-time clinical practice for double the amount of time or, for NHSC loan repayment recipients, to accept half the loan repayment award amount in exchange for a two-year service obligation. We would like similar flexibility.

Being able to access resources is key to amplifying our work. It is critically important that we receive the funding the President requested in his Fiscal Year (FY) 2017 Budget, which includes: an increase of \$159 million above FY 2016 to fund medical inflation, pay costs, and accommodate population growth for direct health care services; an increase of \$20 million for health information technology to fund the development, modernization, and enhancement of IHS' critical health information technology systems; \$2 million to create a new program which will focus on reducing medical errors that adversely affect patients; and \$12 million specifically for staff quarters at current facilities, in addition to staff quarters associated with new facilities.

CONCLUSION

Our entire Department is committed to making meaningful and measurable progress in the way that IHS delivers care. While the Administration has concerns about this bill, we look forward to working with the Committee to improve it as it moves through the legislative process. Thank you, and we are happy to take your questions.