TESTIMONY OF

VICTORIA KITCHEYAN, TREASURER

WINNEBAGO TRIBE OF NEBRASKA

BEFORE THE UNITED STATES SENATE

COMMITTEE ON INDIAN AFFAIRS

OVERSIGHT HEARING ON

"REEXAMINING THE SUBSTANDARD QUALITY OF

INDIAN HEALTH CARE IN THE GREAT PLAINS"

Submitted January 25, 2016

Good afternoon Mr. Chairman and Members of the Committee:

My name is Victoria Kitcheyan. I am a member of the Winnebago Tribe of Nebraska and I am currently serving as Treasurer of the Winnebago Tribal Council. Thank you for holding this very important hearing. Your Committee's interest and your personal involvement in this matter is encouraging as we work collaboratively to improve the health care provided to our people. I would also like to thank the Members of our Nebraska and Iowa Congressional delegations, who have given us a great deal of support in these past few months, as well as the Members of the South Dakota and North Dakota Congressional delegations and the House and Senate Appropriations Committees. Without all of this support, none of the preliminary improvements that we have seen in these past few months would have happened. We also appreciate the work of the other Tribes in Nebraska and the Tribal leaders and staff of the Great Plains Tribal Chairmen's Association, the Great Plains Tribal Health Board and the National Indian Health Board, all of whom have gone out of their way to assist.

The Winnebago Tribe is located in rural northeast Nebraska. We are served by a small thirteen (13) bed Indian Health Service (IHS) operated hospital, clinic and emergency room located on our Reservation. This hospital provides services to members of the Winnebago, Omaha, Ponca and Santee Sioux Tribes. It also provides services to a sizable number of individual Indians from other tribes who reside in the area. Collectively, the hospital has a current service population of approximately 10,000 people.

The Winnebago Tribe has already provided the Committee staff with a number of documents, including numerous independent reports from the Centers for Medicare and Medicaid Services (CMS) and a report from the independent contractor hired by IHS last fall to evaluate the facility. These materials document in great detail the appalling conditions which exist at the IHS hospital in Winnebago. I would ask that these materials all be incorporated into the record of this hearing.

It would be impossible to cover everything contained in those hundreds of pages, so I will summarize a few of the very disturbing problems that these outside investigators uncovered. Many of these are problems that the Winnebago Tribe has been pointing out for years, but which have remained unaddressed. Many of these issues were also documented in this Committee's 2010 Report "In Critical Condition: The Urgent Need to Reform the Indian Health Service's Aberdeen Area", which is now known as the Great Plains Area. Since 2010, the situation has moved from bad to worse and we are anxious to work with you and the other Members of Congress to find real concrete solutions. This is imperative because people's lives are literally at stake.

Because my testimony will be highly critical of the IHS, I would like to note that there are a number of fine and talented people who work for that Agency. Many of these individuals are as appalled as we are about what has happened at the Winnebago Hospital and are working hard to find solutions. Some are even risking their careers to accomplish this goal and have had to seek whistleblower protection for choosing to report incidents at an IHS facility. We thank each and every one of those fine IHS employees who perform a difficult job correctly under difficult conditions. We therefore call upon this Committee to protect every federal employee who stands up and does what is right.

Before I provide you with the history of the CMS findings at the Winnebago Hospital, I would like to ask you to think about one thing. When a person suffers a medical emergency, we all do the same thing: We try to get to the place that displays the big bright sign "Hospital." We learn as children that a hospital is a place where we will be assisted by highly trained professionals who have the skills and the desire to make us better. We are taught that we can trust a doctor and a nurse. When they tell us to take the blue pill twice a day for ten days and we will be fine, we believe them. Unfortunately, too many of our tribal people have not found these things to be true at this IHS Hospital.

Since at least 2007, this IHS facility has been operating with demonstrated deficiencies which should not exist at any hospital in the United States. I am not talking about unpainted walls or equipment that is outdated. I am talking about a facility which employs emergency room nurses who do not know how to administer such basic drugs as dopamine; employees who did not know how to call a Code Blue; an emergency room where defibrillators could not be found or utilized when a human life was at stake; and a facility which has a track record of sending patients home with aspirin and other over-the-counter drugs, only to have them airlifted out from our Reservation in a life threatening state. I am also talking about a Hospital which had at least five documented "unnecessary deaths," including the death of a child under the age of three. These are not just our findings, they are the findings of the federal government's own agency, CMS.

In fact, the CMS uncovered deficiencies which were so numerous and so life threatening that this last July 2015, the IHS operated Winnebago Hospital became what is, to the best of our knowledge, the only federally operated hospital ever to lose its Medicare/Medicaid Certification. Because this Committee's 2010 Report was fairly comprehensive, please allow me to pick up where that report left off.

In 2011 CMS conducted a re-certification survey of our hospital and detailed serious deficiencies in nine areas, including Nursing and Emergency Services. My wonderful Aunt, Debra Free, was one of the victims of those deficiencies. She died in the Winnebago Hospital in 2011. According to what our family learned, Debra was overmedicated and left unsupervised, even though the nursing staff at the Hospital knew that she was dizzy and hallucinating from the drugs and should be watched closely. After her death, a nurse at the hospital told my family that Debra had fallen during the night. She said that that nurses from the emergency room had to be called to the inpatient ward to get Debra back into bed because there was inadequate staff and inadequate equipment on the inpatient floor to address that emergency.

While the hospital insisted that they did everything possible to revive her and save her life, we question just how long she remained on the floor and what actually happened. Among those doing the questioning was Debra's sister, Shelly, who was a nurse at the hospital during that period. Unfortunately, Aunt Shelly was not on duty when this occurred, but she did know enough from her professional training to question why the body temperature and reported time of death did not appear to match up. The body was still warm when the family arrived after receiving the call.

When my Aunt Shelly and the family requested to see the charts to determine what actually happened, we were met with immediate resistance. First, my mother, also Debra's sister, was told she was not authorized to request the chart. Then my grandmother, Aunt Debra's own mother,

Lydia Whitebeaver, submitted a request and was denied the information. In fact, the whole family and the Attorney that we were forced to hire were all told that the chart was "in the hands of the Aberdeen Area Office's attorneys" and was not available to us.

Because she demanded answers to our very reasonable questions, my Aunt Shelly was retaliated against in the worst way. As an IHS employed nurse at the Hospital she was regularly intimidated by her supervisors and colleagues, and generally treated in the most horrific way by the Director of Nursing and her cronies. One of those nurses even reported Shelly to the State Licensing Board. Thank goodness the State Licensing Board's Members saw that report for what is was and dismissed the inquiry almost immediately, but this is a prime example of why we have been unable to get the proof that this Committee has been asking for, before the CMS Reports were released. Fear of retaliation within the IHS system is real and as your Committee's 2010 Report document, such retaliation has been present at the Winnebago Hospital since well before 2010. One former IHS employee of our Hospital even told your own Committee Staff that those employees who threaten to speak out are regularly reminded to "remember who you work for." Another employee told your staff that Hospital employees, at least for a period of time, were told not to report incidents of improper care on the Webcident system. This, as you may know, this is the federally established system for reporting improper care in all federally funded facilities.

When the CMS was finally able to obtain the records that we were denied, there was no record whatsoever of the fall that my Aunt Debra suffered. A fall which a nurse told us about in some detail. It is common knowledge in our area that the then Director of Nursing and the two other nurses involved in Debra's care are close friends. It is regularly asserted by other IHS hospital staff that they have been known to cover up events which might get one of them in trouble.

My Aunt Debra Free left behind a nine year old daughter and a loving family. She should not have been allowed to die like this. Her story and those of countless others need to be told. This example of substandard care and the numerous other examples documented by the CMS Reports are indicative of the federal government's loose commitment to upholding its federal trust responsibility. The Great Plains Service Area is in a state of emergency and the patients who seek care at the Winnebago Service Unit are in jeopardy as we speak!

My ancestors made many sacrifices so that our people's livelihood would continue. As a tribal member and tribal leader, it is my responsibility to carry their efforts forward to protect my people. Neither the Winnebago Tribe, nor I, will stand idle as Indian Health Service kills our people, patient by patient.

In addition to my Aunt's case, the 2011 CMS Report also found that during that year: patients who were suicidal were released without adequate protection; that a number of patients who sought care were sent home without being seen, or with just a nurse's visit, were never documented in any electronic medical records; that out of twenty-two (22) patient files surveyed by CMS, four (4) of those patients were not provided with an examination which was sufficient enough to determine if an emergency existed, and that at least one of those patients was sent home from the emergency room. The staff failed to diagnose that he had suffered a stroke.

When some of the findings of the CMS 2011 Report became public, in early 2012, former IHS Director Roubideaux publically promised improvements. While some minor issues were addressed, many other things got worse.

In just the past 2 years, four additional patient deaths and numerous additional deficiencies have been cited and documented by CMS. These incidents and reports include:

- April 2014. A 35 year old male tribal member died of cardiac arrest. CMS investigated this incident and found that the Winnebago Hospital's lack of equipment, staff knowledge, staff supervision and training contributed to his death. Specifically, the nursing staff did not know how to call a Code Blue, were unfamiliar with and unable to operate the crash cart equipment, and failed to assure the cart contained all the necessary equipment. CMS concluded in its report that conditions at the hospital "pose an immediate and serious threat" mandating a termination of the Hospital's CMS certification unless they were corrected immediately.

- May 2014. A second CMS survey conducted a month later found that a number of the conditions which pose immediate jeopardy to patients had not been corrected, and that the Hospital was out of compliance with CMS Conditions of Participation for Nursing Service.

- June 2014. A female patient died from cardiac arrest while in the care of the hospital. This time the death occurred when the staff was unable to correctly board her on the medivac helicopter. This is documented in the July 2014 CMS report. This young woman was employed by the Tribe's Health Department and played an active role in the lives of many youth, who often referred to her as "mother goose."

- July 2014. A 17 year old female patient died from cardiac arrest because the nursing staff did not know how to administer a dopamine drip ordered by the doctor. CMS also documented this event in detail in its July 2014 report and found that numerous nursing deficiencies remained uncorrected at the hospital. This resulted in the issuance of a continuing Immediate Jeopardy citation for the hospital on the Condition of Participation for Nursing Services.

- August 2014. In its fourth survey conducted this year, CMS concluded that failure to provide appropriate medical screening or stabilizing treatment "had caused actual harm and is likely to cause harm to all individuals that come to the hospital for examination and/or treatment of a medical condition."

- September 2014. CMS survey jurisdiction of this hospital was transferred from the Kansas City regional office to Region VI in Dallas, TX.

- November 2014. Just four months later, CMS returned again for another survey. This report again identified more than 25 deficiencies.

- January 2015. Another death occurred when a man was sent home from the Emergency Department with severe back pain. A practitioner later left him a voicemail after discovering his lab reports showed critical lab values telling him to return in 2 days. The patient died at home from renal failure. This situation is documented in the May 2015 CMS report.

- May 2015. CMS conducted another follow up survey. In addition to documenting the January 2015 death noted above, the report states that seven CMS Conditions of Participation and EMTALA requirements were found out of compliance at the hospital.

- July 2015. CMS terminated the Winnebago IHS Hospital provider agreement. CMS stated that the hospital "no longer meets the requirements for participation in the Medicare program because of deficiencies that represent an **immediate jeopardy** to patient health and safety."

Mr. Chairman and Members of the Committee, I know that each of you have families and close friends, and I assume that most of you have also suffered a loss or know someone who has. It is a profoundly painful experience. Now, imagine going through that pain only to learn a year or more later, through some government report, that the death might have, or even should have, been avoided. Keep in mind that the deaths and findings cited here are only the ones that have been documented by CMS. When CMS conducts a survey, only a small sampling of patient records are reviewed. We have no way of knowing how many more unnecessary deaths and misdiagnosis have occurred at the hands of IHS personnel. There is also no way that we can portray the tremendous pain and loss that has been suffered by our families and our community in these few pages. Our people are devastated, angry and demanding change. Given what has happened, and been allowed to continue to happen, I respectfully submit that we have every right to those feelings.

As the CMS reports piled up, we have started to see less Hospital admissions and less care being provided in the Emergency Room. We believe this is due, at least in part, to hospital staff fearing on-going CMS oversight of their lack of training and skills. We have actually been told this by some of our members who work at the facility. This is possibly contributed to the most recent documented death in January 2015 (noted above).

The totality of these circumstances finally led CMS to notify the Indian Health Service in April of 2015 that it was pulling its CMS Certification of the Winnebago Hospital, unless substantial changes were made. Changes were not made and CMS terminated that certification on July 23, 2015.

I wish to note for the record that throughout this period the IHS assured the Winnebago Tribal Council that the CMS findings, most of which were never provided to the Winnebago Tribe at least in their totality, were being addressed. In fact, less than two weeks before CMS actually pulled the Certification, the IHS Regional Director was still telling the Tribal Council that the threatened CMS decertification would not happen because IHS was talking to its lawyers and planning an appeal.

When the termination happened, the Winnebago Tribe and its attorneys asked to see a copy of the latest CMS report. We were told by the IHS Regional office that it needed to be reviewed for privacy concerns before it could be released to us. We finally obtained a copy and also learned that the CMS oversight of Winnebago IHS Hospital was transferred from Kansas City to the Dallas Office. When we asked one CMS employee why this transfer had occurred, he was fairly quick to suggest that, in his opinion, this was forum shopping. Whether there is any truth to this or not, this transfer of CMS oversight certainly raises questions. Perhaps this Committee can get the answers that we cannot.

Immediately after the hospital lost its' CMS Certification, the Winnebago Tribal Council got on a plane and came here to this Committee and to its Congressional delegation for help. You responded. Thank you!

While the Winnebago Tribe had heard and reported stories of these atrocities for years, the CMS reports have provided independent verifiable documentation of what was really going on. What we have learned since then is equally disturbing.

When we asked Acting Director McSwain about the professional medical review that the IHS had engaged in after each of these five deaths occurred, and what role the Central Office played in those reviews, we were shocked to learn that the IHS does not appear to have an established procedure for dealing with questionable deaths or other unusual events that occur in its hospital. In fact, if there was ever a professional peer review of any of those five incidents of questionable death, we can't find it! When we pushed harder on this issue we were told that this review should have been conducted by the "Governing Body" of the hospital. This basically means that a body, composed largely of other IHS employees who are not doctors or other medical professionals, were supposed to review the actions of the physicians, nurses and anesthesiologists in the emergency room. I can assure you that this would not happen at the Georgetown Medical Center or Med Star Hospital in Washington, D.C. The end result, however, is that - to the best of our knowledge - no one was fired, no one was reprimanded, no one was suspended pending a medical investigation and no one was reported to the licensing board. This is outrageous!

Again, many people have asked us why the families of these individuals did not sue. The answer is simple: Most Indian people do not place a dollar value on human life. Others, who might be willing to sue, either did not know that they could, did not know how, or could not afford it. Medical malpractice cases are complicated and expensive. You need expert witnesses who are willing and able to testify, and we have trouble getting federal employees to answer questions about CMS findings. A litigant also needs access to medical records which are not easy to get from the federal government, and they need a lawyer who has the financial means to front the costs for a family with few financial resources. These types of lawyers are not plentiful in our area. So yes, our people have rights under the Federal Tort Claims Act, but taking on an federal agency which has all of its own experts on salary is not as easy as its appears.

It is also important to note that the Winnebago IHS Hospital has become a short term stop for a number of IHS contractors. Many of the doctors who take care of our needs are not federal employees, they are private contractors who rotate in and out of the facility. This forces even the best of those physicians to rely heavily on the nursing staff who remain at the facility, many of

whom have been found by CMS to be serious undertrained. The negative media coverage of our hospital over the past six years has made recruiting all the more difficult. Would you want to see your daughter, fresh out of medical school, step into a mess like this in a hospital managed by a dentist or pharmacist?

After the Tribe met with Secretary Burwell's legal counsel in August of 2015, the IHS finally hired an outside consultant to perform its own review of the facility. This review was conducted applying standard federal and state medical standards. During this review, this independent consultant found 97 deficiencies, many of which were never uncovered, or at least never reported, by CMS.

The IHS also employed that consultant to develop a corrective action plan for the Winnebago facility. This is clearly a step in the right direction. At the same time, I, and the other Members of our Tribal Council, will not be satisfied, until one of our members comes up to me and says "I was just at the emergency room with my mom - what a difference." I am not going to trust that simply checking an item of a list is getting us the real change that we need to see or that those changes will be sustained.

To this day, when we pressure the IHS on the big issues, we get the same excuses:

- "Employees are protected by the Federal Employee Regulations". In fact, it seems all but impossible to fire a federal employee. In conversations with your own Committee staff, Winnebago hospital employees reported that some of their colleagues believe that their job can never be put in jeopardy because they are protected by the Civil Service System. When did there become two standards of care- one for the private sector on one for federally operated hospitals?

- "We wished that we could hire people more quickly but the OPM system has to be followed." How many professional people can wait months for an OMP approval? We have lost a number of good candidates who refuse to wait six months or more to be hired. You simply cannot recruit under these circumstances.

- "IHS lacks the resources to recruit the best people." There is truth to this and we encourage the committee to look into this problem. At the same time, while we hear about recruiting problems, we have seen no real effort to recruit from our local Nebraska, Iowa and South Dakota Medical Colleges. In any event, we will never agree that inadequate resources justifies the continued employment of an undertrained or incompetent individual. It seems like the IHS positon has, over time, evolved into "even a poor doctor is better than none at all."

The IHS hospital management has also been an on-going problem. Even though CMS has documented countless problems in the emergency care division, we have had a pharmacist and a dentist as acting CEO's, and I have to ask you what training a dentist, even one of the top dentists in the country, has in dealing with issues like renal failure, cardiac arrest and overdoses.

So what should be done?

First, we ask the Committee to examine the role that Federal Employment Policies and Regulations are playing in allowing incompetent and undertrained employees to continue to work in the Indian Health Service. Employees need to be held accountable for their actions. No longer can IHS continue to protect, cover up, shuffle, transfer, or perpetuate incompetency.

Second, we recommend that the IHS be mandated to institute a formal process for investigating any report of a questionable death or other unusual medical incident in any of its facilities. If problems are identified, immediate action must be taken to correct the problem, including disciplinary action against any employee who has failed to do their job.

Third, we recommend that the IHS mandate, as a condition of on-going employment, that its employees report any improper care or mismanagement that they observe, and that those reports be sent directly to Central Office. The standard of care must be raised and every IHS employee should feel responsible for helping to fix this problem.

Fourth, we recommend that IHS be authorized and directed to immediately terminate any employee who retaliates or threatens to retaliate against a person who files such a report. The culture must change. Employees should be encouraged to make improvements and find better ways of doing things, not intimidated into maintaining the status quo.

Fifth, we feel strongly that each of the tribes who are served by a direct care facility should be given full and immediate access to any CMS, Accreditation or other third party reports or studies performed on that facility. We further recommend that all negative reports should be shared with this Committee and its counterpart in the House. IHS needs to stop hiding the ball.

Sixth, we recommend that the IHS be directed to insure that no tribe suffers the loss of services or resources because of IHS mismanagement. The third party billing from Medicare and Medicaid represented a sizable percentage of the Winnebago IHS Hospital's operating budget.

Seventh, we insist that IHS mismanagement should not be used as an excuse for eliminating or cutting back on services. Already, IHS is discussing how the underutilization of our facility makes it difficult to seek the funding necessary to fix its problems. It like a death spiral - IHS creates an environment that people do not want to go to. They refuse to admit patients because they fear further scrutiny. Then they conclude that the hospital is too underutilized, so maybe they should shut down some services. This is a totally unacceptable. It is a flagrant violation of the federal government's treaty and trust obligations, and someone should be fired for even raising this as a possibility.

Eighth, tribes should be given a real role to play on the governing bodies of IHS operated facilities, not just a token attendance right. Let me give you an example. The IHS will tell you that since the "corrective action plan" has been implemented, our tribal Chairwoman has been invited to participate in the final interview process for key positions at the hospital. This is true. What they do not tell you is that she only received the resume just before the meeting and she was never told how many others applied for the job, who they were, what the differences were in their credentials, or even how many candidates there were.

The bottom line, Mr. Chairman, is that things need to change and they need to change now. We have just heard that both the Pine Ridge and Rosebud Hospitals are now threatened with a loss of CMS certification and we also know that many of the things that CMS has documented at Winnebago are happening at other hospitals throughout the Great Plains and Billings Regions. These are our families, many of our people are veterans, and they all deserve better.

Two of your own Committee Staff Members were at Winnebago earlier this month. Would any of you want to see one of them to end up in an emergency room with IHS Winnebago's reputation, if they were involved in an automobile accident?

The Winnebago Tribe has already begun developing a draft plan to assume control of this hospital under a P.L. 93-638 compact. For years we have trusted the IHS to do its job. Over and over again, the IHS has failed. At this point, the Tribe feels that it has no alternative. Contracting is a great thing, and our tribe already operates a number of programs under P.L. 93-638. At the same time, contracting or compacting should be a tribal choice, not something forced upon us by circumstances like this. We know that if we move forward with this effort, we are taking on a highly troubled enterprise. That is very concerning to us, and to our members.

Mr. Chairman, the Winnebago Tribe truly appreciates your efforts to date and stands ready, willing and anxious to work with you, the Members of this Committee and our fellow tribes to insure that our members receive the health care that they deserve and that no other tribe suffers these same tragedies.