



U.S. Department of Health and Human Services
Office of Inspector General

Rosebud Hospital

Indian Health Service Management of
Emergency Department Closure and Reopening

A Case Study

OFFICE OF INSPECTOR GENERAL

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REPORT IN BRIEF

Case Study: Indian Health Service Management of Rosebud Hospital Emergency Department Closure and Reopening, OEI-06-17-00270

WHY OIG DID THIS REVIEW

The Indian Health Service (IHS) provides comprehensive Federal health services to approximately 2.6 million American Indians and Alaska Natives. In 2016, OIG found significant problems in the quality of care and oversight of IHS-operated hospitals. Congressional testimonies in recent years and deficiency findings by the Centers for Medicare & Medicaid Services (CMS) also raised concerns about quality and patient access to care in IHS hospitals.

During a 3-year period, IHS temporarily closed the emergency department (ED) at 4 of its 24 hospitals. The Rosebud Hospital ED remained closed for more than 7 months. We conducted this study to examine IHS's management of the closure and reopening of the Rosebud Hospital ED to identify lessons learned that IHS could apply should similar situations arise in the future.

HOW OIG DID THIS REVIEW

This report provides a chronology of events and identifies factors that led to the closure of the Rosebud Hospital ED, improvement efforts to reopen the ED, and continued lapses in compliance. We interviewed leadership and staff at IHS headquarters, the Great Plains Area Office (AO), and Rosebud Hospital, and other stakeholders, including administrators at CMS, receiving hospitals, and the Rosebud Sioux Tribe. We also reviewed both internal and publicly available documents from IHS and stakeholders.

CHRONOLOGY OF EVENTS

Decision to Close and Impact of Closure

After receiving citations during a CMS survey deemed of immediate jeopardy (IJ) to ED patients, IHS closed the Rosebud Hospital ED in December 2015. IHS diverted Rosebud patients to the nearest hospitals but did not provide the hospitals or the emergency medical services (EMS) adequate time to prepare. The receiving hospitals were overwhelmed by the volume and complexity of patients, and EMS struggled to meet demands with its limited staff and longer patient transports. Our review identified several factors that led to and complicated the closure of the Rosebud Hospital ED:

› Insufficient hospital staffing

Staffing shortages, particularly in the ED, contributed to findings of noncompliance with the Medicare Conditions of Participation and increased dependence on contracted providers rotating in and out.

› Changing and inconsistent hospital leadership

Instability and inexperience in key leadership positions made it more difficult for IHS to make strategic, long-term improvements at Rosebud Hospital.

› Inadequate hospital infrastructure

Rosebud Hospital did not have an adequate infrastructure to ensure basic quality care, including policies and procedures, working equipment, and staff training.

› Lack of oversight by IHS

IHS officials and staff described poor relationships between the Great Plains AO and Rosebud Hospital, and communication breakdowns across IHS, which limited support for identifying and correcting problems.

› Poor coordination with local partners

IHS submitted a plan to CMS for operating without an ED but did not adequately communicate with hospital staff, EMS, and receiving hospitals, who received little warning and were overwhelmed with demand.

KEY TAKEAWAY

IHS made significant improvements at Rosebud following the ED closure but continues to struggle with securing adequate onsite staffing and leadership, both of which are critical to sustaining hospital operations. Enhanced attention and oversight by IHS and CMS provided momentum for Rosebud to address its problems, but recent deficiencies indicate that IHS did not sustain the improvements in staffing and leadership after this focus diminished.

Corrective Action and Reopening

To correct Rosebud Hospital's deficiencies and re-open the ED, IHS provided additional resources and support from across IHS, sought assistance from other agencies, and entered into a Systems Improvement Agreement (SIA) with CMS. IHS made improvements prompted by the SIA, which included updating policies and revising governing board bylaws. Our review identified several factors that led to improvement and reopening of the ED in July 2016:

- › **Accountability for compliance and quality**

IHS brought in an accomplished team of clinical and management leaders with experience in solving problems and maintaining compliance, holding staff accountable, and fostering a culture of shared responsibility.

- › **Systemic changes**

IHS and hospital officials employed systemic methods to identify and address problems, leading to widespread change for the hospital and agency.

- › **Standardized policies and procedures**

IHS and hospital officials developed and revised hospital policies, delineated clearer roles and responsibilities, and streamlined procedures.

- › **Investment in staff training**

IHS and hospital officials conducted assessments and training to better ensure that hospital staff were prepared and proficient in treating patients.

- › **Improved communication and support from IHS**

Rosebud Hospital officials had more frequent communication and closer collaboration with the Great Plains AO and IHS headquarters, and additional support across the Department of Health and Human Services.

Continuing Concerns and Sustainability of Improvements

IHS completed the SIA to CMS's satisfaction in September 2017, but CMS cited Rosebud Hospital again with ED-related IJ deficiencies in July 2018. Our review identified several factors that led to continued lapses in compliance:

- › **Continuing turnover in hospital leadership**

IHS brought strong leadership teams from across IHS and other agencies to correct problems at Rosebud. However, those teams were temporary and frequent changes in leadership continued to hamper operations.

- › **Insufficient transition of new hospital leaders**

IHS did not build in sufficient overlap and transition of incoming and departing leadership. This resulted in a lack of cohesive strategy, nonadherence to agency priorities, and discontinuation of improvement efforts.

- › **Continuing difficulty maintaining staff**

As before, IHS and hospital officials struggled to recruit and retain long-term hospital staff and relied on contracted providers to temporarily fill the gaps.

- › **Corrective actions not engrained**

Temporary leaders at Rosebud instituted new policies, procedures, and training. However, those solutions were not employed long enough to fully take root with leadership and contracted staff rotating in and out of the hospital.

- › **IHS could not sustain attention**

Rosebud Hospital and the Great Plains AO received enormous support and focus from IHS and other agencies following the ED closure, but this attention could not continue indefinitely.

WHAT OIG RECOMMENDS

To correct underlying problems and better serve its beneficiaries, we recommend that IHS, as a management priority, develop and implement a staffing program for recruiting, retaining, and training clinical and leadership staff in remote hospitals. This is a necessary first step to addressing quality issues long term; however, other actions are also needed, including taking steps to ensure that IHS intervenes early and effectively when problems emerge. To ensure better management of any future ED closures, we also recommend that IHS develop procedures for temporary ED closures and communicate those procedures with receiving hospitals and EMS to ensure that they are adequately prepared for such events. IHS concurred with our recommendations.

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BACKGROUND

OBJECTIVE

To examine Indian Health Service (IHS) management of and procedures for the temporary closure and subsequent reopening of the Rosebud Hospital emergency department (ED), including the agency's collaboration and coordination with affected parties.

BACKGROUND

IHS is responsible for providing Federal health services to American Indians and Alaska Natives (AI/ANs), and has an annual budget of \$5.6 billion.¹ The Indian Health Care Improvement Act (IHCA) provides the legal authority for the provision of healthcare to AI/ANs.² In partnership with the 573 federally recognized tribes, IHS provides primary and preventative healthcare services to approximately 2.6 million AI/ANs living in the United States.³ IHS's mission is to raise the "physical, mental, social, and spiritual health of AI/ANs to the highest level."

However, reports of health disparities and inadequate healthcare services for AI/ANs have been a Federal government concern for nearly a century. In recent years, much attention has focused on inadequacies at IHS hospitals in the Great Plains Area, which serves tribes in parts of Iowa, Nebraska, North Dakota, and South Dakota.^{4,5,6} In February 2016, the Senate Committee on Indian Affairs held a hearing on the substandard quality of care in IHS facilities in the Great Plains Area.⁷ Testimony from the Centers for Medicare & Medicaid Services (CMS) and tribal representatives described concerns about several hospitals in the Area, including noncompliance with the Medicare Conditions of Participation (CoPs) and the Emergency Medical Treatment and Labor Act (EMTALA) requirements. During a congressional hearing in March 2017, a member of the House Committee on Appropriations' Subcommittee on Labor, Health and Human Services, Education, and Related Agencies raised similar concerns about quality of care and specifically hospital ED closures in the Great Plains Area.⁸

Between 2014 and 2016, IHS temporarily closed four hospital EDs, forcing patients to seek treatment elsewhere.⁹ One of these—Rosebud Hospital—discontinued its emergency services for more than 7 months (December 5, 2015, through July 15, 2016). Rosebud Hospital is a 35-bed medical facility located in the Great Plains Area and is the primary source of healthcare for the Rosebud Sioux Tribe in South Dakota.¹⁰ During the ED closure, patients had to travel farther for emergency services—the nearest emergency rooms were 45 and 55 miles away.¹¹ An IHS press release about the event cited "staffing changes and limited resources" as reasons for the closure, while other sources suggested that the care was deemed unsafe.^{12,13} After the closure, tribal representatives raised allegations that the lengthy ambulance transports to other healthcare facilities during the closure contributed to several patient deaths. They also expressed concerns about IHS's decision process, communication, and management of the closure.¹⁴

Rosebud Hospital



Photo: HHS-OIG, 2017

OVERVIEW OF INDIAN HEALTH SERVICES

IHS provides healthcare services to AI/ANs directly through IHS-operated facilities or provides financial support for the tribes to operate their own healthcare systems.¹⁵ In fiscal year (FY) 2019, about 40 percent of IHS's \$2 billion appropriation to provide healthcare services in hospitals and health clinics was allocated to Federal operations serving tribes directly. The remaining 60 percent was allocated to individual tribes or tribal organizations.¹⁶

IHS Headquarters and Area Offices. IHS headquarters provides general direction, policy development, and support to each of the 12 Area Offices (AOs) and their healthcare delivery sites, which may include hospitals, urgent-care clinics, and/or other types of facilities. AOs oversee the delivery of health services and provide administrative and technical support to the federally operated facilities. The Great Plains AO is responsible for the oversight of five IHS-operated hospitals, including Rosebud Hospital, and other direct-service health centers and clinics in the Area. The Great Plains Area covers 17 tribes (approximately 130,000 tribal members) across 4 States (Iowa, Nebraska, North Dakota, and South Dakota).¹⁷

IHS maintains its current policies, procedures, and operating standards in the *Indian Health Manual* (IHM). IHS policy directs that the IHM is the "preferred reference" for IHS staff regarding IHS-specific policy and procedural information.¹⁸

IHS Hospitals. IHS directly operates 24 acute-care hospitals in 7 Areas, many of which are small and rural.^{19, 20} Most IHS hospitals have fewer than 30 beds. In FY 2017, the average daily census was 158 inpatients for all IHS-operated hospitals and 6 inpatients for individual IHS hospitals.²¹ IHS hospitals are led by Chief Executive Officers (CEOs) responsible for facility management and accountable to IHS AOs.

Rosebud Hospital. For Rosebud Hospital, the average daily census was 3 inpatients in FY 2017, and the average number of ED encounters was 38 per day (or 14,046 ED patients for the year).^{22, 23} Rosebud Hospital provides a range of services, including obstetric, dental, and pediatric services, for about 35,000 AI/ANs residing in and around the Rosebud Indian Reservation.^{24, 25} The Rosebud Sioux Tribe provides emergency medical services (EMS), which include both air and ground transportation.

Hospital Funding. In addition to funding appropriated by Congress for healthcare services in hospitals and health clinics, IHS hospitals may be reimbursed by Medicare, Medicaid, and private insurance entities for services they provide to AI/ANs enrolled in these programs or health plans.²⁶ IHS estimates that it will collect slightly over \$1 billion from these three sources in FY 2019.²⁷

Purchased and Referred Care. In certain circumstances, IHS may supplement the care available in a particular location by purchasing services for specific AI/AN patients from non-IHS healthcare entities. Under this program, known as Purchased and Referred Care (PRC), IHS hospitals use PRC funds to refer patients for emergency or specialty care that is beyond the scope or capacity of the IHS facility. However, IHS is the payer of last resort and patients are required to exhaust all healthcare resources available to them from private insurance, State health programs, and other Federal programs before the PRC program can provide payment. The PRC program does not have sufficient funds to cover all care needs and thus allocates healthcare on the basis of a medical-priority rating system. In FY 2018, the PRC program denied and deferred an estimated 163,058 services needed by eligible AI/ANs, totaling nearly \$677 million.²⁸

Catastrophic Health Emergency Fund. The PRC program also administers the Catastrophic Health Emergency Fund (CHEF), which covers extraordinary medical costs associated with treatment of victims of disasters or catastrophic illnesses or injuries, such as those resulting from motor vehicle accidents. IHS headquarters manages the CHEF funds and can use those funds for high-cost cases after a threshold payment amount of \$25,000 is met.²⁹

MEDICARE CONDITIONS OF PARTICIPATION

IHS requires hospitals to be certified by CMS or accredited by an accrediting organization that supports the reimbursement requirements established by CMS.^{30, 31} Among these requirements are the CoPs, a set of minimum quality and safety standards. The CoPs include requirements such as establishing an effective governing body legally responsible for the performance of the hospital, maintaining an organized medical staff that is responsible for the quality of patient medical care, and developing and maintaining Quality Assessment and Performance Improvement (QAPI) programs.³² A governing body is the only authority that can grant medical staff membership and/or clinical privileges through a comprehensive credentials review.^{33, 34} Each hospital is responsible for ensuring that it meets applicable standards and for reporting its certification or accreditation status to the Area Director. The Area Directors are responsible for forwarding this information annually to IHS headquarters.³⁵

CMS and accrediting organizations monitor IHS hospitals' compliance with the CoPs through periodic onsite surveys.³⁶ Surveyors observe how hospitals provide care to patients, and assess whether that care meets the needs of the patients and is in compliance with all requirements. To indicate noncompliance, surveyors cite hospitals with deficiencies that hospitals must correct in a timely manner to continue participating in Medicare. If surveyors identify an "immediate jeopardy" (IJ), which is noncompliance with one or more requirements that caused, or is likely to cause, serious injury, harm, impairment, or death to a patient, the hospital must immediately develop and implement a plan of correction to remove the IJ or face termination from the Medicare program by CMS.³⁷ CMS may also terminate hospitals if they receive "condition-level" deficiencies, meaning that one or more deficiencies related to a particular CoP are extensive or severe enough that CMS considers the hospital to be out of compliance with the entire condition. To avoid termination in the event of condition-level deficiencies, hospitals must submit a plan of correction and, within 90 days of the survey, implement changes to re-gain compliance.^{38, 39}

Systems Improvement Agreement. If a hospital is unable to correct its deficiencies, CMS may terminate the hospital's participation in Medicare or enter into a Systems Improvement Agreement (SIA) with the hospital. The SIA is a binding agreement, entered into voluntarily by the hospital and CMS. Through the SIA, CMS can extend the effective termination date to allow the hospital additional time to achieve compliance with the CoPs, contingent on the hospital's participation in quality improvement activities and demonstration of improved outcomes.⁴⁰

REQUIREMENTS FOR HOSPITAL EMERGENCY SERVICES

For hospitals that have a dedicated ED (department designated for emergency care), additional requirements apply. These hospitals must have appropriate policies and procedures to meet patients' emergency needs, integrate emergency services with other hospital departments, and ensure adequate medical and nursing staff qualified in emergency care, among other requirements.^{41, 42} Although hospitals are not required to have a dedicated ED, all hospitals must provide emergency services, which include initial evaluation, diagnosis, and treatment for medical conditions that could place the health of an individual in serious jeopardy or result in serious impairment without medical attention.^{43, 44} EMTALA requires all Medicare-participating hospitals to provide a medical screening exam and stabilizing treatment for individuals with potential medical emergencies.^{45, 46}

Diversion. When a hospital ED is functioning at, or close to, its maximum capacity, hospitals can invoke "diversionary status."⁴⁷ Diversionary status directs ambulances to bypass the hospital ED and transport patients to other nearby medical facilities. Hospitals diverting patients to other facilities must still follow EMTALA requirements to examine and stabilize patients who arrive at the hospital.^{48, 49}

Closure. IHS has specific requirements pertaining to the closure of a facility or portion of a facility, including the ED. The IHCA requires the Secretary of the Department of Health and Human Services (HHS) to notify Congress at least 1 year in advance of a permanent closure and to evaluate the closure's impact on the community prior to the closure. The evaluation must include an analysis of alternative healthcare resources for the affected population, with

consideration given to cost-effectiveness, quality of care, and the views of the tribes served by the facility.⁵⁰ These requirements do not apply to facilities in which a temporary closure has been deemed necessary for medical, environmental, or safety reasons.⁵¹

RELATED WORK

This study expands on prior and ongoing work by OIG. In October 2016, OIG issued companion reports describing lack of quality oversight and a number of challenges that affect IHS hospitals' ability to provide quality care and maintain compliance with the Medicare CoPs.^{52, 53} OIG made several recommendations to IHS, such as implementing a quality-focused compliance program, establishing standards and expectations for AO/Governing Board oversight activities, conducting a needs assessment, and developing an agency-wide strategic plan to address IHS priorities. OIG also recommended that CMS conduct more frequent surveys of non-accredited hospitals and inform IHS leadership when citing hospitals with deficiencies. Additionally, OIG recommended that the Office of the Secretary of HHS lead an examination of the quality of care delivered in IHS hospitals through the HHS Executive Council on Quality Care, which is currently inactive, and identify and implement innovative strategies to mitigate IHS's longstanding challenges. In response to our recommendations, IHS implemented a Quality Framework to guide the agency's strategic vision for quality and patient safety, established a new Office of Quality, and revised the Governing Board structure.

Prior work by the U.S. Government Accountability Office (GAO) also identified issues in IHS oversight and facility operations. In January 2017, GAO found inconsistencies in governing board meetings, reporting of quality data, and reporting of adverse events (harm to a patient because of medical care).⁵⁴ In a more recent report, in August 2018, GAO found that despite IHS recruitment and retention efforts, the agency continued to face significant challenges in filling provider vacancies, which affects patient access and quality of care.⁵⁵

Ongoing work by OIG includes a medical review that will determine the incidence, preventability, and contributing factors of adverse events in IHS hospitals. OIG is also conducting a management review of IHS headquarters operations.

METHODOLOGY

Scope. This study reviews IHS actions and policies regarding the closure and reopening of the Rosebud Hospital ED from December 5, 2015, through July 15, 2016. The report provides a chronology of events and identifies factors that contributed to the closure, the closure decision, challenges that IHS and other affected parties experienced during the closure, improvement efforts that ultimately led to the ED reopening, and continuing concerns. The report describes communication and collaboration between IHS and the involved parties, including CMS, and the roles and responsibilities of each level at IHS, including Rosebud Hospital, Great Plains AO, and IHS headquarters. See the Appendix for a detailed timeline of key events related to the Rosebud ED closure.

Data Sources. Report findings are based on data from interviews and document reviews collected between June 2017 and December 2018.

Interviews with officials and staff from IHS, CMS, HHS leadership, Rosebud Sioux Tribe, receiving hospitals, and the South Dakota Department of Health. We conducted in-depth onsite and telephone interviews with 53 respondents, individually or in small groups, about their roles during the ED closure and in the subsequent reopening. We present interview data in both aggregate analysis and individual quotations.

- › *IHS leadership and staff at IHS headquarters, Great Plains AO and Rosebud Hospital*—respondents were the Acting Director, Deputy Director, Chief Medical Officer (CMO), former CMO, Acting Deputy Director for Quality Health Care, Deputy Director of Field Operations, Director of Office of Public Health Support, former Director

of Office of Management Services, Acting Area Director, Area CMO, and former and current Acting Hospital CEOs, Hospital Clinical Directors, and Federal and contracted hospital staff.

- › *CMS leadership and staff*—respondents were the Director of the Quality, Safety and Oversight Group, Associate Regional Administrator of Survey and Certification, Survey Branch Managers, and surveyor staff.
- › *HHS leadership and staff*—respondents were a former Acting Secretary of HHS, the Surgeon General, Director of the U.S. Public Health Service Commissioned Corps (USPHS) Personnel and Readiness Division, Director of the USPHS Readiness and Deployment Operations Group, and other staff.
- › *Rosebud Sioux Tribe administrators*—respondents were the Director of the Tribal Health Board and the Director of EMS.
- › *Receiving hospital leadership and staff*—respondents were Administrators/CEOs, Chief Financial Officers, and other hospital staff from the two hospitals that received most of Rosebud’s ED patients during the closure.
- › *South Dakota Department of Health*—respondent was the Assistant Administrator for Rural Health.

Documents from IHS, CMS, USPHS, Rosebud Sioux Tribe, and receiving hospitals. We verified issues raised during interviews when possible by reviewing selected internal and publicly available documentation obtained from the respondents. The documents included internal management reports, meeting minutes, staffing and patient census data summaries, survey deficiency reports, corrective action plans, SIA provisions, CMS monitor reports, and documentation exchanged between interview respondents, such as requests for assistance.

Limitations. We did not examine the appropriateness of IHS’s closure of the Rosebud ED and subsequent reopening or whether the closure constituted a “permanent closure” pursuant to Section 1631(b) of the IHCA or whether IHS’s actions were legally compliant with this section of that Act. Additionally, we did not assess whether any patient deaths that occurred during the ED closure were avoidable or whether other patient harm could have occurred if the ED had remained open despite quality-of-care problems.

STANDARDS

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

SECTION 1

DECISION TO CLOSE AND IMPACT OF CLOSURE

IHS's decision to temporarily close the Rosebud ED in December 2015 was largely due to quality-of-care concerns and staffing shortages

“Immediate Jeopardy” is the most serious deficiency categorization based on the scope and severity of the actual or potential harm to patients.

CMS cited Rosebud Hospital with IJ and condition-level deficiencies after failing to provide adequate emergency services. During an onsite survey in November 2015, CMS found both quality-of-care and operational problems across Rosebud Hospital departments and cited the hospital for noncompliance with nearly one-third (7 of 23) of the Medicare CoPs. Surveyors identified condition-level deficiencies related to the Governing Board, Patient Rights, QAPI program, Medical Staff, Medical Record Service, Physical Environment, and Emergency Services. CMS found the deficiencies in the ED to be particularly problematic, and cited them at the IJ level, an immediate jeopardy to patient health and safety. The ED deficiencies involved failure to provide adequate and timely treatment for four patients:

- A patient with chest pain who did not receive a timely medical screening exam, and had a delayed transfer to another facility better equipped to treat the condition;
- A pediatric patient with a possible head injury from a car accident who did not receive appropriate care or monitoring;
- A patient with chest pain who was not triaged appropriately and did not receive adequate monitoring or timely care; and
- A patient who delivered a pre-term baby unattended on the ED bathroom floor.

IHS officials and staff attributed Rosebud's deficiencies to longstanding problems with insufficient staffing, rotating leadership, and equipment issues. In interviews, IHS officials and staff reported that the deficiencies CMS found in the November 2015 survey were evidence of deeper problems with the hospital, including difficulty in filling vacancies, leadership instability, outdated equipment, and limited clinical support and oversight by the Great Plains AO. Respondents reported that IHS has struggled for years to recruit and retain sufficient numbers of providers (physicians, nurses, and other clinical staff) at Rosebud because of the hospital's remoteness, and relied on contracted providers to fill critical gaps, particularly in the ED. Furthermore, hospital staff reported that these contracted providers did not always meet the hospital's needs or acceptable standards.

“Hospital leadership sometimes kept poorly performing contracted staff around just as warm bodies.”

—Rosebud staff member

Staff reported that they voiced concerns about insufficient staffing to hospital leadership to no avail and recalled several occasions when the ED had few staff and no supervisor available on call. At the time of the CMS survey, the Rosebud Hospital ED had only one physician assistant on duty and no physician, as required. Area staff noted that to be fully staffed, Rosebud should have at least one physician and one midlevel provider (e.g., nurse practitioner, physician assistant) per shift, in addition to three nurses.

Changing Leadership

In the 9 years leading up to the ED closure, Rosebud Hospital had 27 CEOs.

Leadership. According to an IHS official, Rosebud Hospital had 27 CEOs over a 9-year period, averaging 3 CEOs per year. Many of these CEOs served in an acting capacity and lasted only a few months before they left voluntarily, were fired by IHS, or were removed by a tribal resolution. Although many of these CEOs may have initially appeared to be a good fit, several IHS officials indicated that the CEOs often lacked experience and were ill-equipped to fulfill that role. One official described how some CEOs, due to their inexperience and lack of knowledge about hospital operations, depended on Clinical Directors to run the hospital, meaning that the CEO position sometimes added little value to hospital management. Shortly after the November 2015 survey, both the CEO and the Clinical Director left Rosebud. Interview respondents reported that these leadership changes and voids resulted in a lack of oversight to ensure that other hospital functions ran smoothly, such as ensuring staff training and the adequacy of equipment.

Equipment. CMS surveyors found several equipment issues, including an oxygen leak in the ED, problems with the phone and call light system, and broken steam autoclaves (used to sterilize surgical instruments). Hospital staff indicated that equipment was often broken or lacking in the ED, with examples including equipment considered critical to daily ED operations, such as suction tubes (used to remove secretions) and heart monitors.

Breakdowns in communication between the hospital, Great Plains AO, and IHS headquarters further exacerbated the issues at Rosebud and limited IHS oversight and support. IHS officials indicated that the relationships between officials at Rosebud Hospital and the Great Plains AO were at times strained, and that breakdowns in communication limited AO support to address problems. IHS officials described the relationship between the AO and the Great Plains hospitals as lacking trust and clear roles and responsibilities. Hospitals operated on their own, with little support or input from the AO, and there was a lot of “finger pointing” and disagreement about who was responsible for addressing issues that arose at the hospital level. One official noted that although the AO was aware of Rosebud’s longstanding issues, Rosebud received little support or assistance because Area leadership did not believe it was their responsibility to correct hospital deficiencies.

“There was no cohesive ownership in Great Plains... Hospitals ran their own thing, independent of the AO.”

—IHS official

According to interviews, the AO may have been more active in the past, conducting mock surveys of Rosebud and other Great Plains hospitals to provide hospital leadership and staff experience with the survey process and give the AO an interim assessment of hospital

operations. Mock surveys simulate the actual survey process and typically include direct observation, policy reviews, and medical record reviews.⁵⁶ Although the surveys identified a wide range of problems, including quality-of-care issues in the Rosebud ED, an Area staff member reported that the AO medical team stopped them a few years before the Rosebud ED closure. According to the staff member, the AO team limited their scrutiny to only medical record reviews following significant occurrences, such as a patient death or other sentinel (serious or widespread) event. IHS officials also reported that the AO provided little information to IHS headquarters about the problems in the Great Plains, including Rosebud Hospital. Although IHS headquarters leadership were aware of problems and asked questions, they did not know the extent or severity of the problems.

IHS's inability to remove the IJ deficiencies in the Rosebud ED and secure sufficient staffing prompted IHS leadership to suspend Rosebud's emergency services. Following the survey, it quickly became clear to both IHS and CMS that Rosebud was unable to resolve the IJ, primarily due to staffing shortages in the ED. When the Area CMO went onsite shortly after the CMS survey to review Rosebud's plan of correction, the one doctor on duty in the ED had been on call for 36 hours. The Area CMO reached out to other contractors and hospitals in the Great Plains but was unable to acquire additional providers.

“Hospital termination” from Medicare is rare. In 2017, CMS terminated four hospitals for failure to meet health and safety requirements.

Given that IHS was unable to correct the deficiencies in the Rosebud ED, CMS issued a letter of termination to Rosebud in December 2015. The same day, the Great Plains Area Director and Area CMO, with support from IHS headquarters leadership, temporarily closed the ED. IHS did not conduct an analysis of the impact of the ED closure on the community prior to this temporary closure (such an analysis is only required by the IHCA for a permanent closure). Instead, Area leadership met with the tribal council and the tribally operated EMS to inform them that the ED diversion would begin the following day. IHS also issued a press release on its website about the closure. Shortly after the ED closed and patient diversion began, the Great Plains Area Director and the Area CMO left their positions at IHS. Once the ED was on diversion, CMS suspended the deficiencies related to emergency services and excluded the ED from its surveys until Rosebud was ready to resume those services.

IHS did not inform Rosebud staff of plans for diverting patients and failed to adequately notify receiving hospitals of the ED closure, giving them no time to prepare for an influx of patients

IHS did not adequately notify its own staff or surrounding hospitals that it planned to close the ED, causing confusion from the onset of the closure. Within a week of the closure, the Area CMO submitted a written plan to CMS to operate Rosebud Hospital without a dedicated ED, as required. However, in interviews, we found that Rosebud staff were unaware of the plan or its details. The hospital also lacked agreements and memoranda of understanding (MOUs) with neighboring hospitals for diverting emergency patients, despite Rosebud Hospital frequently using diversion in the past for specialty services, such as obstetrics and surgery. Rosebud staff also reported that they did not receive any training or information about ED diversion prior to the closure, and noted that Area leadership was slow to notify them of the decision to close. Some Rosebud staff reported that they learned about the closure only

when the hospitals that received Rosebud's emergency patients began contacting them with inquiries about the closure. Area leadership eventually held a staff meeting to inform Rosebud staff about its decision to close, but IHS's lack of guidance on roles and procedures during ED diversion caused confusion among staff.

Receiving hospitals learned about the ED diversion through non-IHS sources shortly before it began and were quickly overwhelmed by the volume and complexity of Rosebud patients.

Despite IHS's attempts to publicize the closure on its website and directly notify the receiving hospitals, administrators from the two non-IHS hospitals that received most of Rosebud's patients reported that IHS failed to alert them of the ED diversion. One of the administrators stated that the hospital learned about the closure from a local radio station that had tuned into the broadcasted tribal council meeting, during which IHS announced the ED diversion. Shortly after the broadcast, the tribally operated EMS notified the hospital that ambulances were en route to the facility with patients. An administrator from the second receiving hospital reported that they received a letter from IHS about the diversion nearly 2 weeks after the Rosebud ED closed. The lack of notification prevented the receiving hospitals from preparing for the incoming patients. Furthermore, confusion about the actual start time of the diversion resulted in ambulances diverting patients several hours before the ED was set to close, giving receiving hospitals even less time to prepare.

In addition, the receiving hospitals struggled to receive sufficient notice from EMS about incoming patients throughout the closure. An administrator from one of the receiving hospitals reported that ambulances often notified the hospital only a few minutes before they arrived or sometimes they showed up without warning. The small window of notice made it difficult for hospital staff to adequately prepare for the patients, particularly in the event of complex cases such as premature infants. An administrator from the South Dakota Department of Health, who communicated regularly with the tribally operated EMS, reported that EMS staff sometimes did not contact the receiving hospitals in advance of transporting patients due to fear of being diverted again.

The receiving hospitals experienced a significant increase in the number and case mix of emergency patients and reported struggling to meet patient needs. These hospitals are both fairly small (25-bed) facilities located in communities with fewer than 3,000 people, about an hour away from Rosebud Hospital. One of the hospital administrators described this event as "an avalanche." Within the first 6 weeks of the closure, the number of ED patients increased by 67 percent and the intensity of demand tested the hospital's capabilities. The hospital saw substantial increases in particular of mental health patients, drug overdoses, shootings, and sexual assaults—areas in which staff had limited experience. Drug overdoses were especially difficult for the hospital to treat because patients needed multiple supports that relied on continual staff monitoring and equipment, including airway support, IV fluids, and kidney dialysis (which the hospital typically provided only to stable outpatients with chronic illness). The acuity of the incoming patients often required a transfer to a larger hospital farther away. An administrator from the other receiving hospital reported that its ED visits increased by 38 percent during the Rosebud ED closure, which had a trickle-down effect on the other

hospital departments. For example, the hospital’s inpatient and obstetrics admissions increased by 51 and 21 percent, respectively, during the closure.

The influx of emergency patients was taxing on staff, and receiving hospitals reported losing staff as a result. Administrators from the receiving hospitals reported that when the diversion first began, they did not have sufficient staff to handle the volume and complexity of the ED patients, which took a toll on staff who worked many overtime hours trying to fill the gaps. Both hospitals indicated that they lost staff as a result of the influx of patients. The ED diversion affected all hospital operations, from billing to housekeeping. One administrator questioned why IHS did not send any Rosebud staff to assist with the patient influx given that the ED was closed. Both hospitals reported that they contracted with additional providers and security staff to address the increased needs of their EDs.

IHS’s short notice of the ED diversion also made it difficult for tribal EMS to mobilize and meet demands with its staffing shortages and longer transports of patients. The ED closure had a significant impact on the tribally operated EMS, which was understaffed. The EMS Director explained that IHS’s short notice prevented EMS from mobilizing and adequately preparing for the closure. EMS received 2,867 dispatch calls during the months that the ED was closed, and more than half of those calls (1,514) resulted in patient transports to other facilities. Ambulances had to travel longer distances, often with high-acuity patients, which resulted in delays in EMS response time to emergency calls. Many of these transports took several hours to complete. Of the 1,514 patient transports conducted by local EMS during Rosebud’s ED closure, 32 percent of transports (481) took between 3 and 5 hours to complete, roundtrip, and 27 percent of transports (403) took more than 5 hours to complete.

27%
of EMS transports to receiving facilities took more than 5 hours to complete.

“If patients were truly having a cardiac event, the heart muscles would be damaged during the long route to the receiving hospitals.”

—EMS Director

To manage the workload, EMS hired eight additional staff, revised shifts, and worked overtime. Despite these additional hires, EMS was short-staffed throughout the closure and posted multiple job advertisements for drivers, paramedics, and emergency medical technicians that it was unable to fill. As described by one of the receiving hospital administrators, EMS had ambulances but not enough staff to sufficiently meet the needs. According to the EMS Director, the closure was also emotionally hard on EMS staff, who felt they were carrying the weight of the diversion on their own with no backup, and some staff left as a result. The South Dakota Department of Health administrator who communicated regularly with EMS explained that ambulance staff not only had to manage what was going on at the scene when they picked up a patient, but also assess the patient’s needs during long transits and decide which of the two overrun facilities was best-suited at that time to accept the patient.

IHS's lack of communication with receiving hospitals and EMS continued throughout the closure and made it difficult for these entities to anticipate staffing needs. Administrators from the receiving hospitals reported that communication with IHS was insufficient during the months that the ED was closed. They noted that it was difficult to find a person in charge either at Rosebud or at the AO because of constant leadership changes. The Tribal Health Board Director also reported difficulty in receiving timely updates from IHS during the closure and noted that Rosebud Hospital staff would turn off the ringer when EMS tried to call the hospital. IHS later addressed this issue when it provided EMS with its own direct line to the hospital. An administrator at one of the receiving hospitals expressed that they expected IHS leadership to reach out to the receiving hospitals and discuss the terms of the closure, but that never happened. The administrator noted that it was not clear when the Rosebud ED would reopen or whether it would reopen as an outpatient clinic or an ED. Without knowing the length of the closure, it was difficult for the hospital to anticipate staffing needs and determine whether or not to renew its contracted staff.

An administrator from the other receiving hospital reported that IHS initially told the hospital that the Rosebud ED would be back up and running within 30 days. The administrator periodically contacted Rosebud for updates on the reopening date, but the date kept changing and the administrator had a hard time finding anyone to talk to other than PRC staff. The administrator stated that not knowing how long Rosebud's ED diversion would last was the "worst part."

Receiving hospitals and tribal EMS met weekly to discuss diversion-related issues, and expressed frustration over IHS's absence. Shortly after IHS closed the Rosebud ED, an administrator in the South Dakota Department of Health began coordinating weekly calls with all the receiving hospitals in Nebraska and South Dakota and the tribal EMS. According to the administrator, the purpose of the calls was to open channels of communication to mitigate challenges and share concerns and updates among the affected parties. An administrator from one of the receiving hospitals reported that although these calls were helpful for sharing needs and identifying available hospital beds, IHS was not present during the calls. The EMS Director also noted IHS's absence on the calls but recalled two occasions during which IHS listened into the calls. The administrator from the South Dakota Department of Health indicated that he inquired about having someone from the AO participate on the calls, but he was never able to locate anyone. Once the ED reopened, these calls discontinued.

"We needed boots on the ground, but no one offered to help... This was IHS's crisis, but to find anyone willing to talk with us was difficult."

—Receiving hospital administrator

Some of these communication gaps during the closure may have emerged due to changing leadership, with no one person or group following through to ensure that communication with receiving hospitals was widespread and continuous. During our interviews, IHS officials and Rosebud staff reported that communication with the receiving hospitals improved in the weeks leading up to the ED reopening and in the months that followed. During our onsite

review in August 2017, Rosebud staff reported that they held weekly calls with the receiving hospitals to provide status updates and discuss any issues that could potentially affect the receiving hospitals.

IHS opened an urgent-care clinic at Rosebud to meet community needs, but confusion about its services led to some emergency patients presenting at the clinic

On the same day that the ED closed, Rosebud Hospital began providing 24-hour urgent-care services by using the ED staff and contracted providers. The purpose of the urgent-care clinic was to increase the availability of primary care services and to minimize the number of patients that sought care at receiving hospital EDs for non-emergencies. According to an IHS official, many of the patients in the IHS hospital EDs are the “worried well”—patients who need primary care but present in the ED instead of the outpatient clinic.

IHS announced the opening of the urgent-care clinic through a press release on its website on the day of the closure. A CMS official and staff who were onsite when the Rosebud ED closed reported that they conducted a walkthrough of the hospital to ensure that the ED was not being used. Hospital staff covered the ED signs and posted urgent-care signs throughout the facility. As the CMS official noted, IHS was still responsible for providing first aid at Rosebud but could not use the ED or exceed the capabilities of an urgent-care clinic.

Although EMS transported most emergency patients to the receiving hospitals, EMS staff and tribal members continued to bring some patients to Rosebud after the ED closed, and hospital staff struggled to care for those patients in the urgent-care setting. Despite IHS’s announcement of its ED closure and the opening of the urgent-care clinic, confusion about the types of services provided by urgent care resulted in emergency patients continuing to arrive at Rosebud. Hospital staff described the onset of the closure as chaotic and reported receiving large volumes of high-acuity patients at the urgent-care clinic. Cases ranged from heart attacks, women in labor, and car accidents to snake bites. According to the EMS Director, IHS did not specify what services Rosebud would provide during the closure, and the community continued to perceive the urgent-care clinic as an ED because the staff and the physical space of the ED were still intact. Rosebud staff eventually clarified to EMS that ambulances could not bring any emergency patients to the urgent-care clinic or drop them off near the hospital. Instead, they had to transport all emergency patients to the receiving hospitals for treatment.

EMS eventually stopped bringing patients to Rosebud, but tribally operated transportation services and family members continued to drop emergency patients off at the urgent-care clinic. The EMS Director explained that if an ambulance picked up a patient who was stable enough and wanted to go to Rosebud, EMS would contact tribal transportation services and have them take the patient to Rosebud’s urgent-care clinic. According to Rosebud staff, some of the patients who arrived in the vans operated by the tribe had acute medical needs beyond the capability of an urgent-care facility and had to be flown out to other facilities.

Although the ED was not supposed to be in use, Rosebud staff reported that some staff continued to “sneak” patients into the ED to provide emergency services. This stopped when IHS began renovating the ED, and staff could only stabilize and transfer emergency patients who arrived at the hospital. Rosebud staff described how caring for high-acuity patients in the urgent-care setting was challenging because the rooms were not equipped to treat emergency patients and lacked appropriate monitors, oxygen equipment, and lighting.

“The closure increased risks for patients. When you can’t use the ED and you try to take care of an emergency in an urgent-care setting, you’re tying the arm on the provider’s back.”

–IHS official

Many patients sought emergency treatment during the closure, but some patients who needed emergency treatment did not seek care. According to Rosebud staff, some patients feared being unable to find their way back to the reservation after treatment at the receiving hospital. Or, they feared receiving a medical bill that they could not afford to pay if the PRC program declined to cover their expenses.

To offset costs for patient diversion, Rosebud received additional PRC and other funds, but receiving hospitals and EMS struggled to absorb their increased costs

The closure quickly depleted Rosebud’s PRC program, but the Great Plains AO and IHS headquarters provided additional funds to cover some of the expenses. According to Rosebud and Area staff, the hospital’s PRC program was stretched thin prior to the closure, and once the ED diversion began, patient needs further exceeded available funds and depleted the PRC program. Rosebud staff noted that the hospital typically ran out of PRC funds several months before the new PRC budget cycle began, which resulted in large numbers of deferred cases. To offset some of the diversion-related costs, the Great Plains AO and IHS headquarters provided additional funds to Rosebud during the closure. The AO has an emergency fund from which Great Plains facilities can make requests. Area staff reported that over the years Rosebud received more assistance from this fund than many other Great Plains facilities. Rosebud also received additional funds from IHS headquarters to cover PRC needs during the closure, in addition to CHEF funds that assisted Rosebud in covering patient cases with extraordinary medical costs.

Although Rosebud received additional funds during the closure, it struggled to handle the administrative workload of the PRC program. According to staff, the workload quadrupled as a result of the ED diversion and caused a backlog. Rosebud staff who normally only processed PRC payments now also had to track diverted patients, which rapidly became an overwhelming task due the large volume of patients. Staff also noted that there was no preparation, guidance, or protocol for the PRC program to handle the ED diversion, and that Rosebud staff, receiving hospitals, and patients were confused about what services PRC would cover during the closure.

At the onset of the closure, the Area Director incorrectly stated that IHS would cover all ED-related costs, regardless of whether patients’ conditions met Rosebud’s PRC criteria, which

included only emergent or acutely urgent-care services (i.e., services necessary to prevent the immediate threat to life, limb, or senses). Shortly thereafter, IHS clarified that the Rosebud PRC program would continue to follow the same guidelines used under normal circumstances and only cover “life-or-limb” cases, which raised concerns in the tribal community. The Tribal Health Board Director stated that IHS’s decision to cover only life-or-limb cases sent a message to the community to “triage” themselves during the closure. If a tribal member presented at one of the receiving hospital EDs with a condition that the patient believed was emergent but turned out to be non-emergent, the medical services would typically not be covered by PRC. Instead, the patient would be responsible for the medical expenses. However, if the same patient had presented at the Rosebud ED, if it had remained open, the costs for the medical services would have been covered by IHS regardless of whether the condition was emergent.

Receiving hospital administrators reported that the closure was costly, and that IHS did not always provide reimbursements in a timely manner. The receiving hospitals were accustomed to receiving patients from Rosebud during other types of diversions (e.g., surgery, obstetrics), but the ED closure was different and posed a greater burden on these hospitals. The length of the closure and the large number of emergency patients arriving in their EDs resulted in greater expenses for the receiving hospitals. For example, one of the receiving hospital administrators explained that in addition to the costs associated with the services provided to the diverted emergency patients, the hospital accrued expenses related to staff overtime hours, salaries for new hires brought onboard to handle the patient influx, and air transports for the diverted patients whom the receiving hospital was unable to care for. The administrator also noted that the hospital covered other costs, such as patient co-pays, medications, and transportation of discharged patients.

Although Rosebud received additional funds during the ED closure, administrators from the receiving hospitals reported that IHS was sometimes slow to reimburse the hospitals for their medical expenses associated with the diverted patients. The receiving hospitals often waited several years to get paid for services provided to Rosebud patients. The administrator at one of the receiving hospitals noted that IHS’s payment system is complex as it does not cover all costs and often runs out of money, causing reimbursement delays.

IHS provided some additional funds to EMS, but the tribe reported that these funds were insufficient to cover all the costs associated with the closure. According to the EMS Director, the EMS fleet and personnel budget incurred substantial extra costs as a result of the closure. EMS had to hire additional staff and work many overtime hours to transport the high volume of emergency patients to other facilities. Although IHS provided some additional funds to reduce the burden on the tribally operated EMS program, the EMS Director reported that these funds did not cover all of the additional expenses resulting from the closure.

Section 1: Key Contributing Factors

Factors that led to and complicated the ED closure

Insufficient hospital staffing

Staffing shortages at Rosebud Hospital, particularly in the ED, contributed to findings of noncompliance with the Medicare CoPs and increased dependence on contracted providers rotating in and out.

Changing and inconsistent hospital leadership

Instability and inexperience in key leadership positions made it more difficult for IHS to make strategic, long-term improvements at Rosebud Hospital.

Inadequate hospital infrastructure

Rosebud Hospital did not have an adequate infrastructure to ensure basic quality care, including policies and procedures, working equipment, and staff training.

Lack of oversight by IHS

IHS officials and staff described poor relationships between the Great Plains AO and Rosebud Hospital, and communication breakdowns across IHS, which limited support for identifying and correcting problems.

Poor coordination with local partners

IHS submitted a plan to CMS for operating without an ED but did not adequately communicate with hospital staff, EMS, and receiving hospitals, who received little warning and were overwhelmed with demand.

SECTION 2

CORRECTIVE ACTION AND REOPENING

Despite HHS-wide assistance, IHS was unable to correct Rosebud’s deficiencies and entered into an SIA with CMS in April 2016, facing termination from Medicare

IHS developed a plan of correction and obtained assistance from other IHS hospitals and Commissioned Corps officers, but CMS found continued noncompliance during a revisit.

Shortly after the CMS onsite survey in November 2015, which led to the ED closure, IHS submitted a plan of correction to CMS to address Rosebud’s noncompliance with the CoPs and temporarily reassigned staff from other facilities to assist at the hospital. Rosebud Hospital staff reported that these reassignments sometimes placed undue burden on other facilities because those facilities already struggled to ensure sufficient staffing levels. In the days that followed, the former IHS Principal Deputy Director, with assistance from the former Acting Deputy Secretary of HHS at the time, made a special request to the Office of the Surgeon General and the USPHS for deployments of Commissioned Corps officers to assist Rosebud and other Great Plains facilities. USPHS, which comprises approximately 6,500 licensed, public health and safety professionals (e.g., doctors, nurses, and mental health providers), assigned to over 20 Federal agencies, is available to the President and the HHS Secretary to rapidly respond to any public health emergency or crisis within or outside the United States.

In early January 2016, USPHS deployed its first officers to Rosebud—including three nurses, an ED physician, and an occupational therapist—to provide healthcare facility leadership, direct patient care, clinical quality management, and other professional services. According to Great Plains Area staff, the primary task for these officers, who were onsite for approximately 6 weeks, was to help Rosebud staff develop and implement policies across the hospital (e.g., nursing, ED) to meet the CoP requirements.

Despite IHS’s plan of correction and reassignment of staff, and USPHS’s deployment of Commissioned Corps officers, IHS was unable to achieve compliance with the CoPs at Rosebud Hospital. During a followup survey in February 2016, CMS found continued noncompliance with five CoPs: Governing Board, QAPI, Medical Staff, Medical Record Service, and Physical Environment. CMS also found

“Everything was broken, knowing what I know... We were creating task-oriented solutions to address deficiencies, but the problems were bigger than the tasks.”

—IHS official

noncompliance with an additional CoP, Nursing Services. A CMS official acknowledged that IHS attempted to make corrections but indicated that leadership churn and staffing shortages plagued the hospital's ability to sustain those corrections. The official also noted an apparent lack of urgency for IHS to properly address the problems at Rosebud.

“SIA” agreements are fairly rare, and typically reserved for serious and longstanding problems. CMS reported to OIG that during 2016, only four hospitals nation-wide were under SIAs.

CMS entered into an SIA with IHS after recognizing the impact the termination would have on the community, and outlined specific tasks for IHS to achieve compliance and reopen the ED.

CMS granted IHS several extensions to the termination date of Rosebud, while exploring the option of developing an SIA. After considering the impact that the termination would have on the Rosebud Sioux Tribe, CMS entered into an SIA with IHS in April 2016 and suspended the termination pending Rosebud's fulfillment of the agreement.⁵⁷ A few days before the SIA was signed, AO staff met with the tribe to inform them of the agreement. These meetings continued through the duration of the SIA, during which IHS provided the tribe with updates on Rosebud's improvement activities. IHS also communicated regularly with CMS, both at the regional and headquarters level, about Rosebud's progress on SIA-related tasks.

The SIA outlined an actionable plan with descriptive tasks for IHS to address Rosebud's compliance issues. Those tasks were as follows:

- › Update hospital policies, procedures, and processes;
- › Design and implement an effective and sustainable QAPI program;
- › Improve Rosebud's governing body;
- › Improve privileging and credentialing processes of medical staff; and
- › Develop recruitment, integration, and retention strategies to address vacancies.

An IHS official explained that the SIA put the deficiencies and corresponding tasks into an understandable and user-friendly format. The SIA laid out specific tasks for reopening the ED and ensuring safe provision of emergency care. To reopen the ED, IHS had to evaluate and address resources needed for safe operation (e.g., staffing, equipment); supplement qualified and credentialed IHS staff with contracted providers until IHS could recruit an experienced and qualified ED staffing contractor to operate the ED; conduct a mock survey to ensure compliance with the CoPs and EMTALA requirements; and notify CMS of its intent to reopen the ED at least 10 days in advance of the reopening.

“The SIA focused on the efforts that needed to be addressed and put them into practice.”

—IHS official

As part of the SIA, CMS contracted with an independent quality monitor who provided onsite observations and evaluations of Rosebud's progress in meeting the terms of the SIA. The monitor worked directly with Rosebud leadership and staff and provided CMS with monthly summary reports of the onsite visits and quarterly reports of Rosebud's overall progress. CMS shared these reports with IHS and the tribe throughout the SIA. Rosebud and Area staff noted that having the monitor onsite was helpful and reinforced the importance of making changes.

IHS made improvements at Rosebud prompted by the SIA, some of which resulted in agency-wide changes, but struggled to secure staff and resume ED services

The SIA was a turning point for Rosebud and intensified IHS's focus to make systemic improvements and reopen the ED. According to Rosebud staff, there was no structure prior to the SIA to address deficiencies systemically. To meet the demands of the SIA and to reopen the ED, IHS reassigned experienced and highly qualified staff from across the agency for temporary duty assignments at Rosebud, requested additional deployments of Commissioned Corps officers, and contracted with a staffing company to operate the ED once it reopened.

IHS assigned a leadership team to direct the improvement efforts at Rosebud, which included addressing personnel issues, policies, QAPI, governing body, and renovations.

A month after signing the SIA, IHS assembled a team of experts from across the agency, known as the SIA Phase 1 team ("SIA team") and sent them to Rosebud to provide immediate onsite management, leadership, and support. The SIA team members served in acting capacity as the CEO, Chief Operations Officer, Chief Information Officer, CMO, Director of Nursing (DON), and Director of QAPI at Rosebud. They were tasked with mitigating risk factors, preventing deficiencies identified by CMS, and reopening the ED.

The SIA team remained at Rosebud until it was replaced by another team a few months after the ED resumed its services. Rosebud and Area staff noted that the SIA team was key to turning the hospital around and reopening the ED. Upon arrival, the team began making immediate changes, including activating a hospital incident command system (HICS); addressing personnel issues; developing, updating, and implementing policies, procedures, and processes; designing and implementing a QAPI program; developing a robust governing body; and directing renovations in the ED.

HICS. Within a week of arriving at Rosebud Hospital, the SIA team activated the HICS, a management system designed to deal with an event that challenges or exceeds the medical infrastructure (such as an emergency or a disaster). The HICS structure establishes a clear chain of command, allows collaboration across departments and delegation of responsibilities, provides logistical and administrative support to operational personnel, and ensures coverage of key functions.⁵⁸ A member of the SIA team reported frequent meetings (twice per day) with hospital staff under the HICS structure to assign tasks and monitor the progress of the SIA activities. The team also held weekly meetings to review the SIA plan in its entirety and discuss any challenges or possible barriers.

Personnel issues. The SIA team took immediate action to instill a culture of trust within the hospital and the community by addressing personnel misconduct and building rapport with staff through open communication and behavior modeling. An IHS official, who served on the SIA team, reported that there was a significant amount of personnel-related fraud, waste, and abuse at Rosebud (e.g., staff not reporting to work or staff clocking in, leaving, and later returning to the hospital to clock out). IHS terminated several hospital staff during the team's first month onsite. The IHS official emphasized the importance of setting the tone early on about acceptable and unacceptable conduct, and for leadership to model and not just

6,500
hospital policies
removed
that were obsolete or
duplicative.

verbalize appropriate behavior. According to the official, with the many changes in leadership over the years, Rosebud staff “had not seen what appropriate leadership looked like.”

Policies. To address systemic issues, the SIA team completely overhauled Rosebud’s policies, procedures, and processes, which were in disarray after years of poor management and lack of policy review. Rosebud staff and SIA team members reported that the absence of clear ownership of policies, and of a sufficient cataloging system of hospital policies, procedures, and processes, had resulted in duplications and multiple revised versions of the same documents, which made it difficult for anyone to identify current policies. These documents resided on a shared drive without any access control, which meant that anyone could modify the documents without approval. To address this problem, Rosebud acquired a web-based management software tool and spent many hours reviewing, updating, approving, and implementing policies, procedures, and processes. The SIA team began this effort in the ED, but eventually all hospital departments were included in the effort. The result was a significant reduction in the number of policy, procedure, and process documents—from approximately 8,000 to 1,500. At the time of our onsite review, in August 2017, nearly all IHS-operated hospitals in the Great Plains had begun using this same web-based management software tool.

The SIA team also implemented an approval process for revising or adding policies. Any policy changes now had to go through the committee of the department from where the policy originated (e.g., ED committee reviewed ED policy) and obtain approval from the medical executive, hospital leadership, and occasionally the governing board. To ensure that Rosebud staff were aware of policy changes, staff received an email notification if a document was revised or added, which required their review and signature.

QAPI. To improve quality of care and oversight, the SIA team established a QAPI program across the hospital departments, which other facilities later adopted. Although Rosebud had some semblance of a QAPI program, the program lacked the capability to detect and resolve issues. Hospitals may customize QAPI programs to best suit their individual needs, but the programs should be data-driven, hospital-wide, and result in specific interventions designed to improve health outcomes for patients.⁵⁹ Rosebud staff noted that past leadership did not understand the importance of the QAPI program and lacked knowledge to implement the needed structure. Staff had previously requested assistance to improve the QAPI program but reported that they never received a well-suited person for that role. With the SIA team onsite, Area and Rosebud staff stated that the hospital was able to establish a functioning QAPI program by using the SIA team’s expertise and assistance from across IHS to identify appropriate metrics. Rosebud primarily based its QAPI goals on each department’s plan of correction. These plans were developed in response to the CMS deficiency citations.

As part of the QAPI program, the team implemented daily quality assurance meetings. Also, once the ED reopened, Rosebud began conducting trigger chart reviews and remediation if any issues were identified. According to an IHS official, Rosebud’s QAPI improvement efforts eventually spread throughout the Great Plains and other Areas. The AO also began to have a

larger role in the hospital's QAPI program. At the time of our onsite review, Area staff were meeting monthly with Rosebud staff to discuss QAPI-related issues.

Governing body. Prior to the arrival of the SIA team, Rosebud did not have a rigorous governing body to provide sufficient oversight. Area staff described how the governing body was disproportionately heavy in AO representation and disconnected from the issues that arose at Rosebud. To prevent further failure to recognize and address problems at Rosebud, the SIA team leveraged their expertise and lessons learned from other facilities to create a more robust governing body. An IHS official reported that Rosebud's revised approach served as the model for IHS's standardization of governing board bylaws across all IHS-operated hospitals, which went into effect in January 2017.

Under the revised structure, the Area Director served as the chair of the governing board and ensured adequate representation of disciplines to carry out the required activities. All governing board members had a vote and although the majority of voting members had to represent the AO, the governing board could include similar representation from the hospital. Tribal leaders no longer had a vote on the governing board, but AO staff noted that tribal leaders were encouraged to participate and present tribal reports during governing board meetings, except when personnel issues or patient data were on the agenda. The new bylaws required that governing board meetings, at a minimum, included topics of quality of care, patient safety, and hospital operations. The bylaws also required that the governing board met twice per year, but at the time of our onsite review, Area staff noted that the governing board convened quarterly, twice onsite to allow more interaction with the tribe and twice by phone.

Rosebud could also request ad hoc governing board meetings, which occurred frequently, to discuss incidents or to initiate the credentialing process of a provider. Rosebud staff reported that the credentialing process improved with the revised governing board. Before the new bylaws, Rosebud had frequently used 120-day temporary credentialing approvals to bring staff onboard quicker because the credentialing process at the AO was slow. This practice stopped once the new structure was put into place.

No Renovation for Years

Prior to 2016, Rosebud went 26 years without a major renovation.

Renovations. Rosebud had not undergone a major renovation in 26 years and hospital staff reported that the ED was not well laid out. The location of certain walls affected accessibility and separated staff, which ultimately affected the oversight of both patients and staff. To optimize and improve the physical space of the ED, IHS seized the occasion to reconstruct the space while it was closed, and remodeled the nurses' station, triage, and trauma, using funds from IHS headquarters. IHS also repaired and replaced some equipment, and Rosebud provided training to ensure that staff knew how to operate the equipment.

The Great Plains AO and IHS headquarters also undertook improvement efforts while assisting and supporting Rosebud. At the time of the ED closure, it became apparent to IHS leadership that the Great Plains AO also needed to make improvements to restore collaboration and to provide better monitoring of Rosebud and other facilities. An IHS official indicated that if the AO had been functioning properly, then Rosebud could have received more support and

guidance, which in turn may have prevented the hospital from ending up in such a dire situation. To address the issues at the AO, IHS temporarily assigned experienced staff from across the agency who worked on improving all aspects of Area operations, from finance to acquisition to human resources. An IHS official reported that these changes were initially resisted by some of the existing staff, and as with Rosebud, the temporarily assigned staff had to address several performance and conduct issues shortly after arriving at the AO.

IHS headquarters also made some changes during the closure, which it launched in the months following the ED reopening. In November 2016, IHS launched the IHS Quality Framework and undertook several improvement efforts following the launch. These efforts included: (1) awarding a master contract for accreditation of hospitals; (2) acquiring a credentialing software system to standardize the credentialing process; (3) implementing a quality assurance accountability dashboard to improve transparency on access to and quality of care; (4) establishing patient wait time standards for primary- and urgent-care settings; (5) developing a standard patient experience of care survey; and (6) implementing ED telehealth consultation in the Great Plains and Billings Areas to provide access to specialized emergency medicine doctors and nurses.⁶⁰ In December 2018, IHS announced a reorganization plan that included a new Office of Quality, which would be responsible for the agency's quality and safety-related work. This reorganization became effective in January 2019, and the Office of Quality is now led by the Deputy Director of Quality Health Care.⁶¹ Under this structure, each AO has a Chief Quality Officer and each facility has a QAPI Officer.⁶²

Additionally, with assistance from agencies represented on the HHS Executive Council on Quality Care, IHS implemented several recruitment and retention strategies to better attract qualified candidates. Through its partnership with USPHS, IHS now had priority access to Commissioned Corps applicants. IHS also exercised its partnership with HRSA to recruit and retain primary-care providers, using HRSA's National Health Service Corps scholarship and loan repayment incentives. IHS also utilized global recruitment, which allowed applicants to apply to a single job posting and be considered for multiple positions at different locations. To prepare individuals selected to serve in leadership positions at the different levels of the agency, IHS developed leadership training, which it launched a month prior to the ED reopening.⁶³

Throughout the closure and following the reopening, the AO and IHS headquarters communicated with Rosebud about the improvement activities at the hospital, AO, and IHS headquarters. An IHS official who served on the SIA team reported that Rosebud met weekly with IHS headquarters and Area leadership to discuss the progress and any challenges they faced in fulfilling the SIA and reopening the ED. The official stated that the AO and IHS headquarters initially requested an overwhelming amount of reporting, which hindered the team from effectively working on tasks. The SIA team voiced this concern and, given that the requests often overlapped, IHS leadership agreed to reduce and compile the reporting.

For the weekly meetings with IHS leadership and the AO, the SIA team developed and presented a briefing document, which typically covered five key focus areas for that week. The team also did a walkthrough of any recent updates to the SIA work plan during those

meetings. Rosebud staff and SIA team members alike said that they felt supported by IHS leadership throughout this event. One SIA team member said that IHS leadership tried to find solutions to help close every gap that the team identified. An IHS official who was temporarily assigned to the AO noted that, prior to the ED closure, IHS leadership did not fully grasp the needs and challenges in Great Plains or at Rosebud. With first-hand experience, IHS leadership now has a better understanding of the situation, the IHS official said.

IHS requested additional deployments of Commissioned Corps officers who, despite their short stays, were key for getting the ED ready for reopening. In 2016, USPHS deployed 193 Commissioned Corps officers to the Great Plains, at the request of IHS and HHS leadership. A total of 52 officers were assigned to assist at Rosebud Hospital. They filled various non-medical and medical roles, ranging from facility managers to safety officers to physicians. A USPHS official noted that officers were deployed on the basis of IHS's request for specific professions or tasks. Many officers who were sent to Rosebud had medical backgrounds but had not practiced medicine for some time and were not clinically current. The SIA team assigned those officers to administrative functions such as revising policies and procedures, conducting quality assurance checks, implementing processes, developing QAPI dashboard systems, establishing infection control program, and mentoring staff. The officers who were still practicing medicine assisted with clinical care throughout the hospital departments, including inpatient and urgent care.

Although IHS wanted longer deployments, the Commissioned Corps officers generally rotated in and out of Rosebud every 2–4 weeks. A USPHS official explained that deployments were designed to be short-term so that officers could assist at other locations because there were not enough officers to meet the national and global demands. The official stated that USPHS previously had an Inactive Reserve Corps, comprising 10,000 inactive officers, who could be called on to assist during an event. However, the Inactive Reserve Corps was abolished under the Affordable Care Act in 2010, which significantly reduced the number of available officers.⁶⁴ Rosebud staff reported that the short stints of the deployments were sometimes disruptive and difficult to work around, particularly if the officers were unfamiliar with IHS and needed time to learn the system. Yet, staff noted that these officers played a crucial role in ramping up the improvement efforts needed to reopen the ED. As described by an IHS official, Rosebud was able to “stop the bleeding” with the help of the Commissioned Corps officers.

The deployments of the Commissioned Corps officers continued for several months after the ED reopened. This arrangement was unusual and somewhat challenging for USPHS because the deployment request did not have an end date. A USPHS official explained that deployments are typically based on a public health emergency declaration, which has a built-in timeframe that can be extended if needed. The deployments to the Great Plains were different because the directive came from the HHS Office of the Secretary without a declaration of a public health emergency. A few months after the Rosebud ED reopened, USPHS began to look for an exit strategy, and together with IHS leadership established an end date for December 2016.

IHS awarded a staffing contract for the ED but struggled to obtain qualified providers. Around the time that the SIA went into effect, IHS awarded a contract for a private staffing company to staff the ED. Although IHS had prior experience working with this contractor both in the Great Plains and in other Areas, an IHS official noted that this was the first time that IHS had ever outsourced an entire ED, including management, which proved to be a challenging task. The contractor had difficulty delivering enough qualified providers in a timely manner. An IHS official who was part of the SIA team acknowledged that the contractor worked hard to fulfill the contract but noted that IHS was ultimately responsible for ensuring that providers were qualified.

A former IHS official who was involved in the vetting and credentialing process of providers at the AO reported rejecting many of the providers forwarded by the contractor because of problematic backgrounds or insufficient qualifications. For example, the official recalled rejecting a provider who failed to disclose a DUI (driving under the influence) arrest on the application. Another prospective provider, whom IHS also rejected, had a record of sexual abuse. Furthermore, some providers in the contractor's staffing pool had worked at Rosebud in the past but had been removed due to performance or conduct issues.

The first contracted staff began to arrive at Rosebud about a week before the ED reopened, but it soon became clear to IHS that the contractor would not be able to fully staff the ED by the expected reopening date as promised. IHS had already delayed the reopening date several times due to staffing shortages and was set on keeping its July 2016 reopening date. To keep the date and adequately staff the ED, IHS had to find another solution. IHS officials reported that this involved supplementing the contracted ED providers with existing Federal staff, including former Rosebud ED nurses, and providers from the urgent-care clinic who were under different contracts. This arrangement, and the staggered arrival of contracted providers, continued long after the ED reopened.

Prior to the ED reopening, IHS conducted several assessments and trainings to ensure that the ED was ready to resume services

In the weeks leading up to the reopening, IHS conducted and contracted numerous assessment, analysis, and training activities to ensure that the ED was survey-ready for CMS and capable of caring for emergency patients. The SIA team reported performing mock surveys, sometimes with the assistance of staff from across the agency. During the ED mock surveys, the SIA team checked crash carts to ensure that they were easily accessible and fully stocked with essential medications and equipment, and assessed both Federal and contracted hospital staff's ability to operate the crash carts. The mock drills also included trial runs with EMS during which an ambulance would bring a mannequin ("patient") on a stretcher into the ED. If the team identified inadequacies during a mock survey, it would rectify the problems and provide additional

"We had to make sure we were ready because if we failed, that would be hard to recover from."

—IHS official

training to staff. According to an SIA team member, Rosebud ran these drills until a couple of days before the reopening.

In addition to the mock surveys, the SIA team conducted tabletop exercises. These exercises are meetings during which hospital leadership and staff typically review and discuss roles and responsibilities during an imagined scenario, which may identify gaps in planning and communication.⁶⁵ The SIA team also conducted multi-week failure mode and effects analysis, a proactive method for identifying and addressing potential problems or failures and their resulting effects on the system or process before an undesirable event occurs.⁶⁶ The failure mode and effects analysis at Rosebud included all hospital departments and looked for failure process points in every part of the hospital. As directed under the SIA, IHS also contracted with an accrediting organization to conduct gap analysis at Rosebud to inform the SIA team of the hospital's readiness for a CMS survey. Similar to the other assessment and analysis activities, the SIA team worked on addressing any deficiencies identified in the gap analysis.

IHS reopened the Rosebud ED in July 2016 after correcting its deficiencies, but concerns about sustainability remained, primarily because of staffing instability

ED Critical to Rosebud Operations
During the first 2 weeks after the ED reopening, Rosebud had 732 ED patients.

Seven months after IHS closed the ED and after numerous improvement efforts and assessments, the SIA Acting CEO determined that the hospital was ready to resume emergency services. This decision, approved by IHS leadership, came after CMS conducted a walkthrough of the ED and confirmed that Rosebud had cleared the ED-related deficiencies found during the November 2015 survey. Prior to resuming services, IHS notified the tribe of its decision to reopen the ED and issued a press release on its website. The ED immediately began treating patients once it reopened, but it continued to experience staffing challenges. During the 16 days that remained in July, Rosebud reported 732 ED visits, averaging 46 ED visits per day. In following months, IHS continued working on the improvement efforts laid out by the SIA, but frequent shift in leadership sometimes caused confusion and disruption. The improvement efforts eventually led to the completion of the SIA and CMS's removal of Rosebud's pending termination from Medicare; however, continued leadership instability raised concerns about the sustainability of those improvements

The preparedness efforts in the ED were put to the test immediately after the reopening, and Rosebud experienced challenges with the staffing contract and frequent changes in leadership. The ED began seeing patients on the first day it reopened, and within the first week, a nearby fatal car collision, involving eight people, tested Rosebud's capabilities. EMS transported all victims to the Rosebud ED, which at the time was staffed with a mixture of Federal and contracted providers. The EMS Director described the event as chaotic and indicated that although there were many medical staff present in the ED, some of the new contracted staff were ineffective because they were unfamiliar with the hospital.

Although the SIA called for a contractor to operate and manage the ED, IHS officials and staff reported that the outsourcing of the ED was a challenge because not only was the contractor unable to fill all shifts until nearly a year after the ED reopened, some of the contracted providers struggled to keep up with Rosebud policies and procedures. For example, Rosebud

staff stated that some providers failed to consistently document their medical decisions in the medical records and did not participate in remediation activities when issues were identified. The CMS monitor, who frequently visited and observed Rosebud's progress as directed by the SIA, also noted in her reports to CMS that staffing continued to be a problem in the ED after it reopened. Some of the issues that the monitor observed related to contracted staff not showing up for work or leaving without notice, forcing IHS to try to backfill staffing at the last minute. The staffing shortages sometimes resulted in longer wait times for patients or patients leaving without being seen by a healthcare provider.

An IHS official who served on the SIA team said that it was a mistake to have a contractor manage the ED. With contracted staff overseeing other contracted staff, IHS had to follow the contractor's processes when dealing with performance issues in the ED. An Area staff member underscored the importance of having a strong Federal presence in the ED because IHS was ultimately responsible for the care provided at Rosebud.

"In hindsight, the agency should never have entered into a management contract in the ED."

—IHS official

To ensure that the quality and safety in the ED were satisfactory, an IHS official reported that the SIA team implemented several monitoring tools after the reopening. The team held daily ED-specific meetings and developed an ED dashboard with various data analytics for daily review. The team also implemented comprehensive chart reviews of every new provider for the provider's first 30 days. To ensure that medical staff were familiar with hospital policies, procedures, and processes, Rosebud established a 3-day orientation for new staff and a 1-day orientation for returning staff who had not worked at the hospital in the last 30 days, given that many contracted staff rotated between facilities. In addition to these oversight and training activities, IHS continued to work on the hospital-wide improvement efforts outlined by the SIA.

Despite the many improvements at Rosebud, staff reported concerns about the frequent rotation in hospital leadership. After the SIA Phase 1 team departed a few months after the ED reopened, several other SIA teams came and left, which staff explained caused confusion and frustration because each team would change direction and focus, often without any input from permanent staff. A Rosebud staff member indicated that there was a clear separation between the temporary leadership teams and the rest of the hospital staff. The staff member questioned how the hospital could sustain improvements without stable leadership and inclusion and mentoring of permanent staff. A CMS official also expressed concerns about the leadership churn impacting Rosebud's ability to achieve and maintain compliance with the CoP requirements. A CMS surveyor reported that every time the survey team went onsite, they were greeted by a new, acting leadership team at Rosebud and they would find deficiencies that had not been addressed or corrected.

Section 2: Key Contributing Factors

Factors that led to improvements and reopening of the ED

Accountability for compliance and quality

IHS brought in an accomplished team of clinical and management leaders with experience in solving problems and maintaining compliance, holding staff accountable, and fostering a culture of shared responsibility.

Systemic changes

IHS and hospital officials employed systemic methods to identify and address problems, leading to widespread change for the hospital and agency.

Standardized policies and procedures

IHS and hospital officials developed and revised hospital policies, delineated clearer roles and responsibilities, and streamlined procedures.

Investment in staff training

IHS and hospital officials conducted assessments and training to better ensure that hospital staff were prepared and proficient in treating patients.

Improved communication and support from IHS

Rosebud Hospital officials had more frequent communication and closer collaboration with the Great Plains AO and IHS headquarters, and additional support across HHS.

SECTION 3

CONTINUING CONCERNS AND SUSTAINABILITY OF IMPROVEMENTS

IHS completed the SIA in September 2017, but Rosebud was again cited in July 2018 with an IJ-level deficiency in the ED and placed by CMS on a termination track

Vacancies in ED
In September 2018, Rosebud Hospital had 69 vacancies and 7 of these were in the ED.

Despite earlier progress and extensive support from IHS and other HHS agencies, the Rosebud Hospital continued to struggle to remain in compliance with the Medicare CoPs. In September 2017, CMS determined that Rosebud met all CoPs and provisions outlined in the SIA, and rescinded the hospital's pending termination from Medicare. However, in the following months, IHS continued to have difficulty securing long-term hospital staff and adequate leadership at Rosebud. In September 2018, Rosebud Hospital had 69 vacancies (7 were in the ED) that were mostly filled by contracted providers, and between July 2016 (the ED reopening) and September 2018, Rosebud had 6 CEOs, 3 Clinical Directors, and 9 DONs.

Less than a year after IHS completed the SIA, in July 2018, CMS found new compliance issues in the ED during a complaint survey. These compliance issues involved an IJ for failing to ensure that the ED call system was working and failing to provide emergency care for two patients who presented in the ED with behavioral health needs:

- A pediatric patient with alcohol intoxication who was left unattended in a separate room during which the patient attempted suicide; and
- An adult patient suffering from paranoia and with methamphetamine in the system who died after being chemically and physically restrained.

To remove the IJ, IHS provided Rosebud Hospital staff with additional training on the ED call system and re-educated staff on hospital policies. During a followup survey in August 2018, CMS determined that IHS had corrected the IJ deficiency in the ED. However, in conducting the followup survey, CMS surveyors found other issues and cited Rosebud for condition-level deficiencies with five CoPs: Governing Body, QAPI, Radiological Services, Utilization Review, and Infection Control. Two of these CoPs, Governing Body and QAPI, were CoPs for which the hospital had previously been cited in November 2015 and February 2016. Given that these were condition-level deficiencies, Rosebud Hospital was again placed by CMS on a track toward termination from the Medicare program.

IHS officials and staff attributed the recent deficiencies to a new hospital leadership team, installed at Rosebud in December 2017, not following IHS directives and discontinuing improvement efforts and processes established during the SIA. IHS officials reported that In February 2018, Rosebud Hospital leadership failed to submit performance data and documentation on hospital improvement activities during a governing board meeting. Shortly after that meeting, the AO began providing enhanced guidance to the hospital leadership team, but the problems continued. In April 2018, the Acting Area Director ordered an independent mock survey of the hospital to further assess its performance and provide additional oversight. The mock survey team found an array of problems, including documentation issues; failure to update, implement, and train staff on policies; lack of adherence to QAPI processes; and deterioration of care, particularly related to infection control. The Acting Area Director informed hospital leadership of the findings and requested immediate correction but to no avail. IHS finally removed the leadership team, around the time of the CMS survey in July 2018, and sent AO staff with previous Acting leadership experience at Rosebud Hospital to resolve the deficiencies and achieve compliance with the Medicare CoPs.

IHS Corrected Deficiencies

Two weeks before the expected termination date, Rosebud came back into compliance with the CoPs.

The termination from Medicare was initially set for August 2018, but CMS reported that it extended the termination date to November 2018 after IHS submitted a plan of correction. A couple of weeks before the termination date, CMS revisited Rosebud Hospital and determined that IHS had corrected the deficiencies, and that the hospital was in compliance with all Medicare CoPs. However, in a subsequent interview with OIG, CMS survey staff expressed concerns about the sustainability of those corrections, given that IHS continued to rely on short-term contracted providers to fill vacancies and temporarily reassigned agency staff to fill leadership positions. Over the years, CMS surveyors noticed a pattern when citing Rosebud Hospital with deficiencies: IHS would reassign top-performing teams from across the agency to quickly resolve the deficiencies at the hospital, but once these teams were replaced with new and often inexperienced leadership, the problems would resurface. CMS staff suggested that the cyclical compliance issues may have been further affected by IHS's lack of training and transition of new leadership and staff. Insufficient overlap between incoming and departing staff likely prevented new staff from effectively understanding their roles and fully grasping IHS's priorities and the hospital's improvement activities and processes.

During CMS's revisit in November 2018, several key leadership positions had new Acting personnel, including the CEO, Clinical Director, DON, and the ED Nurse Supervisor. An IHS official reported that the agency was in the process of posting new job announcements for these positions, but emphasized that IHS continued to face challenges recruiting and retaining permanent leadership and staff, primarily due to the remote location of Rosebud Hospital and IHS's limited compensation packages.

Section 3: Key Contributing Factors

Factors that led to continued lapses in compliance

Continuing turnover in hospital leadership

IHS brought strong leadership teams from across IHS and other agencies to correct problems at Rosebud. However, those teams were temporary and frequent changes in leadership continued to hamper operations.

Insufficient transition of new hospital leaders

IHS did not build in sufficient overlap and transition of incoming and departing leadership. This resulted in lack of a cohesive strategy, nonadherence to agency priorities, and discontinuation of improvement efforts.

Continuing difficulty maintaining staff

As before, IHS and hospital officials struggled to recruit and retain long-term hospital staff and relied on contracted providers to temporarily fill the gaps.

Corrective actions not engrained

Temporary leaders at Rosebud instituted new policies, procedures, and training. However, those solutions were not employed long enough to fully take root with leadership and contracted staff rotating in and out of the hospital.

IHS could not sustain attention

Rosebud Hospital and the Great Plains AO received enormous support and focus from IHS and other agencies following the ED closure, but this attention could not continue indefinitely.

CONCLUSION and RECOMMENDATIONS

The problems at Rosebud Hospital that led to the closure of the ED were manifold and systemic. To resolve those problems, IHS leadership had to make changes at the hospital, AO, and headquarters levels, which required extensive assistance and support from across the agency and other stakeholders, including CMS, USPHS, tribal EMS, and surrounding community hospitals. IHS's longstanding problems at Rosebud Hospital, including provider recruitment and retention challenges and frequent changes in leadership, were evident throughout this time period and remain a concern.

Following the closure, IHS and CMS focused substantial resources on improving the quality and safety of care in the Rosebud ED and throughout the hospital. This focus came at a cost to other IHS hospitals in leadership, staffing, and other resources. The SIA was a turning point for IHS to address the problems at Rosebud, and the SIA team in particular played a key role in correcting the deficiencies in Rosebud's ED and across the hospital. The team addressed personnel issues, revised policies, established a QAPI program, and restructured the governing body, among other efforts. IHS made many improvements at Rosebud and has continued to make changes throughout the agency.

Still, CMS found a new IJ deficiency and condition-level deficiencies in the Rosebud ED during July–August 2018, which raises the question of whether the improvements were sustainable. Despite the intense focus of the SIA and other efforts, leadership and staffing instability continues to affect hospital operations.

There is little question that IHS's handling of the ED closure was problematic and had negative consequences for the affected parties. But it is important to recognize that the closure was preceded by Rosebud's inability to remain in compliance with the Medicare CoPs. The factors that contributed to the noncompliance, including staffing inadequacies and changing leadership, were longstanding and occurred before, during, and after the closure. These issues will require IHS's continued focus. Innovative solutions are needed to avoid cyclical noncompliance by Rosebud and prevent residual impact of that instability on the hospital and the overall agency.

To address the problems that we identified in this case study of Rosebud Hospital, and to avoid and minimize similar problems across IHS hospitals, we make four recommendations to IHS:

As a management priority, develop and implement a staffing program for recruiting, retaining, and transitioning staff and leadership to remote hospitals

IHS had difficulty maintaining an adequate workforce and consistent leadership at Rosebud before, during, and after the ED closure, which affected the hospital's ability to maintain compliance. Frequent changes led to confusion about the roles and responsibilities, instability among staff and the hospital culture, and continuing shifts in management strategies for improving operations. The impact of these longstanding challenges, particularly inadequate staffing, is profound and inhibits progress in correcting all other problems.

As such, IHS should intensify efforts and build on the goals and objectives of its strategic plan to stabilize staffing and leadership at Rosebud and other remote hospitals. IHS's top priority should be to find innovative ways to recruit and retain permanent providers and long-term hospital leaders, which includes establishing tangible targets for filling staffing and leadership positions. This alone will not solve all of Rosebud's challenges, but it is necessary for long-term success. Without addressing this staffing issue, it is difficult to envision how IHS could achieve sufficient and lasting clinical improvements.

IHS should maximize opportunities to access Departmental resources and experts, and continue to look for new partnerships both within and outside of HHS to identify and implement additional recruitment and retention tools.

Possibilities include working with the Office of Personnel Management to develop a new model for staffing remote IHS facilities, and looking at how other Federal agencies, such as the Department of Defense, and private healthcare organizations have structured programs to address similar staffing challenges. IHS should also consider seeking the necessary regulatory and/or legislative changes to implement a new sustainable plan for staffing remote IHS facilities.

Enhance training and orientation for new hospital leaders to ensure that they follow IHS directives and continue improvement efforts

IHS launched a leadership training, shortly before it reopened the Rosebud ED, to prepare new leaders at different levels of IHS for their new roles. However, it is unclear whether IHS continued this training effort after its initial launch and whether the training addressed hospital-specific needs. To counter confusion about the roles and expectations of new hospital leaders, IHS should continue to provide leadership training that includes specific instructions and information related to hospital management.

IHS should also establish longer transition periods and overlap between incoming and departing leadership to ensure that new hospital management teams understand the priorities and directives of IHS. This action could include having experienced leadership and staff from other facilities and AOs working side-by-side with new hospital leaders for an extended period of time to provide mentoring and guidance on IHS improvement efforts and hospital policies, procedures, and processes.

Continue to take steps to ensure early and effective intervention when IHS identifies problems at hospitals

Given the frequent change in hospital leadership and contracted providers, it is crucial for IHS to closely monitor hospitals' performance and intervene early and effectively to correct problems before they reach a level of noncompliance. IHS revised the governing board structure to improve AO oversight of hospitals, and following the revelation of renewed problems at Rosebud in February 2018, the Great Plains AO took quick and substantial action to make changes and improve practices. This quick turnaround appears to have been supported throughout the AO and IHS headquarters. To ensure that IHS policies outline the necessary steps for closer monitoring and quicker intervention by AO and headquarters leadership, IHS should assess its policies and revise them as needed. Close monitoring and quick action could avoid a potential crisis and ensure that IHS addresses problems that may arise at its hospitals in a timely and consistent manner.

Develop procedures for temporary ED closures and communicate those procedures with receiving hospitals and EMS to ensure that they are adequately prepared to receive diverted patients during such events

IHS and Rosebud Hospital leadership did not effectively plan for, coordinate, or communicate the ED closure, which caused confusion among some staff and had serious ramifications for surrounding hospitals and the community. The receiving hospitals and EMS received little warning about the closure and were quickly overwhelmed with demand. IHS's lack of problem management continued throughout the closure and afterward. An administrator from one of the receiving hospitals reported continuing uncertainty about who to contact at IHS if a future ED closure occurs. Despite lessons learned from problems caused at the closure, Rosebud and IHS continued to be slow in supporting its partners and failed to substantially improve its transparency and communication. Given that IHS temporarily suspended emergency services in several hospitals in recent years, it is incumbent on IHS to ensure that hospitals are adequately prepared to handle any future ED closures.

To ensure preparedness, IHS should develop plans, procedures, and training that clearly define leadership and staff roles and responsibilities at all levels of IHS (hospital, AO, and headquarters) during an ED closure, all of which were lacking at Rosebud. Such efforts could include activating the HICS, which could assist hospitals in managing the closure and addressing the problems needed to resume services. Each hospital should tailor its plans and procedures to the hospital-specific needs and environment, and could include forming MOUs with surrounding hospitals and EMS, likely to be affected by the ED closure and diversion of emergency patients. The plans should also include instructions for notifying affected parties of the temporary closure, including the IHS hospital staff, tribes, receiving hospitals, and EMS. Inconsistent notifications during IHS's closure of the Rosebud ED caused confusion and hindered adequate preparation among the affected parties.

To ensure that IHS hospitals are familiar with the plans and procedures, IHS should provide training to all staff. Prior to the closure, Rosebud staff had no information or knowledge about the procedures or expectations during an ED closure. Considering that some hospitals and AOs struggle with frequent staff and leadership turnover, IHS should ensure that all new staff are aware of the plans and procedures for ED closures, and that plans are reviewed and updated regularly. As part of the training, IHS could share lessons learned across the facilities, including its experiences in closing and reopening the Rosebud ED. IHS should also communicate the plans and procedures with the receiving hospitals and EMS, to ensure that the affected healthcare providers can plan and prepare accordingly.

AGENCY COMMENTS and OIG RESPONSE

IHS concurred with all four recommendations and stated that it will use the findings and recommendations in this report to improve its management and operations. In its comments, IHS provided actions taken and planned as of May 2019.

In response to our first recommendation to develop and implement a staffing program for recruiting, retaining, and transitioning staff and leadership to remote hospitals, IHS stated that it has outlined the agency's commitment to recruit and retain quality staff across IHS in the IHS Strategic Plan FY 2019–2023, released in February 2019.⁶⁷ IHS stated that it will assemble a multidisciplinary, senior-level workgroup tasked with developing a comprehensive workforce plan. The workforce plan, which IHS expects to complete by May 2020, will address recruitment, training, and placement of staff into leadership positions, particularly in remote locations, as well as succession planning.

In response to our second recommendation to enhance training and orientation for new hospital leaders to ensure that they follow IHS directives and continue improvement efforts, IHS stated that it has implemented an agency-wide leadership training program for all leaders across IHS, including hospital leaders. IHS also stated that it will establish a workgroup, comprising experienced AO management and operational staff, to identify and share best practices for training and orienting new hospital leadership. IHS will incorporate the best practices into a training policy, required for all new hospital leadership, which IHS expects to complete by March 2020.

In response to our third recommendation to continue steps to ensure early and effective intervention when IHS identifies problems at hospitals, IHS stated that it is working to improve governance and accountability and provided a list of efforts undertaken. These efforts include establishing the Office of Quality, launching a national accountability dashboard for quality to measure outcomes, contracting with Joint Commission Resources for consultation services and mock surveys of IHS hospitals, implementing a new credentialing software, awarding a contract to develop a new adverse events reporting system, enhancing collaboration with CMS, and further training staff in quality improvement.

Lastly, in response to our fourth recommendation to develop procedures for temporary ED closures, and communicate those procedures with receiving hospitals and EMS to ensure that they are adequately prepared to receive diverted patients during such events, IHS stated that it has developed a preliminary outline of considerations and procedures when closing an ED under various scenarios. IHS will form a multidisciplinary workgroup that will use the outline to develop an ED closure procedure, which hospitals will incorporate into their respective emergency management plans. IHS expects to complete the ED closure procedure by December 2019.

OIG values the steps that IHS has taken, and will continue to assess updates from IHS regarding progress in implementing these recommendations.

For the full text of IHS's comments, see Appendix B.

APPENDIX A

TIMELINE OF KEY EVENTS FOR IHS CLOSURE OF THE ROSEBUD ED, 2015–2018

2015

November 19 CMS cited Rosebud with seven CoP deficiencies, including IJ in the ED.

December 4 CMS issued termination letter to IHS with an effective date of February 17, 2016.

December 5 IHS closed Rosebud ED and opened 24-hour urgent-care clinic.

December IHS requested deployments from USPHS.

2016

January USPHS began deployments of Commissioned Corps officers to Rosebud.

February 12 CMS revisited Rosebud and cited five CoP deficiencies and extended termination to March 16, 2016.

March 4 CMS extended termination date to April 29, 2016, to explore possibility of formulating an SIA with IHS.

April 30 IHS entered into an SIA with CMS and extended the termination date to May 16, 2017.

May 17 IHS awarded Rosebud ED staffing contract.

May 31 IHS assembled SIA Phase 1 team at Rosebud.

June 6 SIA team activated HICS at Rosebud.

June 16 IHS finalized revised Rosebud ED policies.

June 16-23 IHS provided Rosebud staff training on emergency services.

June 24 IHS conducted mock survey to assess Rosebud ED readiness.

June 26 IHS conducted risk management review of Rosebud.

June 29 Rosebud began daily tabletop exercises for the ED using failure mode and effects analysis.

June 30 IHS completed ED renovations.

July 1 IHS conducted risk management review of Rosebud.

July 5 IHS notified CMS of its intent to reopen the ED.

July Contracted ED staff began to arrive at Rosebud.

July 12 CMS cleared ED for reopening.

July 14 IHS conducted mock survey of the Rosebud ED.

July 15 Rosebud resumed ED services and closed urgent-care clinic.

2017

September 1 IHS completed SIA and CMS removed pending termination.

2018

July 26 CMS cited Rosebud with IJ deficiencies in the ED.

August 7 CMS issued termination letter to IHS with an effective date of August 30, 2018.

August 17 CMS revisited Rosebud and found that the IJ was resolved but cited five CoP deficiencies.

September 24 CMS extended termination date to November 26, 2018.

September 28 CMS accepted IHS plan of correction.

November 20 CMS removed pending termination after a revisit that found Rosebud compliant with all CoPs.

APPENDIX B

IHS COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

JUN 04 2019

Indian Health Service
Rockville, MD 20857

TO: Inspector General

FROM: Principal Deputy Director

SUBJECT: IHS Comments on *OIG Draft Report: Case Study: IHS Management of Rosebud Hospital Emergency Department Closure and Reopening* (OEI-06-17-00270)

We appreciate the opportunity to review the OIG draft report titled *Case Study: IHS Management of Rosebud Hospital Emergency Department Closure and Reopening*, (OEI-06-17-00270), dated April 26, 2019. The IHS concurs with each of the four OIG recommendations. Below you will find a description of the status of actions taken to date to implement the OIG recommendations, and those planned in the near future.

OIG Recommendation No. 1: The IHS concurs with this recommendation.

As a management priority, develop and implement a staffing program for recruiting, retaining, and transitioning staff and leadership to remote hospitals.

Actions taken and planned actions as of May 31, 2019

In February 2019, the IHS published a 5-year Strategic Plan for fiscal year (FY) 2019 through FY 2023. *Objective 1.1 of the Strategic Plan: "Recruit, develop, and retain a dedicated, competent, and caring workforce"* demonstrates the Agency's commitment to recruit and retain quality staff throughout the IHS, including hospitals. As a part of the implementation plan for this objective, the IHS Principal Deputy Director will identify a multi-disciplinary, senior-level working group to develop a comprehensive workforce plan to address the recruitment, training, and placement of staff into hospital leadership positions, particularly in remote locations. The comprehensive workforce plan will also include a component for succession planning, which is a factor in recruitment and retention for these sites. The target date for completion of the comprehensive workforce plan is May 2020.

OIG Recommendation No. 2: The IHS concurs with this recommendation.

Enhance training and orientation for new hospital leaders to ensure that they follow IHS directives and continue improvement efforts.

Actions taken and planned actions as of May 31, 2019

Each IHS Area has a variety of methods for providing training and orientation for new hospital leaders. The IHS has implemented an Agency-wide Leadership Training program that is available to all IHS leaders, including hospital leaders. In addition, the IHS Deputy Director for Field Operations will convene a workgroup composed of experienced, IHS Area-level

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management and operational staff to identify and share best practices within each Area for training and orienting new hospital leadership. Best practices will be shared among all IHS Areas and the results will inform new training elements that will be incorporated into a policy and required for all new leadership. The target date for the best practices document is October 31, 2019, and the related policy development is March 31, 2020.

OIG Recommendation No. 3: The IHS concurs with this recommendation.

Continue to take steps to ensure early intervention when IHS identifies problems at hospitals.

Actions taken and planned actions as of May 31, 2019

On December 26, 2018, the IHS formally established the Office of Quality (OQ) at IHS Headquarters. The IHS Deputy Director for Quality Health Care provides senior management oversight to the OQ to improve quality, accountability, and safety within the IHS health system. The IHS is working to improve governance and has established systems for accountability. For example, the IHS has established the National Accountability Dashboard for Quality (NADQ), which summarizes quarterly outcomes on a set of nine measures focused on system accountability. Additionally, the IHS has established contracts with Joint Commission Resources to provide consultation services to IHS hospitals to meet accreditation standards established by The Joint Commission and perform mock surveys to promote compliance with Centers for Medicare & Medicaid Services (CMS) Conditions of Participation. The IHS has implemented a credentialing software to promote standardization for credentialing of providers and has awarded a new contract for an adverse events reporting system. The IHS is working in partnership with CMS to reduce all-cause harm, improve and sustain compliance, and improve transitions in care. The IHS is implementing programs to develop internal quality improvement capacity within the IHS health system through training and education of staff in quality improvement science and application of quality improvement methods.

OIG Recommendation No. 4: The IHS concurs with this recommendation.

Develop procedures for temporary ED closures, and communicate those procedures with receiving hospitals and EMS to ensure that they are adequately prepared to receive diverted patients during such events.

Actions taken and planned actions as of May 31, 2019

The IHS Office of Clinical and Preventive Services (OCPS) has developed a preliminary outline of overarching considerations and procedures to be followed when closing an Emergency Department (ED) under various scenarios. The IHS OCPS is in the process of forming a multi-disciplinary workgroup to develop the outline into an ED Closure Procedure that will be distributed to hospitals for review and approval by each hospital governing body, and

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incorporated into each hospital's respective emergency management plan. The target date for completion of the ED Closure Procedure is December 31, 2019.

We sincerely appreciate the opportunity to comment on this draft report. The OIG's feedback will be used to help the IHS improve the Agency's overall management control systems. If you have technical questions about this response, please contact Mr. Darrell LaRoche, Director, OCPS, IHS, by telephone at 301-443-4754. Please contact Ms. Athena Elliott, Director, Office of Management Services, IHS, by telephone at (301) 443-5104 with general questions or concerns about the response.



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This report was prepared under the direction of Ruth Ann Dorrill, Regional Inspector General for Evaluation and Inspections in the Dallas regional office, and Amy Ashcraft and Petra Nealy, Deputy Regional Inspectors General.

ENDNOTES

- ¹ IHS, *Justification of Estimates for Appropriate Committees*, Fiscal Year 2020, p. CJ-7. Accessed at https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2020CongressionalJustification.pdf on June 28, 2019.
- ² P.L. No. 94-437, Indian Health Care Improvement Act. 25. U.S.C. § 1601. The IHCA identifies a major national goal “to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services.”
- ³ IHS, *Justification of Estimates for Appropriations Committees*, Fiscal Year 2020, p. CJ-1-2. Accessed at https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2020CongressionalJustification.pdf on June 28, 2019.
- ⁴ U.S. Senate Committee on Indian Affairs, *In Critical Condition: The Urgent Need to Reform the Indian Health Service’s Aberdeen Area*, December 28, 2010. Accessed at <https://www.indian.senate.gov/sites/default/files/upload/files/Chairman-s-Report-In-Critical-Condition-12-28-10.pdf> on June 28, 2019.
- ⁵ U.S. Commission on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System*, September 2004. Accessed at <http://www.usccr.gov/pubs/docs/nabroken.pdf> on June 28, 2019.
- ⁶ The Institute for Government Research, *The Problem of Indian Administration*, February 21, 1928, Ch. I. Accessed at http://www.alaskool.org/native_ed/research_reports/IndianAdmin/Indian_Admin_Problms.html on June 28, 2019.
- ⁷ U.S. Senate Committee on Indian Affairs, *Reexamining the Substandard Quality of Indian Health Care in the Great Plains*, February 3, 2016. Accessed at <https://www.indian.senate.gov/hearing/oversight-hearing-reexamining-substandard-quality-indian-health-care-great-plains> on June 28, 2019.
- ⁸ U.S. House of Representatives Committee on Appropriations, *Management Challenges at the Departments of Labor, Health and Human Services, and Education and the Social Security Administration: Views from the Inspectors General*, March 9, 2017. Accessed at <https://www.govinfo.gov/content/pkg/CHRG-115hrg27208/pdf/CHRG-115hrg27208.pdf> on June 28, 2019.
- ⁹ IHS temporarily closed Acoma-Canoncito-Laguna Service Unit ED on multiple occasions during a 5-month period in 2014, Crownpoint Hospital ED for approximately 2 months in 2015, and Rosebud Hospital ED for 7 months in 2015–2016. Sioux San Hospital ED has remained closed since September 2016. In July 2017, IHS submitted a report to Congress to permanently discontinue emergency and inpatient services at Sioux San Hospital by July 2018. OIG email correspondence with IHS officials on February 14, 2017. IHS, *Indian Health Service Report on Proposed Closure of the Sioux San Hospital Emergency and Inpatient Departments*, July 2017.
- ¹⁰ IHS, *Rosebud Service Unit*. Accessed at <https://www.ihs.gov/greatplains/healthcarefacilities/rosebud/> on June 28, 2019.
- ¹¹ *Indianz.com*, “Rosebud Sioux Tribe sues Indian Health Service over ‘crisis’ in care,” April 28, 2016. Accessed at <http://www.indianz.com/News/2016/04/28/rosebud-sioux-tribe-sues-india.asp?print=1> on June 28, 2019.
- ¹² IHS, Press Release, *Rosebud Hospital Diverts Emergency Room Services*, December 4, 2015. Accessed at <https://www.ihs.gov/newsroom/index.cfm/pressreleases/2015pressreleases/rosebud-hospital-diverts-emergency-room-services/> on June 28, 2019.
- ¹³ Letter from Representative Kristi Noem to (former) IHS Principal Deputy Director Robert McSwain, December 18, 2015. Accessed at <http://dakotawarcollege.com/noem-seeks-information-on-critical-conditions-within-indian-health-service-facilities/> on June 28, 2019.
- ¹⁴ In July 2016, then IHS Acting Director testified before the Indian, Insular, and Alaska Native Affairs Subcommittee of the House Natural Resources Committee that she would join committee members in asking OIG to investigate deaths considered related to the Rosebud ED closure. Following the testimony, IHS forwarded to OIG a letter sent by the Rosebud Sioux Tribe president to IHS, dated August 9, 2016. In the letter, tribal leadership requested an OIG investigation into deaths that occurred during the ED closure. In subsequent conversations with OIG, tribal representatives raised additional concerns about IHS’s management and handling of the closure.
- ¹⁵ Pursuant to the Indian Self-Determination and Education Assistance Act, P.L. No. 93-638, IHS contracts and/or compacts with tribes or tribal organizations to deliver services. IHS, *Fact Sheets: A Quick Look*. Accessed at <https://www.ihs.gov/newsroom/factsheets/quicklook/> on June 28, 2019.
- ¹⁶ IHS, *Justification of Estimates for Appropriations Committees*, Fiscal Year 2020, p. CJ-7, CJ-56. Accessed at https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2020CongressionalJustification.pdf on June 28, 2019. In addition to the \$2 billion appropriated for hospitals and health clinics, IHS supports programs such as dental services and public health, among others.

- ¹⁷ IHS, *Great Plains Area*. Accessed at <https://www.ihs.gov/greatplains/> on June 28, 2019. The number of hospitals operated by IHS in the Great Plains Area decreased from seven to five hospitals after the Winnebago Tribe assumed operations of Winnebago Hospital in July 2018 and IHS converted Rapid City Hospital to a health center in 2019. OIG email correspondence with IHS official on January 24, 2019 and July 1, 2019.
- ¹⁸ IHS, *Indian Health Manual*, pt. 1; Ch. 1; section 1-1.2 (Indian Health Manual).
- ¹⁹ IHS, *Justification of Estimates for Appropriations Committees*, Fiscal Year 2020, p. CJ-57. Accessed at https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2020CongressionalJustification.pdf on June 28, 2019. The number of hospitals operated by IHS decreased from 26 to 25 hospitals in 2018 after the Winnebago Tribe assumed operations of Winnebago Hospital. OIG email correspondence with IHS official on January 24, 2019. In 2019, the number IHS-operated hospitals decreased from 25 to 24 hospitals after IHS converted Rapid City Hospital to a health center. OIG email correspondence with IHS official on July 1, 2019.
- ²⁰ IHS, Internal document, “Inpatient Summary Data for Indian Health Service Hospitals by Area and Facility – October through September Fiscal Year 2017,” April 9, 2018.
- ²¹ *Ibid.*
- ²² *Ibid.*
- ²³ OIG email correspondence with IHS officials on February 21, 2018.
- ²⁴ *Ibid.*
- ²⁵ IHS, *Rosebud Service Unit*. Accessed at <https://www.ihs.gov/greatplains/healthcarefacilities/rosebud/> on June 28, 2019.
- ²⁶ Social Security Act §§ 1880(a) and 1911(a), P.L. No. 94-437, Indian Health Care Improvement Act (codified at 25 U.S.C. § 1621(e)).
- ²⁷ IHS, *Justification of Estimates for Appropriations Committees*, Fiscal Year 2020, p. CJ-7. Accessed at https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2020CongressionalJustification.pdf on June 28, 2019.
- ²⁸ *Ibid.*, pp. CJ-115-117.
- ²⁹ *Ibid.*, p. CJ-116.
- ³⁰ IHS, Circular No. 97-01. Accessed at https://www.ihs.gov/ihs/index.cfm?module=dsp_ihm_circ_mainandcirc=ihm_circ_9701 on June 28, 2019. On September 29, 2017, IHS awarded a contract to The Joint Commission for accreditation of all IHS direct-service hospitals. IHS, *Justification of Estimates for Appropriations Committees*, Fiscal Year 2020, p. CJ-58.
- ³¹ Social Security Act §§ 1880(a) and 1865(a)(1).
- ³² 42 CFR §§ 482.1, 482.12, 482.21, and 482.22.
- ³³ 42 CFR § 482.12.
- ³⁴ IHS, *Indian Health Manual*, pt. 3; Ch. 1; section 3-1.2B (Governing Body).
- ³⁵ IHS, Circular No. 97-01. Accessed at https://www.ihs.gov/ihs/index.cfm?module=dsp_ihm_circ_mainandcirc=ihm_circ_9701 on June 28, 2019.
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- ³⁷ CMS, *SOM*, Appendix Q—Guidelines for Determining Immediate Jeopardy.
- ³⁸ CMS, *SOM*, Appendix A—Survey Protocol, Regulations and Interpretive Guidelines for Hospitals. CMS, *Schedule of Termination Procedures—Noncompliance With One or More CoPs or Conditions for Coverage Cited Deficiencies Limit Capacity of Provider/Supplier to Furnish Adequate Level or Quality of Care (Medicare)*. Accessed at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationEnforcement/Downloads/Schedule-of-Termination-Procedures.pdf> on June 28, 2019.
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- ⁴³ 42 CFR § 482.55. 42 CFR § 489.24(b) defines “dedicated emergency department.”
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- ⁴⁵ P.L. No. 99-272, Emergency Medical Treatment and Active Labor Act, 100 Stat. 164 (1980). SSA § 1867(e). 42 U.S.C. § 1393dd et seq.
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- ⁴⁸ Ibid.
- ⁴⁹ 42 CFR § 489.24(b)(4).
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- ⁵¹ P.L. No. 94-437, Indian Health Care Improvement Act. 25 U.S.C. § 1631(b)(2).
- ⁵² OIG, *Indian Health Service Hospitals: More Monitoring Needed to Ensure Quality Care*, OEI-06-14-00010, October 2016.
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