



U.S. Department of Health and Human Services

Office of Inspector General

Organizational Challenges to Improving Quality of Care in Indian Health Service Hospitals

OEI-06-16-00390

August 2019

oig.hhs.gov

Suzanne Murrin

Deputy Inspector General
for Evaluation and Inspections





Organizational Challenges to Improving Quality of Care in Indian Health Service Hospitals

What OIG Found

OIG identified underlying issues that are hindering the Indian Health Service (IHS) from improving its management of its hospitals, and recommends strategies for IHS as it implements new improvement plans. The issues represent core organizational challenges that, if not addressed, could continue to limit IHS's ability to improve hospital operations and quality of care:

- › **Lack of Formal Structure, Policies, and Roles:** IHS officials reported that they were often uncertain about their roles and those of other officials, including the authority to act in correcting problems. Consequences included lack of accountability and undermining of quality of care. This absence of clear roles was especially problematic with regard to the roles and responsibilities of IHS headquarters (HQ) and Area Offices.
- › **Lack of a Clear View of Hospital Performance and Problems:** We found that IHS HQ lacked awareness and insight about Area Office activities and hospital performance. In addition, IHS's organizational culture did not always encourage candid communication, with what one official called a "culture of niceness" that sometimes impeded useful discussion of problems.
- › **Lack of Confidence in IHS's Ability to Succeed:** IHS officials consistently expressed a deep commitment to and passion for the agency's mission and beneficiaries. However, officials also expressed doubt in the agency's ability to make sustained improvements.

Addressing Organizational Challenges

To address these underlying organizational challenges, IHS should incorporate the strategies we outline in this report as it implements its new plans to improve operations: establish strong agency structures; ensure that leaders have a clear view of problems and champion "continuous learning" in their work; and leverage the deep commitment of officials and staff to foster a greater confidence in the agency moving forward.

In other evaluations, OIG has recommended specific actions for improving quality in IHS hospitals, such as establishing a comprehensive compliance program focused on quality of care. We continue to urge IHS to implement those recommendations.

Full report can be found at oig.hhs.gov/oei/reports/oei-06-16-00390.asp

Why OIG Did This Review

This study identifies underlying organizational challenges that may hamper IHS's ability to address critical longstanding problems at its hospitals. At times, these problems have had serious consequences, including difficulty maintaining compliance with Federal quality-of-care requirements. OIG and others have previously analyzed these problems and recommended corrective actions. IHS has made important new plans for improving the quality of care that it provides in its hospitals. However, if underlying organizational challenges are not addressed, they may prevent IHS from bringing its full organizational strength to these efforts.

How OIG Did This Review

We based our findings on interviews with IHS officials and other stakeholders, and our observations of agency practices while we were conducting this and other OIG studies. Interview topics included challenges to the operations of IHS HQ, Area Offices, and hospitals, and suggestions for accelerated progress. We did not independently verify the substance of the statements provided to us in interviews. We also reviewed agency documents, including the Strategic Plan that IHS released in 2019. We conducted qualitative analysis to identify challenges to IHS agency management of its hospitals, and to develop strategies for improvement.

TABLE OF CONTENTS

BACKGROUND	1
Methodology	8
ORGANIZATIONAL CHALLENGES	
Challenge 1: Lack of Formal Structure, Policies, and Roles	11
Strategy: Establish and follow formal structures and policies that define roles, responsibilities, and accountability	
Challenge 2: Lack of a Clear View of Hospital Performance and Problems	15
Strategy: Ensure that leaders have a clear and comprehensive view of performance and problems, and champion “continuous learning”	
Challenge 3: Lack of Confidence in IHS’s Ability To Succeed	18
Strategy: Leverage the deep commitment to mission among IHS officials and staff, and foster greater confidence in the agency’s capacity to make sustained improvements	
ADDRESSING ORGANIZATIONAL CHALLENGES	
Incorporate the organizational strategies outlined in this report as it implements its new plans to improve hospital quality and agency operations	21
Take specific actions to improve quality and oversight of IHS hospitals, in line with OIG’s recommendations and with the IHS Strategic Plan and Quality Framework	22
APPENDICES	
Appendix A: Previous OIG Recommendations	23
Appendix B: Interview Participants	24
ACKNOWLEDGMENTS	26

BACKGROUND

Objective: To identify and propose methods to improve Indian Health Service (IHS) management of hospitals.

Indian Health Service

IHS is responsible for providing Federal health services to American Indians and Alaska Natives. Its mission is to raise the “physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.”¹ The Indian Health Care Improvement Act provides the legal authority for IHS’s provision of health care to its beneficiaries.² IHS has an annual budget of \$5.6 billion, and in partnership with the 573 federally recognized tribes, it provides free primary and preventive health care services to approximately 2.6 million beneficiaries living in the United States.³

Within the Department of Health and Human Services (HHS), IHS is unique in its role as a direct provider of health care. In addition to providing health care services directly through IHS-operated facilities, IHS also provides financial support for the tribes to operate their own health care systems.⁴ In fiscal year (FY) 2019, about 40 percent of IHS’s \$2 billion appropriation to provide health care services in hospitals and health clinics was allocated to Federal operations that serve tribes directly. The remaining 60 percent was allocated to individual tribes or tribal organizations.⁵

IHS headquarters (HQ), located in Rockville, Maryland, provides general direction, policy development, and support to each of 12 Area Offices and their sites for direct delivery of health care. The IHS Area Offices are responsible for overseeing these IHS sites, including 24 acute-care hospitals, 50 health centers,

¹ IHS, *Justification of Estimates for Appropriations Committees*, FY 2020, p. CJ-1. Accessed at https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2020CongressionalJustification.pdf on August 19, 2019.

² P.L. No. 94-437, Indian Health Care Improvement Act. 25 U.S.C. § 1601.

³ IHS, *Justification of Estimates for Appropriations Committees*, FY 2020, pp. CJ-2, CJ-7. See footnote 1 for URL information.

⁴ Pursuant to the Indian Self-Determination and Education Assistance Act, P.L. No. 93-638, IHS contracts or compacts with tribal organizations to deliver services. IHS, *Quick Look* (fact sheet). Original link no longer works and is not archived online. The current *Quick Look* fact sheet is online at <https://www.ihs.gov/newsroom/factsheets/quicklook/>.

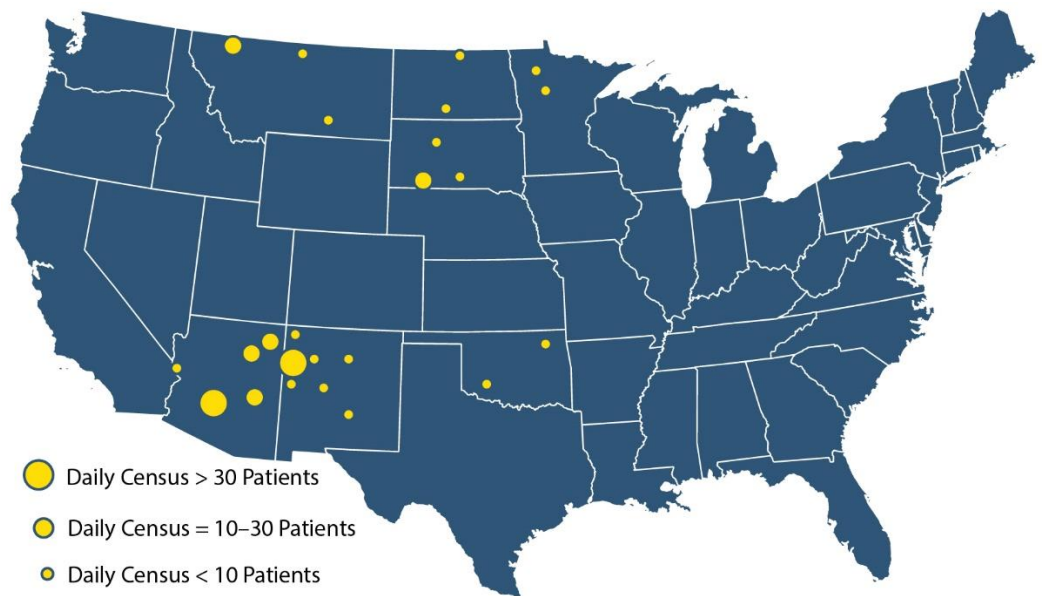
⁵ IHS, *Justification of Estimates for Appropriations Committees*, FY 2020, pp. CJ-16, CJ-56. See footnote 1 for URL information. IHS has a \$2 billion appropriation for hospitals and health clinics, and the agency also supports programs such as dental services.

26 health stations, and 2 school health centers.⁶ IHS hospitals are generally small and rural; most have fewer than 30 beds.⁷

The Great Plains Area Office is responsible for the oversight of one-fourth of IHS-operated hospitals (6 of 24 hospitals). The Great Plains Area spans four States: Iowa, Nebraska, North Dakota, and South Dakota.⁸ (See Exhibit 1 for locations of the 24 IHS hospitals.)

IHS maintains its policies, procedures, and operating standards in the *Indian Health Manual* (IHM). IHS policy states that the IHM is the “preferred reference” for IHS staff regarding agency-specific policy and procedural information.⁹ The IHM dictates that Area Offices manage oversight of IHS hospitals.¹⁰ Area Offices oversee the delivery of health services and provide administrative and technical support to IHS facilities, including monitoring hospitals through a Governing Board process that requires hospitals to (1) report quality data and other performance and management data and (2) hold semiannual meetings of hospital and Area Office officials.

Exhibit 1: Locations of the 24 IHS-Operated Hospitals, 2019



⁶ IHS, *Justification of Estimates for Appropriations Committees*, FY 2020, pp. CJ-54, CJ-57. Accessed online on April 8, 2019. See footnote 1 for URL information.

⁷ IHS, *Fiscal Year 2017 Hospital Inpatient Statistics for IHS and Tribal Sites With Prior Fiscal Year Comparisons* (FY 2016), July 13, 2018.

⁸ IHS, *Great Plains Area*. Accessed at <https://www.ihs.gov/greatplains/> on August 19, 2019. The number of hospitals that IHS operates in the Great Plains Area decreased from 7 to 6 hospitals after the Winnebago Tribe assumed operations of Winnebago Hospital in July 2018.

⁹ IHS, *IHM*, pt. 1, ch. 4, Appendix 1-4-A.

¹⁰ *Ibid.*

Longstanding Problems at IHS Hospitals

Reports of health disparities and inadequate health care services for IHS beneficiaries have been a subject of concern for nearly a century.¹¹ In recent years, much attention has focused on inadequacies at IHS hospitals in the Great Plains Area. In February 2016, the Senate Committee on Indian Affairs held a hearing on the substandard quality of care in IHS hospitals in the Great Plains Area. Testimony from the Centers for Medicare & Medicaid Services (CMS) and tribal representatives described quality-of-care concerns about several hospitals in the Area, including noncompliance with the Medicare Conditions of Participation and the requirements of the Emergency Medical Treatment and Labor Act. Findings of noncompliance included deficiencies in critical capabilities such as maintaining staffing and equipment. Subsequent hearings in 2017 and 2018 raised similar concerns about IHS hospitals, with testimony covering the following issues: problems with access to care, hospital closures, and difficulty—particularly in the Great Plains Area—maintaining staffing.¹²

During this timeframe, IHS hospitals in the Great Plains Area continued to struggle with compliance. CMS terminated one Great Plains hospital from the Medicare program in 2015 and another in 2017. To avoid termination, another hospital completed a Systems Improvement Agreement (SIA)—a corrective action contract that CMS may undertake with hospitals facing termination.¹³ A fourth Great Plains hospital, which was at risk for termination, voluntarily stopped accepting inpatient admissions.¹⁴ Additionally, between 2014 and 2016, IHS temporarily closed the emergency departments at four hospitals, forcing patients to seek treatment elsewhere.¹⁵ Among these four hospitals were the hospital that completed the Systems Improvement Agreement and the hospital that stopped accepting inpatient admissions.

¹¹ The Institute for Government Research, *The Problem of Indian Administration*, February 21, 1928, ch. 1. Accessed at http://www.alaskool.org/native_ed/research_reports/IndianAdmin/Indian_Admin_Problms.html on January 14, 2019. U.S. Commission on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System*, September 2004, pp. 2-4. Accessed at <http://www.usccr.gov/pubs/nahealth/nabroken.pdf> on August 19, 2019.

¹² Committee on Indian Affairs, *Oversight Hearing on the President's FY 2019 Budget Request for Indian Programs*, Senate, 115th Congress (2018), April 11, 2018. Accessed at <https://www.indian.senate.gov/hearing/oversight-hearing-presidents-fy2019-budget-request-indian-programs-0> on August 19, 2019.

¹³ CMS terminated Pine Ridge Hospital and Winnebago Hospital; Rosebud Hospital completed a Systems Improvement Agreement; and Sioux San Hospital stopped inpatient admissions.

¹⁴ IHS, *Indian Health Service Report on Proposed Closure of the Sioux San Hospital Emergency and Inpatient Departments*, July 2017. Accessed at https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/ReportToCongress_SiouxSanHospital_07282017.pdf on August 19, 2019.

¹⁵ IHS temporarily closed the Acoma-Canoncito-Laguna Hospital emergency department on multiple occasions during a 5-month period in 2014; closed the Crownpoint Hospital emergency department for 2 months in 2015; and closed the Rosebud Hospital emergency department for 7 months in 2015-2016. The Sioux San Hospital emergency department has remained closed since September 2016.

Recent IHS Efforts To Improve Quality of Care in IHS Hospitals

IHS has developed plans in recent years to improve hospital management and performance (see Exhibit 2), in particular creating a new office and program for improving quality and establishing a long-term strategic plan.

Exhibit 2: Selected IHS Initiatives To Improve IHS Hospital Quality and Management Under IHS Quality Framework and Other Initiatives, 2016–2019

Initiative	Year	Actions
Launched the Quality Framework	2016	<ul style="list-style-type: none">- Implemented telehealth consultation in some Areas- Developed Accountability Dashboard for Quality
Enhanced recruitment and retention policies and procedures	2017	<ul style="list-style-type: none">- Priority access to Commissioned Corps applicants- Increased scholarship and loan repayment incentives
Awarded system-wide accreditation contract	2017	<ul style="list-style-type: none">- Awarded system-wide accreditation contract to The Joint Commission for accreditation of all IHS hospitals
Revised provider credentialing system	2018	<ul style="list-style-type: none">- Purchased software and hired contractor to operate new credentialing system for enhanced screening at hire
Established Office of Quality	2019	<ul style="list-style-type: none">- Established position for Deputy Director of Quality- Announced improvements to the quality dashboard
Released Strategic Plan, FY 2019–2023	2019	<ul style="list-style-type: none">- Set goals to improve access, quality, and management- Revised priorities and organizational structure

Sources: IHS, *The Principal Deputy Director writes to Tribal Leaders and Urban Indian Organization Leaders to provide the final 2016–2017 Quality Framework and Implementation Plan*, November 16, 2016; IHS, *National Quality Accountability Dashboard Fact Sheet*, February 2018; IHS, *IHS Strategic Plan FY 2018–2022*, July 2018; IHS, January 7, 2018; and IHS, *Justification of Estimates for Appropriations Committees*, Fiscal Year 2019, p. CJ-74, December 2018.

Quality Framework. In November 2016, IHS began to develop the IHS Quality Framework.¹⁶ In December 2018, IHS announced the final provisions of the Quality Framework, including establishing—effective January 2019—a new Office of Quality that would be responsible for the agency’s quality- and safety-related work, to be led by the Deputy Director of Quality Health Care.¹⁷ IHS said that it intends to establish—under this structure—a Chief Quality Officer in each Area Office and a Quality Assurance and Performance Improvement Officer in each hospital.¹⁸

¹⁶ IHS, *Quality at IHS*. Accessed at <https://www.ihs.gov/quality/> on August 19, 2019.

¹⁷ IHS, Press Release, *Indian Health Service Announces Office of Quality*, December 21, 2018. Accessed online on January 16, 2019. Original link no longer works; for an archived version, see https://web.archive.org/web/20190614222230/https://www.ihs.gov/newsroom/includes/themes/responsive2017/display_objects/documents/PressRelease-IndianHealthServiceAnnouncesNewOfficeofQuality_122118.pdf.

¹⁸ IHS, *Indian Health Service Quality Framework 2016–2017*, October 2016. Accessed online on January 26, 2019. Original link no longer works; see archived version at https://web.archive.org/web/20190614211420/https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/IHS_2016-2017_QualityFramework.PDF.

The Quality Framework seeks to centralize several IHS functions related to quality of care, such as physician credentialing, patient surveys, standards for wait times, and quality metrics. Additionally, IHS has implemented new recruitment and retention strategies and developed a leadership training program for hospitals.¹⁹ Future plans include standardizing quality metrics, conducting mock accreditation surveys, and creating a new protocol for patient safety reporting.²⁰ Additionally, the Quality Framework includes a plan to establish within the Office of Quality a new liaison position that will communicate directly with HHS OIG and the Government Accountability Office (GAO) to prioritize recommendations and corrective actions.²¹

The IHS Office of Quality is divided into four divisions:²²

1. **Quality Assurance:** Manages programs to promote compliance with Federal regulations, accreditation, and professional standards.
2. **Innovation and Improvement:** Manages quality improvement efforts throughout IHS, including measuring progress.
3. **Patient Safety and Clinical Risk Management:** Manages programs to promote patient safety and to identify risks to patient safety in hospitals.
4. **Enterprise Risk Management:** Manages progress of agency strategic planning and internal controls across IHS direct delivery of health care.

Strategic Plan. In February 2019, IHS released its *IHS Strategic Plan FY 2019–23* (Strategic Plan), the first such document since its last strategic plan ended in 2011.²³ The plan outlines three IHS-wide goals related to IHS hospitals and other IHS programs:

1. **Access:** To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to IHS beneficiaries.
2. **Quality:** To promote excellence and quality through innovation of IHS into an optimally performing organization.
3. **Management:** To strengthen IHS program management and operations.

¹⁹ RADM Chris Buchanan, IHS Deputy Director, testimony before the U.S. House of Representatives Committee on Natural Resources, Subcommittee on Indian, Insular, and Alaska Native Affairs, June 21, 2017. Accessed online on January 26, 2019. Original link no longer works; see archived version at https://web.archive.org/web/20190614151309/https://www.ihs.gov/newsroom/includes/themes/responsive2017/display_objects/documents/testimony/115/115th-June-21-2017.pdf.

²⁰ IHS, *Organization, Functions, and Delegations of Authority; Part G; Indian Health Service*, 83 Fed. Reg. 66284 (Dec. 26, 2018). Accessed at <https://www.federalregister.gov/documents/2018/12/26/2018-27793/organization-functions-and-delegations-of-authority-part-g-indian-health-service> on August 19, 2019.

²¹ Ibid.

²² Ibid.

²³ IHS, *Indian Health Service Strategic Plan FY 2019–23*, February 27, 2019. Accessed at <https://www.ihs.gov/strategicplan/ihs-strategic-plan-fy-2019-2023/> on August 19, 2019.

OIG Work Regarding IHS Hospitals

The Strategic Plan references IHS hospitals specifically in a number of its provisions, including goals for compliance with the Medicare Conditions of Participation and plans to address longstanding issues with hospital and Area Office staffing.²⁴

OIG has long reported on IHS management of its hospitals and other agency operations. Between 2001 and 2011, OIG released 26 audits and evaluations in three broad categories: financial management, quality of care, and program management.²⁵ This work included IHS hospital operations as well as other agency functions. Specific to hospitals, OIG found problems with IHS credentialing practices, facility management, and access to services.²⁶ Since 2016, OIG has focused largely on IHS management of hospitals, making multiple recommendations to IHS to improve operations and quality of care. (See Appendix A for a list of outstanding OIG recommendations related to IHS hospital management.)

IHS Hospital Challenges and Monitoring

In 2016, OIG released two reports describing challenges faced by IHS hospitals and IHS monitoring of hospital quality and performance.²⁷ OIG found that longstanding challenges affected IHS hospitals' ability to provide quality care and comply with the Medicare requirements—specifically, the requirements regarding ensuring access to needed care; maintaining clinical competence; recruiting and retaining essential staff; and keeping patients safe. We also found that IHS was limited in its ability to provide rigorous quality oversight of hospitals, with few sources of information about hospital performance; had limited capacity to provide clinical support; and had insufficient procedures and infrastructure to maintain quality assurance and monitoring.

We concluded that given the duration and extent of IHS's problems, the agency was unlikely to overcome its management challenges without broad support from experts within and outside HHS, and without consideration of different models for providing services. We made recommendations to IHS and the HHS Office of the Secretary for them to identify and implement innovative strategies to mitigate IHS's longstanding challenges, and to develop an IHS-wide strategic plan and a quality-focused compliance program.

²⁴ Ibid.

²⁵ OIG, *White Paper: Summary of OIG IHS Activities*, October 5, 2011. Accessed at <https://oig.hhs.gov/newsroom/spotlight/2011/ihs-whitepaper.pdf> on August 19, 2019.

²⁶ Ibid.

²⁷ OIG, *Indian Health Service Hospitals: More Monitoring Needed to Ensure Quality Care* (OEI-06-14-00010), October 2016, and *Longstanding Challenges Warrant Focused Attention To Support Quality Care* (OEI-06-14-00011), October 2016.

Case Study of IHS Management of the Closure and Reopening of the Rosebud Hospital Emergency Department

In July 2019, OIG issued a case study examining IHS management of the 7-month closure and subsequent reopening of the emergency department of Rosebud Hospital in the Great Plains Area.²⁸ The case study provides a chronology of events and identifies the following: factors that led to the closure; improvement efforts to reopen the emergency department; and continued lapses in compliance. We recommended that to correct underlying problems and prevent closures, IHS—as a management priority—develop and implement a staffing program for recruiting, retaining, and training staff in remote hospitals. We also recommended that IHS continue taking steps to ensure that it intervenes early when problems emerge at hospitals, and develops procedures for temporary closures of emergency departments.

Adverse Events in IHS Hospitals

OIG is in the process of determining the incidence of patient harm in IHS hospitals, using a panel of patient safety experts to conduct a medical record review of IHS hospitalizations.²⁹ This work is one in a series of OIG studies identifying adverse events in different health care settings nationwide, including acute-care hospitals, skilled nursing facilities, rehabilitation hospitals, and long-term care hospitals. The resulting report will include incidence rates for patient harm events for a sample of IHS beneficiaries admitted to IHS hospitals, as well as a medical assessment of the preventability of the events and factors that contributed to the events. An additional report will use cases from the patient harm study to examine whether care specific to maternal health; infant health; and labor and delivery at IHS hospitals met standards for quality.

Patient Abuse in IHS Hospitals

Following the conviction of an IHS pediatrician for sexual abuse, OIG is reviewing the sufficiency and implementation of IHS's current policies and procedures for preventing, reporting, and addressing patient abuse. This work is also responsive to requests from the HHS Deputy Secretary and Congress.

OIG Quality and Compliance Training

OIG has also provided compliance training to support IHS and tribal officials in improving quality and management. In 2017–2018, OIG hosted two compliance training conferences for tribal officials in South Dakota and Oklahoma. These conferences gathered hundreds of representatives from OIG, CMS, IHS, and tribal organizations. Conference sessions covered a variety of topics, including

²⁸ OIG, *Case Study: Indian Health Service Management of Rosebud Emergency Department Closure and Reopening*, OEI-06-17-00270, July 2019.

²⁹ OIG, *Indian Health Service Hospitals: Incidence of Adverse Events*, OEI-06-17-00450, report forthcoming.

Methodology

guidance for complying with HHS program provisions and efforts to improve the quality of health care. OIG is continuing these efforts in 2019 and 2020.

This study describes underlying organizational challenges that IHS faces as it seeks to improve hospital quality, including through implementation of its Quality Framework and its Strategic Plan. We identified these issues primarily during interviews and other discussions with IHS officials and stakeholders in 2016–2019. Where possible, we supplemented this information with documentation from IHS, reports by other organizations such as GAO, congressional testimony, and previous and ongoing research by OIG regarding IHS policies and practices, and hospital quality of care. Our data collection and analysis for this evaluation focused on IHS HQ and Area Office management of hospitals collectively, rather than facility-level management of specific hospitals.

Interviews with IHS Officials and Other Stakeholders

We conducted 16 in-depth, semistructured interviews with officials at IHS HQ and Area Offices. We selected interview respondents on the basis of their agency responsibilities related to IHS hospitals and familiarity with hospital operations, particularly in the Great Plains Area.

Interview topics included roles and responsibilities of IHS HQ management with respect to health care service and delivery; management challenges to improving IHS hospital care; and clinical standards at IHS facilities. For example, we asked officials what would most improve their daily work and facilitate improvement.

From 2017 to early 2019, we interviewed and consulted with IHS officials as part of two other OIG studies focused on the closure and reopening of the Rosebud Hospital emergency department, and on adverse events in IHS hospitals. These meetings included discussion of the underlying organizational issues that this report describes. Among the officials with whom we met were the individual who was serving as Acting Director and Principal Deputy Director, and the individual serving as Chief Medical Officer. (IHS has not had a Director since 2015. With the change in Administration in 2017, a new individual was named as Acting Director; this official then became the Principal Deputy Director in 2018.) In addition to drawing on our notes from these interviews and discussions, we used our observations based on years of interaction with IHS officials and evaluations of IHS programs.

We also met in December 2016 with officials from CMS and other members of the HHS Executive Council on Quality Care, formed by the then-Acting Deputy Secretary of HHS. We interviewed representatives from 11 HHS agencies who served on this council. (See Appendix B for a list of IHS officials we interviewed and HHS agencies that were represented in the meeting.)

We did not independently verify the substance of the statements provided to us in these interviews.

Document Reviews

We reviewed supporting documents such as the IHS Quality Framework and organizational charts, and we added information that we had gleaned from our contact with IHS officials during other OIG studies. In addition to reviewing information that we received directly from IHS and HHS, we also reviewed other reports—such as congressional testimony and GAO reports—regarding IHS management and related issues.³⁰

These sources included a 2017 report by the Council of the Inspectors General on Integrity and Efficiency (CIGIE) that outlined management deficiencies that Inspectors General from multiple U.S. Government departments had found in programs serving American Indians and Alaska Natives.³¹ These deficiencies included failures to segregate staff responsibilities, maintain recordkeeping, and update infrastructure. Lastly, we followed updates from across government regarding IHS hospital funding and areas that the Administration's 2020 budget raised as particular concerns, such as providing general health services, combating opioid abuse, and managing chronic diseases.³²

Analysis and Presentation

We conducted qualitative analysis of interview and discussion notes, agency documents, and our own observations to identify underlying organizational challenges in how IHS manages its hospitals. This analysis included comparing IHS operations to OIG-identified effective management practices in three areas: policy, leadership, and organizational culture. Within each area, we provide examples to illustrate specific points.

We also used quotations from IHS officials to provide insight and further illustrate our findings. Most quotations come from the 2016 interviews, with additional information from later discussions and documents as noted. We identified the organizational challenges by analyzing IHS officials' responses to our questions regarding IHS's hospital management, and considered updates provided by IHS to acknowledge recent efforts such as the Strategic Plan and Quality Framework.

³⁰ GAO, *Indian Health Service: Actions Needed to Improve Oversight of Quality of Care*, January 2017. Accessed at <https://www.gao.gov/assets/690/681951.pdf> on August 19, 2019.

³¹ CIGIE, *Vulnerabilities and Resulting Breakdowns: A Review of Audits, Evaluations, and Investigations Focused on Services and Funding for American Indians and Alaska Natives*, December 2017. Accessed at https://www.ignet.gov/sites/default/files/files/CIGIE_AIAN_Vulnerabilities_Report.pdf on August 19, 2019.

³² IHS, *Justification of Estimates for Appropriations Committees*, FY 2020, p. CJ-2. See footnote 1 for URL information.

Standards

Limitations

OIG did not independently verify the information that we received from our interviews with IHS and HHS officials or from supplemental sources, beyond reviewing supporting documentation where available.

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.

ORGANIZATIONAL CHALLENGES and STRATEGIES

IHS has had longstanding problems managing its hospitals and ensuring that they consistently provide high-quality care. It has developed new plans for improving hospital operations and quality, which are promising. However, to make meaningful and lasting improvements, IHS needs to overcome underlying organizational problems that have hampered its success. From our interviews with IHS officials and our studies of the agency, we identified three organizational challenges that have impeded IHS's management and quality improvement efforts in recent years. We encourage IHS to incorporate the following strategies to address these issues and bring its full organizational strength to plans for improving care.

STRATEGY:

Establish and follow formal structures and policies that define roles, responsibilities, and accountability

Challenge 1: Lack of Formal Structure, Policies, and Roles

IHS needs to develop and support a clear agency structure and policies that outline roles and responsibilities, and to endeavor to maintain and enforce that structure. For this structure to be effective, it must meet the agency's needs and objectives; be practical and useful in directing daily work; be actionable by officials and staff; and be supported by the expectation for adherence and accountability.

IHS officials reported that they were often uncertain about their specific roles and responsibilities in relation to those of other officials, including the authority to act in correcting problems. The most common issue that officials reported as negatively affecting their work was the lack of a solid organizational structure regarding management of IHS hospitals, including policies that would direct the work of IHS HQ, Area Offices, and hospitals, and distinguish their respective responsibilities. Officials reported that the lack of structure could lead to frequent changes in policy as leadership changed. In some cases, policies lacked detail and were not specific or prescriptive in mandating particular actions. For example, the IHM does not delineate the actions that IHS HQ should take when it receives reports of problems from Area Office or hospital staff. In other cases, IHS officials said that roles were described in agency documents but officials did not fully understand them, or officials assumed roles that may not be well-suited to their skills and abilities.

When asked what single action would most improve their daily work and progress, IHS officials most often recommended that the agency establish and follow more formal structures.

Repercussions of IHS's lack of clear and accountable roles, responsibilities, and policies included inefficiency, poor coordination, and lack of accountability. Officials reported that in the absence of a solid structure, they were sometimes compelled to take action on their own, rather than in coordination. This lack of coordination led to inefficiencies—multiple groups of officials and staff might be working on the same issue, but without a clear strategy or indication of which actions had been fruitful, how decisions would be made, or how to direct Area Offices and hospitals to take action.

The lack of structure also resulted in actions getting mired in processes and taking longer to resolve. Officials reported that in their confusion about who was responsible for various functions, they sometimes sought review and approval from multiple officials or groups which “increased the bureaucratic hoops.” Another result of this confusion was that some divisions influenced decisions outside of their organizational scope. One official pointed to an IHS organizational chart and said, “That diagram does not describe how things work. We build our own processes as we go, and hope that we are making progress.” Several officials described IHS management as a “siloe” structure wherein groups were working hard, but without a clear view of their objective or how their actions might achieve results. Officials also noted that this separation of efforts led to effects downstream in the workplace; individuals selected “camps” to follow and competed to get others to support their proposed course of action.

“It feels like we are trudging in mud. Things are more difficult bureaucratically than they should be.” – IHS Official

This lack of structure also resulted in an overreliance on the actions of a few strong leaders. Several officials noted that what had held the agency together over the years was the leadership of a small number of impassioned individuals, rather than a strong set of agency policies that could be employed no matter who the specific leaders were. For example, one official noted that in meetings, staff often quoted the statements of current or former leaders rather than referring to agency policies.

Officials also reported that even when policies were in place, the policies were not always followed or fully enforced, including policies for critical functions such as hiring and contracting. They said it was routine across IHS HQ to operate outside of stated policies and procedures, including for individuals to operate outside of their own position descriptions. Consequently, when

problems arose, it could be difficult to determine which official or group was responsible for taking corrective action.

“Some people give up trying to track where they should be in the organization and instead ‘go rogue’ to solve problems without a broader strategy.” – IHS Official

The absence of clear roles and accountability seemed particularly problematic with regard to the division of responsibilities between IHS HQ and Area Offices. Perhaps most problematic in the agency structure is the lack of clarity and accountability in the relationship between IHS HQ and Area Offices. Although IHS policies state that Area Offices should oversee hospital operations, they lack specificity as to how Area Offices should execute that oversight and how IHS HQ should monitor Area Offices’ oversight. Officials reported that Area Offices receive a great deal of discretion and flexibility in managing hospitals and providing assistance to them, but the result of this flexibility may be gaps in oversight and assistance.

Further, some IHS officials reported that they oppose HQ oversight of Area Offices because the monitoring can bring with it added layers for approval and a greater bureaucracy that could hamper action. These officials argued that the Area Offices and their related communities vary so substantially that IHS HQ could not effectively develop national practices that would serve all Areas. They also believed that it was more important for IHS HQ to provide service and support to Area Offices than to provide oversight—in essence, for HQ to put Area Offices on a more equal footing with agency leadership. As one official explained, “They prefer that we all be collegial, that we work side by side. They dread the rumor mill saying ‘HQ is taking over the Areas.’ That would be a sledgehammer, and not perceived as a positive development from either group.”

OIG has recommended that IHS HQ impose greater accountability on, and greater uniformity among, Area Offices. Specifically, OIG recommended that IHS establish standards and expectations for how Area Offices oversee hospitals, and that IHS monitor how Area Offices adhere to those standards. OIG based this recommendation on our findings that IHS may be missing opportunities to identify and remediate quality problems in its hospitals because IHS performed limited oversight regarding quality of care and compliance with the Medicare Conditions of Participation. Area Office staff told OIG that they have few sources of information available regarding hospital quality; that staffing shortages in Area Offices limit the clinical support and guidance that they are able to provide; and that the most promising efforts to improve hospital quality lack dedicated funding.

Formal structures with clear roles and responsibilities could help mitigate the challenges posed by frequent changes in IHS leadership and personnel.

During OIG's reviews of IHS hospital operations from 2013 to 2019, many leadership positions at IHS were vacant or occupied by officials who were in a temporary "acting" capacity. These were often the top positions in the agency—the positions of Director, Deputy Director, Chief of Staff, and Chief Medical Officer. Individuals who IHS assigned to serve in an acting capacity often held other positions in the agency—in some cases, requiring officials to serve in more than one capacity at the same time.

Leaders also changed frequently in some Area Offices and hospitals, and sometimes officials from IHS HQ and other Area Offices had to fill those roles and divide their attention between their prior position and another in the field. IHS also filled positions temporarily with officials from other HHS agencies, such as the Healthcare Research and Services Administration (HRSA) and CMS.

"We have had talented people with great ideas about the nuts and bolts, but there was no time or clear authority to implement." – IHS Official

More clearly defining roles and responsibilities would help reduce the disruption and additional work associated with personnel changes. It could also help new and acting officials better fulfill their responsibilities for performance oversight and accountability, which some reported to be a challenge. For example, temporary leaders are sometimes unsure about their ability to institute policies. As one official noted, individuals in acting positions can lack accountability—and fail to enforce accountability in others—because their newness to the position and temporary status can make it difficult for them to understand and monitor job requirements and performance.

STRATEGY:

Ensure that leaders have a clear and comprehensive view of performance and problems, and champion continuous learning

Challenge 2: Lack of a Clear View of Hospital Performance and Problems

IHS leadership must encourage open communication about agency performance and uncovering problems as they arise. IHS officials need to do the following: know fully and understand the agency's functions; gain a comprehensive view of organizational progress; candidly evaluate the efficacy of the agency's work; and establish an environment of "continuous learning"—an environment that encourages identifying problems and monitoring results on an ongoing basis, and adapting methods as needed for improvement.

IHS HQ has lacked needed awareness and insight into Area Office and hospital performance. The lack of clear oversight responsibilities and Area Office accountability discussed above has frequently left IHS HQ without awareness of and insight into Area Office activities and hospital operations and performance. As one HQ official said, "It is difficult to even get a status check. The Areas sometimes act like it is voluntary to report." Other HQ officials said that even if they preferred to exert greater oversight, they lacked the knowledge, insight, and tools to conduct such oversight. Some officials stated that IHS HQ lacked understanding of Area operations, including accurate and up-to-date information about resources and policies. One official reported, "I couldn't tell you where to find data about AO [Area Office] staffing and facility numbers." Officials also reported that they often received poor or incomplete information about operations, and that they did not feel that anyone in IHS HQ had a comprehensive view of Area Offices and hospitals.

Our case study of the performance problems that led to the closure of the Rosebud hospital emergency department also raised concerns about lack of IHS HQ and Area Office insight into hospital problems. Hospital staff reported poor relationships between the Great Plains Area Office and Rosebud Hospital, as well as communication breakdowns across IHS, which limited support to identify and correct problems. This in turn resulted in a lack of knowledge within IHS regarding whether the agency was making progress, and a slowed sense of urgency. We recommended that IHS ensure that its policies outline the necessary steps for closer monitoring and quicker intervention by Area Office and HQ leadership, given that these measures could avoid a potential crisis and ensure that IHS addresses in a timely and consistent manner any problems that may arise at its hospitals.

IHS's organizational culture has not always encouraged candid discussion of problems among HQ officials, or with Area Offices and hospitals. In describing the agency's organizational culture, several officials cited the tendency to avoid conflict and frank discussion and feedback, and explained that problem-solving efforts can be superficial and sometimes do not squarely target the issues. As one official said, "Given the depth of some of the challenges, they may be difficult to truly overcome. The first thing we must do is live in reality and hit where we are head-on." Further, officials indicated that meetings often covered administrative topics rather than substantive ones. One official complained that meetings often had "too high-level" of a focus; did not include practical discussions about operations and problems; and did not engage the IHS officials and staff most affected.

"Pointing out deficiencies is not what this organization does. IHS as a culture does not like to do that" – IHS Official

IHS's history of problems, and the problems' effects on morale, may also contribute to a feeling of being embattled that discourages candor about ongoing issues. Recent headlines about poor performance in a relative few IHS hospitals may have contributed to feelings of pessimism IHS-wide. Several officials said that it was unfair to the Area Offices and hospitals that were operating successfully that "the media emphasis and the agency's image was forever wrapped around a few problem facilities." They also stated that the problems and resulting poor image have caused a lack of trust among IHS beneficiaries and other stakeholders, which has left officials feeling constantly behind no matter how thoughtful their new plans.

Frequent changes in leadership may also hinder open and candid communication. Several officials reported that the frequent changes in leadership resulted in what one official called a "culture of niceness" that sometimes impeded useful discussion. This occurred when individuals, particularly those who were new in their positions of authority, were unwilling to critique current practices and longtime officials, and chose collegiality over frank discussion of issues and concerns. Officials said that as a result of agency employees' desire not to offend each other, there was sometimes little focus on evaluating the efficacy of strategies; on viewing the organization and its actions comprehensively; or on making changes when warranted.

This lack of frank discussion about problems regarding quality of care and performance may have also created a cultural norm of avoiding negative reports of any sort, including allegations of serious misconduct. In the instance of the IHS pediatrician who was convicted in 2018 for child sexual abuse, a few IHS staff had voiced serious suspicions about this pediatrician, but their concerns had gone unaddressed for years.³³

“We feel we are all in this together, which is a good thing, but not when it means that we all hunker down to avoid reality. We want to support each other, but that can lead to... hiding the facts. We are a family, but we are also a business.” – IHS Official

Cultivating “continuous learning” would support IHS in achieving sustained improvements. In discussions with OIG in the course of our work, IHS leadership have expressed interest in building an environment of continuous learning—i.e., making efforts to promote more open communication about problems and adapt methods in response. IHS officials said that they openly encourage HQ and Area Office officials and staff to voice concerns, and have attempted to respond to problems more quickly. IHS is in the process of establishing a new Quality Assurance and Risk Management Committee to convene and review allegations of patient abuse and other allegations or issues that affect patient safety or quality of care, and to determine appropriate responses. This committee will consist of IHS senior officials, including the new Quality Director.

This approach is promising, but some officials noted that prior IHS plans to improve operations were not fully executed. As IHS further puts its new plans in operation, it should ensure that the policies are fully implemented in practice. Several officials said there may be a tendency by some in IHS to revert to prior policies and practices even when new ones are put into place. They explained that officials who have been in positions at IHS for a long time, though small in number, could exhibit strong predispositions toward certain policies and practices, and may not be open to other viewpoints or new information. As one IHS HQ official said, “People stop listening. The ‘old school’ culture can be very strong.” This commitment to prior practices can lead some officials to take actions that may not be based on solid information and strategy.

³³ As this report mentioned previously, OIG is conducting additional work that examines the sufficiency and implementation of IHS’s policies and procedures for preventing, reporting, and addressing patient abuse.

Promoting continuous learning as a management strategy would mean that IHS would encourage open communication, new information, and creative solutions, and that the organization would change course to address specific problems as needed. This flexibility to learn and change does not eliminate the need for a solid organizational structure; that structure would allow IHS to incorporate new information and pivot more effectively by making clear the basics (policies, roles, responsibilities, and authority). An environment of continuous learning is especially important when there is a great deal of complexity and variability to the enterprise, as with IHS's direct provision of health care.

STRATEGY:

Leverage the deep commitment to mission among IHS officials and staff, and foster greater confidence in the agency's capacity to make sustained improvements

Challenge 3: Lack of Confidence in IHS's Ability To Succeed

IHS has the opportunity to use its strong commitment and important mission to gain momentum toward improved practices. Although IHS has a long history of difficult problems, commitment to the mission remains strong and should serve as a foundation to bolster agency improvement and future success.

IHS officials expressed deep commitment to and passion for the agency's mission and beneficiaries. In interviews, all officials reported that despite the challenges, they remained dedicated and committed to the mission of serving IHS beneficiaries. As one official said, "There are a lot of problems, but it is also an agency full of people who really care about the program and who are dedicated to making positive changes."

This passion for the mission was notable to officials from other agencies, such as HRSA, who had been brought to IHS temporarily to fill vacant positions with experienced Federal staff. Those we interviewed seemed surprised and sometimes overwhelmed by the difficulty of IHS's work, and praised long-time IHS staff for their dedication in spite of the many challenges. An official detailed to IHS from another HHS agency said, "If you ask people why they work at IHS, they will have a story for you. It is usually a passion. No one will say that they just needed a job." A longtime IHS official agreed and said, "Our mission is fantastic. Even when things are lousy, even when things are rough, I will continue to give my best effort because I love our mission."

"Among IHS officials and staff, there is a profound interest in improving our agency and a deep empathy for our beneficiaries." – IHS Official

To motivate and sustain improvements, IHS needs to inspire greater confidence in the agency's capacity to overcome longstanding challenges.

Alongside the strong dedication to the organization's mission, officials often expressed discouragement about IHS's ability to carry out its mission and to make sustained improvements. Many officials spoke enthusiastically about the communities they serve and their aspirations for improving outcomes, but they were far less enthusiastic about IHS's efficacy as an organization, citing protracted bureaucratic processes; lack of a clear vision for how to meet goals; lack of trust within IHS; and lack of trust between IHS and the broader beneficiary community.

IHS leaders expressed optimism about the new Quality Framework and Strategic Plan, but some of them cautioned that much of the plans are still unfolding and it is unclear how they will differ from past efforts. One official said that the long-term nature of the problems seemed to make them build on each other, and their combined effect made solutions more difficult. Another official described the same phenomenon, calling it a "malaise" over agency operations, and attributing it to the sense that current and future actions may not result in meaningful change. One long-time official said that action is difficult even after establishing plans: "Sometimes I feel that we get ideas, but no real action. Maybe action is not rewarded. Maybe we are afraid. But I can tell you for sure that we get paralyzed."

Part of this paralysis appears to come from a perception that change is not fully possible. Several officials said they believed that IHS and its hospitals had more difficult problems than other, non-IHS hospitals, and that as a result, the solutions developed by other systems would not work in IHS. For example, officials expressed doubt that IHS efforts in the Great Plains Area and other heavily rural areas would ever be successful given the challenges of maintaining staff and competency with such low hospital occupancy. One official said, "We need to stop trying to do the things we shouldn't be doing, especially with workforce challenges. A daily census of 0 or 1 [patients]? How is that ever going to work?" However, others countered this sentiment, expressing frustration that IHS officials and staff were sometimes reluctant to learn from and adopt quality improvements that had proven to be successful in other health care systems.

"It bothers me to hear people say, 'We are unique.' Health care is health care. You still need governing boards, bylaws, credentialing, and standardized processes." – IHS Official

Several officials said that IHS officials and staff have over the years thought of IHS as being uniquely burdened, which one official referred to as “underdog status.” These officials described this sentiment as an aspect of IHS organizational culture that had become a barrier to success; the sense of futility hampered change. Officials said that some in the agency have grown accustomed to having problems and feeling “embattled,” and might not be able to envision sustained success because they had never experienced stable, even-keeled operations. Several officials noted that they could not recall any celebrations of success. For example, one official said that meetings usually were just a recitation of longstanding problems without noting positive change or taking action toward solutions.

When we spoke with officials in early 2019, in the midst of the initial rollout of the Quality Framework and Strategic Plan, there seemed to be a sense that these new policy and practice changes were different, and that officials expected them to be more substantial and lasting. Certainly, the Quality Framework and Strategic Plan represent a deliberate and active effort to effect change, but embedding these changes in IHS’s structures, practices, and organizational culture will be crucial to success. According to some IHS officials, part of that change in organizational culture will be to recognize and address any sense of defeatism or lack of faith in the organization that could block progress.

ADDRESSING ORGANIZATIONAL CHALLENGES

IHS has devoted substantial resources in recent years to assessing its policies and practices. This scrutiny has led to long-term plans focused on improving quality of care and operations. Realizing and sustaining these improvements in IHS hospitals will require intense focus and commitment to change—not only in the provision of care, but to the overall organization.

This change should include progress in addressing the core foundational issues presented in this report: establishing strong organizational structures that are maintained throughout changes in leadership and other agency factors; obtaining a comprehensive and candid view of performance and problems; and leveraging the deep commitment of officials and staff to foster a greater confidence in the agency moving forward.

OIG is committed to continuing our evaluation of IHS policies and management, and working with IHS and its stakeholders to improve the effectiveness of IHS's management and the quality of care it provides.

To address the organizational challenges identified in this report and take further steps to improve IHS operations and quality, IHS should:

Incorporate the organizational strategies outlined in this report as it implements its new plans to improve hospital quality and agency operations:

› **Establish and follow formal structures and policies that define roles, responsibilities, and accountability**

IHS must develop and support a clear agency structure and policies that outline roles and responsibilities; such a structure and policies are an essential framework for any organization's success. For this structure to be effective, it must meet the agency's needs and objectives; be practical and useful in directing daily work; be actionable by officials and staff; and be supported by the expectation for adherence to policy and accountability for performance.

› **Ensure that leadership has a clear and comprehensive view of performance and problems, and champion "continuous learning"**

IHS leadership must encourage open communication about agency performance and uncovering problems as they arise. This will require IHS officials to fully know and understand the agency's functions; gain a comprehensive view of organizational progress; candidly evaluate the efficacy of the agency's work; and hold themselves and others accountable for continuous learning and improvement.

-
- › **Leverage the deep commitment to mission among IHS officials and staff, and foster greater confidence in the agency's capacity to make sustained improvement**

Although IHS has a long history of difficult problems, commitment to the mission remains strong and should serve as a foundation to bolster agency improvement and future success. IHS must use the strong commitment of its officials and staff to the agency's mission to effect improvement, and gain momentum from that to sustain improvements ongoing. This will include recognizing barriers to success within IHS's organizational culture, such as defeatism and lack of belief in IHS's efficacy. By diligently executing the new policies, IHS leadership can build a greater sense of confidence among officials and staff, and a sense that the goals are attainable will further strengthen the organization and improve operations.

Take specific actions to improve quality and oversight of IHS hospitals, in line with OIG's recommendations and with the IHS Strategic Plan and Quality Framework

In 2016, OIG made five recommendations to improve the quality and oversight of IHS hospitals (see Appendix A). We recommended that IHS conduct a needs assessment and develop an IHS-wide strategic plan with actionable initiatives and target dates; implement a quality-focused compliance program; establish standards and expectations for Area Office oversight activities; work to identify new, more meaningful hospital performance metrics; and continue to invest in training for hospital administration and staff.

IHS has made progress in implementing these recommendations with its 5-year Strategic Plan and Quality Framework. To fully implement these plans, IHS must continue to work toward fleshing out the related policies and required actions, and include ongoing review of the effectiveness of implementation, such as its new hospital performance metrics and training initiatives. IHS's plans, once fully executed, appear likely to address these five specific recommendations.

In July 2019, OIG also made four recommendations in our case study of the closure and reopening of the Rosebud Hospital emergency department. We recommended that IHS, as a management priority, develop and implement a staffing program for recruiting, retaining, and transitioning staff and leadership to remote hospitals; enhance training for new hospital leaders; continue to take steps to ensure early intervention when IHS identifies problems; and develop procedures for emergency department closures.

Implementing these plans and recommendations will require IHS to work with urgency at all levels and across divisions and offices. As IHS progresses toward implementation, it should monitor the impact and results of these changes in practices, and revise its approach as may be warranted to achieve and sustain improved quality of care.

APPENDIX A: Previous OIG Recommendations

Exhibit A contains a list of prior OIG recommendations by report. All recommendations remain unimplemented at the time of this report's release.

Exhibit A: OIG Recommendations Regarding IHS Hospitals Directed to IHS October 2016–June 2019

OIG Recommendations by Report	Date of Report
IHS Hospitals: More Monitoring Needed To Ensure Quality Care (OEI-06-14-00010)	October 2016
IHS conduct a needs assessment culminating in an agency-wide strategic plan with actionable initiatives and target dates	
IHS Hospitals: Longstanding Challenges Warrant Focused Attention To Support Quality Care (OEI-06-14-00011)	October 2016
Implement a quality-focused compliance program to support Federal requirements for health care programs	
Establish standards and expectations for how Area Offices/Governing Boards oversee and monitor hospitals and monitor adherence to those standards	
Continue to seek new, meaningful ways to monitor hospital quality through the use of outcomes and/or process measures	
Continue to invest in training for hospital administration and staff, and assess the value and effectiveness of training efforts	
Case Study: IHS Management of Rosebud Hospital Emergency Department Closure and Reopening (OEI-06-17-00270)	July 2019
As a management priority, develop and implement a staffing program for recruiting, retaining, and transitioning staff and leadership to remote hospitals	
Enhance training and orientation for new hospital leaders to ensure that they follow IHS directives and continue improvement efforts	
Continue to take steps to ensure early intervention when IHS identifies problems at hospitals	
Develop procedures for temporary closures of emergency departments and communicate those plans with receiving hospitals and Emergency Medical Services to ensure that they are adequately prepared to receive patients diverted during such events	

APPENDIX B: Interview Participants

Exhibit B contains a list of titles and dates for OIG interviews with IHS, HHS and CMS officials at the time of our interviews. In all cases where the official is listed as a “former” official, the individual was still in an official position at IHS but speaking on behalf of their experience in the previous, recently held position.

Exhibit B: Interview Participants from IHS and Other HHS Agencies

Agency and Position	Date of Interviews
IHS Officials Interviewed with Structured Interview Protocol	December 2016
Acting Principal Deputy Director	
Former Deputy Director	
Acting Deputy Director of Field Operations	
Acting Deputy Director for Intergovernmental Affairs	
Former Deputy Director for Intergovernmental Affairs	
Deputy Director for Management Operations	
Special Assistant to the Deputy Director for Management Operations	
Acting Chief Medical Officer	
Clinical Quality Director	
Acting Chief of Staff	
Former Head of Contracting Authority	
Special Assistant to the Acting Principal Deputy	
Special Assistant to the Deputy Director	
Clinical Consultant to the Chief Medical Officer	
Former Area Office Director	
Current Area Office Director	
HHS Agencies Represented at Meeting of the Executive Council on Quality Improvement	December 2016
Agency for Healthcare Research and Quality	
Assistant Secretary for Administration	
Assistant Secretary for Financial Resources	
Assistant Secretary for Health	
Assistant Secretary for Legislation	
Assistant Secretary for Planning and Evaluation	

Agency and Position	Date of Interviews
HHS Agencies Represented at Meeting of the Executive Council on Quality Improvement (continued from previous page)	December 2016
Assistant Secretary for Public Affairs	
CMS	
HRSA	
Office of the National Coordinator	
Substance Abuse and Mental Health Services Administration	
CMS Officials	December 2016
Acting Principal Deputy Administrator and Chief Medical Officer	
Deputy Director of the Center for Clinical Standards and Quality	
Director of the Survey and Certification Group	
IHS Officials Engaged in Discussions Regarding Other OIG Studies	June 2018–February 2019
Acting Principal Deputy Director	
Acting Deputy Director of Field Operations	
Acting Deputy Director for Intergovernmental Affairs	
Deputy Director for Quality of Care	
Deputy Director for Management Operations	
Chief Medical Officer	
Acting Chief of Staff	
Special Assistant to the Deputy Director	

ACKNOWLEDGMENTS

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.

Others in the Office of Evaluation and Inspections who provided support include Joe Chiarenzelli, Ben Gaddis, Evan Godfrey, and Christine Moritz.

To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

ABOUT THE OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nation-wide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the healthcare industry concerning the anti-kickback statute and other OIG enforcement authorities.