



OIG SITE VISITS TO INDIAN HEALTH SERVICE HOSPITALS IN THE BILLINGS, MONTANA AREA

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The following site visit summaries include our observations of Blackfeet Community Hospital and Crow-Northern Cheyenne Hospital, both located in the Indian Health Service's (IHS) Billings Area, which covers the States of Montana and Wyoming. We visited these hospitals in June 2014. During the site visits, we interviewed hospital officials and representatives from tribes served by these hospitals. We also observed key hospital departments and reviewed hospital documentation. Our observations highlight the challenges faced by these hospitals and the strategies that the hospitals use to provide services to their patients. These site visits expand on prior OIG work that has examined longstanding challenges that IHS and tribal facilities face and that affect IHS beneficiaries' access to care.

In partnership with tribes, IHS provides health services for more than 2 million American Indians and Alaska Natives living in the United States. IHS directly operates 28 acute-care hospitals in 8 States and provides preventive health and primary care services at other health care facilities. Together, these facilities serve members of the 566 federally recognized tribes.

SITE VISIT: BLACKFEET COMMUNITY HOSPITAL

Blackfeet Indian Reservation

Overview

Location

Browning, Montana

Size

28-bed hospital

Staffing (Fiscal Year 2014)

About 250 clinical and nonclinical staff positions

- 12 physicians
- 4 nurse practitioners

6 vacant physician positions

Average Daily Census

11–12 patients, lower during summer months

IHS Funding (Fiscal Year 2014)

- Direct clinical services = \$10.8 million
- Purchased/Referred Care = \$ 8.0 million

Services (Fiscal Year 2014)

Emergency Services

Services available 24 hours a day, 7 days a week

Surgery Services

Diagnostic Services

Pharmacy Services

Hospital-Based Outpatient Services

- Family practice
- Children's health
- Women's health
- Dental
- Physical therapy
- Specialty services
- Mental and behavioral health

OIG Site Visit – June 11–12, 2014

OIG staff visited the Blackfeet Community Hospital to gather information for the case study. During the onsite visit, we:

- observed key hospital departments (e.g., outpatient clinics, inpatient ward, emergency department);
- collected and reviewed hospital documentation (e.g., policies, contracts, agreements) and patient records;
- interviewed hospital officials; and
- interviewed representatives from Blackfeet tribal health programs.

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

OBSERVATIONS

Unless otherwise indicated, we based our observations on our review of hospital documentation and a sample of patient medical records, and on interviews with hospital officials and representatives of Blackfeet tribal health programs.

At the time of our site visit in June 2014, Blackfeet Community Hospital faced staffing challenges in providing services

Blackfeet Community Hospital (BCH) faced staffing challenges associated with its hiring process, its remote location, and reductions in its funding. BCH's permanent staff members are Federal employees; therefore, the hospital uses the Federal hiring process to fill its permanent positions. BCH's officials stated that they experienced delays using this process, which made it more challenging to bring new staff to the hospital; delays can cause BCH to lose candidates to other facilities before it is able to offer them a position. At the time of our visit, BCH had vacancies for providers and ancillary staff in a number of departments. Officials also found it difficult to hire providers willing to settle long-term in BCH's remote location. Providers who came to the hospital often left to take positions at other facilities. Furthermore, in the 18 months prior to our visit, BCH lost an audiologist, surgeon, and pediatric physician because of reductions in the Federal funding that the hospital received.

BCH's staffing challenges led to longer waits and difficulty in managing patient care. BCH's officials reported that on occasion, BCH shifted staff from outpatient clinics and the inpatient ward to ensure adequate staffing in the emergency room. This redistribution led to longer waits for patients in outpatient clinics. In addition, according to tribal representatives, staffing challenges made it difficult for patients to receive consistent care for chronic conditions from providers who were familiar with their medical histories.

BCH used various strategies that partially addressed these staffing challenges

To address its staffing challenges, BCH contracted with individual providers to supplement services provided directly by hospital staff. At the time of our visit, BCH used temporary contracts to fill a number of positions throughout the hospital, such as an emergency room physician, nurse anesthetist, surgery department health technician, and family practice physician. These temporary contracts typically lasted a year.

BCH used Purchased/Referred Care (PRC) funds when patients required services that were not available directly from hospital staff; however, those funds were limited. All IHS hospitals can use PRC funds to pay for services for eligible tribal members¹ that are not available from the

¹ 42 CFR § 136.23(a).

OBSERVATIONS

Unless otherwise indicated, we based our observations on our review of hospital documentation and a sample of patient medical records, and on interviews with hospital officials and representatives of Blackfeet tribal health programs.

hospitals' providers. To be eligible for PRC-funded services, members of federally recognized tribes must live on their tribe's reservation or within a designated service area. At the time of our visit, BCH maintained PRC-funded contracts to provide neurology, nephrology, optometry, urology, oral surgery, and cardiology services to its patients. BCH typically offered these services onsite about 1 to 3 days a month. BCH also referred its patients to non-IHS providers and paid for these services using PRC funds. However, in accordance with IHS policy, BCH prioritizes which services it will cover using these funds because PRC funds are limited.² As a result, BCH's officials reported that it could not pay for services needed by some patients with pressing but non-life-threatening needs. Furthermore, BCH could not use PRC funds to pay for services when patients, because of their tribal membership or area of residence, were not eligible to receive these services.

Using PRC funds may not be a cost effective way to provide services to patients. One hospital official reported that it can be more expensive to pay for services using PRC funds than to hire someone to provide the service directly.

Despite efforts to address continuity of care, BCH faced challenges arranging for post-discharge services for patients

At the time of our visit, BCH used a discharge planning process to assess and plan for patients' continuing care needs after discharge from the hospital.³ BCH's officials reported that, as part of this process, the hospital's admission nurse assessed patients and referred them for discharge planning services. If not referred by the admission nurse, patients could still request discharge planning services. The hospital's discharge planner and social worker conducted discharge planning evaluations to help assess patients' continuing care needs. BCH created and used a discharge planning evaluation form to collect patient information such as the patient's medical coverage, home environment (e.g., patient lives alone, patient lives at home with family support), and recent hospitalizations. BCH's officials reported that they were continuing to revise and develop the hospital's discharge planning policies and procedures.

² IHS's standardized medical priority levels are as follows: I—Emergent or Acutely Urgent Care Services, II—Preventive Care Services, III—Primary and Secondary Care Services, IV—Chronic Tertiary Care Services, and V—Excluded Services. Accessed at http://www.ihs.gov/chs/index.cfm?module=chs_requirements_priorities_of_care on May 5, 2015.

³ Medicare's hospital Conditions of Participation require that hospitals have in effect a discharge planning process that applies to all patients. 42 CFR § 482.43.

OBSERVATIONS

Unless otherwise indicated, we based our observations on our review of hospital documentation and a sample of patient medical records, and on interviews with hospital officials and representatives of Blackfoot tribal health programs.

Our review of 40 patient discharge summaries indicated that BCH made plans to address patients' continuing care needs by providing instructions, counseling, or transfers to other facilities. We found that all summaries except one documented discharge instructions provided to patients and/or their family members or discussions between BCH staff and patients regarding counseling services and/or arrangements for transfer to another hospital or facility.⁴ The discharge summaries generally addressed at least one of the following: patients' followup outpatient appointments, medication orders, or self-care at home.

BCH faced challenges arranging for aftercare services because the facilities that provided these services were often full, did not provide the level of care needed by discharged patients, or were far away. Although BCH had relationships with other facilities that provided long-term-care services and rehabilitation services—such as skilled nursing facilities, home health agencies and hospice agencies—it was a challenge for BCH staff to arrange for their patients to receive care from these facilities. For example, BCH's officials reported that skilled nursing facilities did not always have space available for its patients. It was also difficult for BCH to arrange for comprehensive long-term-care services because IHS did not directly provide these services to beneficiaries living in Montana or elsewhere. Although the Blackfoot Tribe operates one long-term-care facility, that facility does not provide the level of skilled nursing care that some patients require. Finally, the community's remote location also created challenges in arranging aftercare services. Even when private providers and other non-IHS providers made long-term-care services available to BCH patients, it has not always been feasible for patients to access these services because of the distance that they and their families would need to travel for them to receive care. Of the three main hospitals to which BCH referred patients, two were over 100 miles away from the town in which BCH is located.

⁴ The one discharge summary without this information was for a patient who left the hospital against medical advice.

SITE VISIT: CROW-NORTHERN CHEYENNE HOSPITAL

Crow Reservation

Overview

Location

Crow Agency, Montana

Size

24-bed Critical Access Hospital

Staffing

About 200 clinical and nonclinical staff

Average Daily Census

1–2 patients

Emergency Department Visits

3,383 patients from January–March 2014

IHS Funding (Fiscal Year 2014)

- Direct clinical services = \$14.3 million
- Purchased/Referred Care = \$ 8.5 million

Services (Fiscal Year 2014)

Critical Access Hospitals are limited in size (no more than 25 beds) and typically are located in rural areas. These hospitals must offer emergency services 24 hours a day, 7 days a week and maintain average inpatient stays of no more than 4 days (96 hours).

Emergency Services

Limited Surgery Services

Pharmacy Services

Hospital-Based Outpatient Services

- Family practice
- Children's health
- Women's health
- Dental
- Mental and behavioral health

OIG Site Visit – June 11–12, 2014

Methodology

OIG staff visited the Crow-Northern Cheyenne Hospital to gather information for this case study. During the onsite visit, we:

- observed key hospital departments (e.g., outpatient clinics, inpatient ward, emergency department);
- collected and reviewed hospital documentation (e.g., policies, contracts, agreements) and patient records;
- interviewed hospital officials;
- interviewed representatives of the Crow Tribal Health Department; and
- interviewed representatives of the Northern Cheyenne Tribe.

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

OBSERVATIONS

Unless otherwise indicated, we based our observations on our review of hospital documentation and a sample of patient medical records, and on interviews with hospital officials and representatives of the Crow and Northern Cheyenne tribes.

In response to staffing and service limitations, Crow-Northern Cheyenne Hospital used temporary contracts and Purchased/Referred Care funding to provide services to its patients

Prior to our visit, Crow-Northern Cheyenne Hospital (CNCH) eliminated a number of services that previously were available at the hospital. As part of OIG's national study examining IHS hospitals, we learned that CNCH no longer offered pediatric inpatient care and a variety of specialty services. The hospital offered limited prenatal services, but no longer scheduled deliveries or provided prenatal care after 30 weeks' gestation.

In response to staffing shortfalls and funding uncertainty, CNCH used short-term contracts to provide services in its emergency department. CNCH experienced staffing shortfalls in the emergency department because, according to hospital officials, it had difficulty recruiting physicians. As a result, CNCH used short-term contracts to staff its emergency department. CNCH also faced uncertainty about its funding, which increased the hospital's dependence on short-term contracting. CNCH's officials reported that the hospital was unable to make long-term plans in fiscal year 2013 because IHS was operating without an approved budget. In some cases, CNCH extended short-term contracts to staff the emergency department for 1 and 2 months at a time.

CNCH used Purchased/Referred Care (PRC) funds on a limited basis to pay for patient services that were not available from IHS providers. All IHS hospitals can use PRC funds to pay for services for eligible tribal members that are not available from the hospitals' providers.¹ To be eligible for PRC-funded services, members of federally recognized tribes must live on their tribe's reservation or within a designated service area.² In accordance with IHS policy, CNCH prioritized which services it covered using these funds because PRC funds were limited.³ CNCH cannot use PRC funds to pay for services when patients, because of their tribal membership or area of residence, are not eligible to receive these services. At the time of our visit, CNCH's officials reported that the hospital used PRC funds primarily for emergency situations. CNCH also used PRC funds to pay for other services under limited conditions. For example, although CNCH typically denied PRC payments for screening exams, hospital officials reported that

¹ 42 CFR § 136.23(a).

² Ibid.

³ IHS's standardized medical priority levels are as follows: I—Emergent or Acutely Urgent Care Services, II—Preventive Care Services, III—Primary and Secondary Care Services, IV—Chronic Tertiary Care Services, and V—Excluded Services. Accessed at http://www.ihs.gov/chs/index.cfm?module=chs_requirements_priorities_of_care on May 5, 2015.

OBSERVATIONS

Unless otherwise indicated, we based our observations on our review of hospital documentation and a sample of patient medical records, and on interviews with hospital officials and representatives of the Crow and Northern Cheyenne tribes.

CNCH would cover a screening exam if it was needed by a high-risk patient.

CNCH used patient transfers and agreements with other facilities to link patients to the services they needed

CNCH transferred patients to other facilities when they needed a higher level of care than was available at CNCH. As a Critical Access Hospital, CNCH focuses on common conditions, short hospital stays, and outpatient services. In the 30 days prior to our site visit, CNCH made 77 patient transfers to other facilities. Of these 77 transfers, we randomly selected 10 and reviewed the associated patient records. CNCH transferred these patients because it did not have the services or equipment available to fully treat their medical needs. The hospital transferred one pediatric patient because it no longer provided any pediatric inpatient services. Other patients transferred by CNCH needed a range of services, from optometry services to dialysis and intensive care treatment. CNCH also transferred patients who needed imaging services, such as ultrasounds and CT scans.

At the time of our visit, CNCH maintained agreements with four other hospitals to supplement the services it provided to patients. CNCH maintained transfer agreements with two acute-care hospitals within about 60 miles of its facility. These agreements established the procedures by which CNCH transferred patients who required the skills, resources, and physical facilities of the receiving hospitals. CNCH also maintained a transfer agreement with a university hospital two States away that could provide intensive burn, trauma, and surgical treatment for those CNCH patients who needed it. Finally, CNCH maintained an agreement with one acute-care hospital that provided pediatric specialty care to CNCH patients by using telemedicine services.