TESTIMONY REGARDING H.R. 5406, "HELPING ENSURE ACCOUNTABILITY, LEADERSHIP, AND TRUST IN TRIBAL HEALTHCARE ACT"

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BEFORE THE UNITED STATES HOUSE SUBCOMMITTEE ON INDIAN, INSULAR, AND ALASKA NATIVE AFFAIRS

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Good afternoon Mr. Chairman and Members of the Subcommittee:

My name is Victoria Kitcheyan. I am a member of the Winnebago Tribe of Nebraska and I currently serve as Treasurer of the Winnebago Tribal Council. Thank you for holding this hearing on this very important piece of legislation which presents a logical first step toward addressing systemic problems in the IHS system which have been allowed to continue for far too long. I say first step because, as my testimony will document, the problems in the current IHS system at Winnebago are so profound that only a long term plan, which implements organizational changes and comes with additional financial resources, is required to make real concrete changes in our current situation. In order to help you understand my point, allow me to provide you with some background information.

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

Since at least 2007, the Winnebago IHS Hospital has been operating with demonstrated deficiencies which should not exist at any hospital in the United States. The CMS deficiencies that have been uncovered are so numerous and so life threatening that in July of 2015, the IHS operated Hospital in Winnebago became what is, to the best of our knowledge, the only federally operated hospital ever to lose its Medicare/Medicaid Certification.

Here is a synopsis of the events that led to this decision:

In 2011, CMS conducted a re-certification survey of the hospital and detailed serious deficiencies in nine areas, including Nursing and Emergency Services. My wonderful Aunt, Debra Free, was one of the victims of those deficiencies. She died in the Winnebago Hospital in 2011 when she was overmedicated, left unsupervised and fell from her bed in the inpatient area. After her death, a nurse at the hospital told my family that Debra had fallen during the night.

She said that that nurses from the emergency room had to be called to the inpatient ward to get Debra back into bed because there was inadequate staff and inadequate equipment on the in-patient floor to address that emergency.

While the hospital insisted that they did everything possible to revive her and save her life, we question just how long she remained on the floor and what actually happened. Among those questioning was Debra's sister, Shelly, who was a nurse at the hospital during that period. Unfortunately, my Aunt Shelly was not on duty when this occurred, but she did know enough from her professional training to question the circumstances of the death.

When my Aunt Shelly and the family requested to see the charts to determine what actually happened, we were met with immediate resistance. First, my mother, also Debra's sister, was told she was not authorized to request the chart. Then my grandmother, Aunt Debra's own mother, Lydia Whitebeaver, submitted a request and was denied the information. In fact, the whole family and the Attorney that we were forced to hire were all told that the chart was "in the hands of the Aberdeen Area Office's attorneys" and was not available to us.

Because she demanded answers to our very reasonable questions, my Aunt Shelly was retaliated against in the worst way. As an IHS employed nurse at the Hospital she was regularly intimidated by her supervisors and colleagues, and generally treated in the most horrific way by the Director or Nursing and her cronies. One of those nurses even reported Shelly to the State Licensing Board. Thank goodness the State Licensing Board's Members saw that report for what it was and dismissed the inquiry almost immediately, but this is a prime example of why we have been unable to get the proof of these incidents before the CMS Reports were released. Fear of retaliation within the IHS system is real. One former IHS employee of the Hospital has said that those employees who threaten to speak out are regularly reminded to "remember who you work for."

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

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

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

undiagnosed stroke and was sent home from the emergency room without any follow up care whatsoever.

When some of the findings of the CMS 2011 Report became public, in early 2012, former IHS Director Roubideaux publically promised improvements. While some minor issues were addressed, many other things got worse. In just the past 2 years, four additional potentially unnecessary patient deaths and numerous additional deficiencies have been cited and documented by CMS. These incidents and reports include:

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

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

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

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

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

- September 2014. CMS survey jurisdiction over the Winnebago IHS hospital was transferred from the Kansas City regional office to Region VI in Dallas, TX, when IHS attempted to forum shop the next CMS review, but in November 2014, that new CMS office identified more than 25 deficiencies.

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

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

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

Keep in mind that the deaths and findings cited by CMS are only the ones that have been documented by CMS. When CMS conducts a survey, only a small sampling of patient records are reviewed. We have no way of knowing how many more unnecessary deaths and misdiagnosis have occurred at the hands of IHS personnel. There is also no way that we can portray the tremendous pain and loss that has been suffered by our families and our community in these few pages. These things are happening not only in Winnebago, but they are also happening in Rosebud, Pine Ridge and Rapid City. Our people are devastated, angry and demanding change.

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

Throughout this period the IHS assured the Winnebago Tribal Council that the CMS findings, most of which were never provided to the Winnebago Tribe at least in their totality, were being addressed. In fact, less than two weeks before CMS actually pulled the Certification, the IHS Regional Director was still telling the Tribal Council that IHS was talking to its lawyers and planning an appeal. There was in fact no basis for an appeal and, one year later, the hospital remains without a permanent qualified CEO and is still not ready to submit an application to CMS for recertification.

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

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

When we asked former Acting Director McSwain about the professional medical review that the IHS had engaged in after each of these five deaths occurred, and what role the Central Office played in those reviews, we were shocked to learn that the IHS does not appear to have an established procedure for dealing with questionable deaths or other unusual events that occur in its hospital. In fact, if there was ever a professional peer review of any of those five incidents of questionable death, we can't find it!

When we pushed harder on this issue we were told that this review should have been conducted by the "Governing Body" of the hospital. This basically means that a body, composed largely of other IHS employees who are not doctors or other medical professionals, were supposed to review the actions of the physicians, nurses and anesthesiologists in the emergency room. The end result, however, is that - to the best of our knowledge - no one was fired, no one was reprimanded, no one was suspended pending a medical investigation and no one was reported to the licensing board. This is outrageous!

The Governing Body for the Winnebago IHS Hospital has also basically been non-functional. The area of governance was cited numerous times in the CMS reports. The governing body is comprised primarily of IHS management officials, many of whom are from the regional office and have no direct personal knowledge of the community, the facility, the staff or the patients served by the hospital. And while there is supposed to be a voting seat on the board from the two primary Tribes served by the hospital, we have found that the tribal representatives are not afforded access to all of the same information as other members of the board, or the information is not timely. Furthermore, training has been inadequate and there is no regular meeting schedule for the governing body.

It is also important to note that the Winnebago IHS Hospital has become a short term stop for a number of IHS contractors. Many of the doctors who take care of our needs are not federal employees, they are private contractors who rotate in and out of our facility. This forces even the best of those physicians to rely heavily on the nursing staff who remain at the facility, many of whom have been found by CMS to be serious undertrained. Most recently, the IHS advertised to find one contractor to operate the Emergency Departments at three hospitals in the Great Plains Region, including Winnebago. The contractor selected by IHS is one of the same problem contractors that has been around for years and that was working at Winnebago during the period of review by CMS. This action was supposedly taken to help improve the quality of services but it was done without consultation with the Tribes and not only did we end up with one of the same companies that failed us in the past, the few permanent providers who did work in the Emergency Department were forced to either leave or transfer to other positions.

In the fall of 2015, the IHS hired an outside consultant to perform its own review of the facility. This review was conducted applying standard federal and state medical standards. During this review, this independent consultant found 97 deficiencies, many of which were never

uncovered, or at least never reported, by CMS. The IHS consultant helped to develop a corrective action plan for the Winnebago facility, and the hospital staff is still continuing to work on implementation of this plan. This is obviously necessary, but the process is slow and it is difficult to trust that checking an item off a list is getting us the real change that we need to see or that those changes will be sustained.

It is clear that management, recruitment, accountability and transparency are all major issues that need to be addressed. One full year has passed since the CMS certification was terminated at Winnebago – and one year later, the CEO position at the hospital and the Director of the Regional Office are still being held by individuals detailed from other IHS positions for 30 or 60 days at a time. Real change and the rebuilding of this organization cannot happen without permanent qualified personnel and the funding necessary to carry out the mission.

Mr. Chairman, these are the reasons that the Winnebago Tribe supports the immediate passage of this legislation. But, I must state clearly and bluntly, that while everything in this bill is needed, this legislation alone will not solve our problem. Proper training of hospital staff costs money, new equipment costs money, and recruitment, under these circumstances is also going to cost money. So, while I encourage you to pass this legislation, please do so as an initial first step. I implore you not to abandon us after this bill is passed because correcting this situation is going to require a team effort, additional resources, and consistent Congressional oversight of IHS activity.

Thank you again for allowing me to testify, I will be happy to answer any questions you may have.