



Report to the Committee on Indian
Affairs, U.S. Senate

March 2016

INDIAN HEALTH SERVICE

Actions Needed to Improve Oversight of Patient Wait Times

GAO Highlights

Highlights of [GAO-16-333](#), a report to the Committee on Indian Affairs, U.S. Senate

Why GAO Did This Study

IHS is charged with providing health care to AI/AN people—members or descendants of 566 federally recognized tribes. AI/AN people die at higher rates than other Americans from conditions that could be mitigated through access to preventive primary care services and have experienced long-standing problems accessing health care services. GAO was asked to review how IHS ensures access to care at its facilities and steps taken to address reports of lengthy wait times for appointments.

This report examines (1) the extent to which IHS oversees access to timely primary care, and (2) any steps that selected facilities have taken to help ensure patient access to timely primary care. GAO reviewed policies and guidance related to access to IHS primary care; interviewed IHS officials; and visited a nongeneralizable sample of seven facilities that varied in their size and services provided. GAO also examined documents from governance meetings between IHS area office and facility staff that took place between January 1, 2014, and September 1, 2015.

What GAO Recommends

GAO recommends that IHS (1) communicate specific agency-wide standards for patient wait times, and (2) monitor patient wait times in its federally operated facilities, and ensure corrective actions are taken when standards are not met.

In commenting on a draft of this report, IHS agreed that setting quality standards and monitoring against those standards is a key strategy for improving patient care.

View [GAO-16-333](#). For more information, contact Kathleen King at (202) 512-7114 or kingk@gao.gov.

March 2016

INDIAN HEALTH SERVICE

Actions Needed to Improve Oversight of Patient Wait Times

What GAO Found

The Indian Health Service (IHS) has not conducted any systematic, agency-wide oversight of the timeliness of primary care provided in its federally operated facilities. IHS has delegated primary responsibility for the oversight of care provided in its facilities to its area offices and has not set any agency-wide standards for patient wait times—including both how long it should take to schedule an appointment and to complete the actual office visit. The oversight provided by area offices has generally only occurred during periodic meetings with facility staff and only when relevant issues, such as patient complaints, have arisen. While staff at some facilities have measured patient wait times, their efforts have been hampered by an electronic health record system that does not provide complete information on patient wait times. In 2009, IHS set four agency-wide improvement priorities of which one was to improve the quality of and access to health care, and the Department of Health and Human Services has identified timeliness as a key component of access. However, the lack of systematic, agency-wide oversight of the timeliness of primary care appointments prevents IHS from knowing the extent to which it is meeting the goal of providing accessible primary care services to American Indian and Alaska Native (AI/AN) people and is also inconsistent with federal internal control standards. Setting agency-wide standards for patient wait times and monitoring compliance with these standards would allow IHS to assess whether it is meeting this program objective and monitoring compliance with these standards would allow IHS to determine what corrective actions are needed when standards are not being met. IHS officials told GAO that they hope to eventually track patient wait times, but they have been focused on other agency-wide efforts, such as ensuring that facilities are accredited.

To help improve patient access to timely primary care, staff at the seven IHS facilities GAO visited reported that they have taken various steps to help ensure that their patients have access to timely primary care, but obstacles remain. Steps taken by facilities include modifying appointment scheduling procedures and improving communication with patients. For example, staff from multiple facilities stated that they have implemented a modified open access scheduling system, whereby staff schedule a certain portion of appointments in advance and keep the remainder of the appointments open for same-day scheduling. Facility staff also reported taking steps to improve communication with tribal members in their service areas in order to reduce missed appointments and educate patients about the importance of primary care. However, facility staff stated that a lack of sufficient primary care providers, as well as aging infrastructure and equipment, are significant obstacles to ensuring that patients receive timely care. IHS officials and facility staff stated that ongoing staff vacancies significantly reduce their ability to ensure that patients receive timely care. For example, staff at one facility stated that, depending on provider availability, new patients may wait 3 or 4 months for an initial appointment. Facility staff also reported working in outdated facilities with insufficient space to accommodate additional providers and with outdated medical and telecommunications equipment, such as analog mammography machines and telephones with an insufficient number of lines for scheduling patient appointments.

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Abbreviations

AAAHC	Accreditation Association for Ambulatory Health Care
AI/AN	American Indian and Alaska Native
CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health and Human Services
IHS	Indian Health Service
IPC	Improving Patient Care
OPM	Office of Personnel Management
PMAP	Performance Management Appraisal Program
PRC	Purchased/Referred Care
RPMS	Resource and Patient Management System
TNA	third-next available
VHA	Veterans Health Administration

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March 29, 2016

The Honorable John Barrasso, M.D.
Chairman
The Honorable Jon Tester
Vice Chairman
Committee on Indian Affairs
United States Senate

The Indian Health Service (IHS), an agency within the Department of Health and Human Services (HHS), is charged with providing health care services to the approximately 2.2 million American Indian and Alaska Native (AI/AN) people who are members or descendants of 566 federally recognized tribes. According to IHS, its agency-wide goal is to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to AI/AN people. In fiscal year 2015, IHS allocated \$3.4 billion for this care.¹ IHS provides health care services directly through a system of federally operated IHS facilities—hospitals, health clinics, and health stations operated by IHS—and also funds services provided in facilities operated by tribes or others.² Federally operated IHS facilities, which received over 5 million outpatient visits in 2013, provide mostly primary and emergency care, as well as some ancillary and specialty services, and are located in 10 federally

¹The total enacted appropriation for IHS for fiscal year 2015 was \$4.6 billion of which approximately 63 percent was allocated to tribes to deliver clinical and preventive services. It also included \$460 million for facilities maintenance and construction. Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, 128 Stat. 2129, 2434 (2014).

²In addition to federally operated IHS facilities, some federally recognized tribes choose to operate their own health care facilities and receive IHS funding. Other operators include 34 non-profit 501 (c)(3) programs nationwide, through which AI/AN people may receive care in certain urban areas funded through grants and contracts from IHS under Title V of the Indian Health Care Improvement Act, as amended, Pub. L. No. 94-437, 90 Stat. 1400 (1976).

designated geographic areas overseen by IHS area offices.³ When health care services at federally operated or tribally operated IHS facilities are not available, however, care may be obtained in certain circumstances from external providers and paid for through IHS's Purchased/Referred Care (PRC) program, formerly known as the Contract Health Services program.⁴

Despite improvements over the past 60 years, AI/AN people born today have a life expectancy that is 4.2 years less than all races in the United States and continue to die at higher rates than other Americans from many causes, including chronic liver disease and cirrhosis, diabetes mellitus, suicide, and chronic lower respiratory diseases. Many of these conditions can be mitigated through access to effective preventive primary care services, but AI/AN people have experienced long-standing problems accessing needed services. We have previously reported that at some IHS facilities, access to primary care was not assured due, in part, to lengthy waits for certain services.⁵ In addition, in 2010, the Senate

³Ancillary services include laboratory, diagnostic imaging, and pharmacy services. Specialty care includes services provided by cardiologists, surgeons, and other physician specialists.

The 10 areas are Albuquerque, Bemidji, Billings, Great Plains, Nashville, Navajo, Oklahoma City, Phoenix, Portland, and Tucson. In two additional areas—Alaska and California—all IHS facilities are tribally operated under the Indian Self-Determination and Education Assistance Act, as amended. This report examines the timeliness of primary care only in federally operated IHS facilities.

⁴Of the \$3.4 billion allocated for health care services in 2015, \$1.8 billion was allocated for health services provided by IHS-funded hospitals, health centers, and stations and \$9.1 million for PRC.

⁵Healthy People 2020—HHS's 10-year national objectives for improving the health of Americans—defines access to health services as the ability to gain entry into the health care system at a location where needed services are provided and with a health care provider with whom the patient can communicate and trust. Optimal access includes insurance coverage that helps enable patients to obtain services such as preventive health care, disease treatment and management and emergency care. This care should be timely—as in the system's ability to provide health care quickly after a need is recognized—and provided by a workforce that includes physicians, optometrists, dentists, nurse practitioners, and pharmacists, among others. See U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, *Healthy People 2020, Access to Health Services*. (Washington: D.C.) Accessed Dec. 16, 2015, <http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services>.

See GAO, *Indian Health Service: Health Care Services Are Not Always Available to Native Americans*, [GAO-05-789](#) (Washington, D.C.: Aug. 31, 2005)

Committee on Indian Affairs identified deficiencies in oversight that contributed to reduced access and quality of health care services at facilities throughout the Great Plains area. More recently, tribal representatives testified at a 2014 Senate hearing about challenges AI/AN people experience scheduling primary care appointments as well as extended delays while awaiting care. At the hearing, tribal representatives testified about delays in the provision of quality care at federally operated IHS facilities, and patients reported difficulty in scheduling primary care appointments because of extended wait times.⁶

You raised questions about how IHS ensures access to care at its facilities. This report examines

1. the extent to which IHS oversees access to timely primary care in its federally operated IHS facilities, and
2. steps that selected federally operated IHS facilities have taken to help ensure patient access to timely primary care, if any.

To identify the extent to which IHS oversees access to timely primary care in its federally operated facilities, we reviewed the Indian Health Manual, IHS guidance, prior GAO reports, and HHS management and employee performance documents, including those related to area office and facility chief executive officer performance agreements and the HHS Performance Management Appraisal Program (PMAP).⁷ We also interviewed officials from IHS Headquarters and senior officials at all 10 area offices that have oversight responsibilities for federally operated IHS facilities about the extent to which the agency has designed processes that enable it to ensure health services provided by its facilities are available and accessible to AI/AN people on a timely basis. In addition, we visited 7 federally operated facilities in three geographically diverse areas located in Medically Underserved Areas and asked staff about any

⁶See *The Indian Health Service: Ensuring the IHS Is Living Up to Its Trust Responsibility*, Oversight Field Hearing, 113th Cong. (2014).

In addition to tribal concerns regarding access to primary care, on July 23, 2015, the Centers for Medicare & Medicaid Services (CMS) terminated its provider agreement with the Winnebago IHS Hospital in Nebraska due to operational deficiencies. As a result, at the time of this report, the hospital may not bill Medicare or Medicaid for any services provided.

⁷The Indian Health Manual is a reference manual for IHS employees that includes IHS-specific policy and procedural instructions.

specific measures or information that IHS uses to monitor the timeliness of primary care appointments.⁸ In addition to being geographically diverse, we selected facilities that provided primary care services but varied in the extent to which they provided emergency and inpatient care. In addition, the facilities varied by the number of direct care visits they received and the number of inpatient hospital beds they had in 2013. This sample is not generalizable to other IHS areas or facilities.

We also examined documents from meetings between area office staff and facility staff that took place between January 1, 2014, and September 1, 2015.⁹ We asked IHS officials at all levels, including the 7 federally operated facilities, about any specific measures and performance data that IHS uses to monitor the timeliness of primary care appointments. If available, we also reviewed data generated by IHS facilities through their electronic health records system to determine whether the system could be used to monitor the timeliness of primary care appointments at its facilities. We compared IHS oversight practices against relevant standards for internal control in the federal government.¹⁰

To identify any steps that selected federally operated IHS facilities have taken to help ensure patient access to primary care services, we interviewed staff at the seven facilities, including facility managers and primary care staff regarding specific efforts to improve timely access to health services. We reviewed documents from meetings between staff at

⁸We visited Cass Lake Hospital, Red Lake Hospital, and White Earth Health Center in the Bemidji area; Crow/Northern Cheyenne Hospital and Lodge Grass Health Clinic in the Billings area; and Gallup Indian Medical Center and Tohatchi Health Center in the Navajo area.

The Health Resources and Services Administration's Medically Underserved Areas are areas designated as having too few primary care providers, high infant mortality, high poverty or a high elderly population.

⁹We reviewed the agendas and minutes of governing board meetings provided by the area offices for meetings conducted between January 1, 2014, and September 1, 2015. Because these governing board meetings generally occur 2 to 4 times per year, we reviewed documents from multiple meetings for each facility. In addition, we reviewed information discussed during these meetings that was specifically related to the timeliness of primary care appointments or appointment cycle times.

¹⁰GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: Nov. 1999). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

federally operated IHS facilities and the 10 area offices conducted between January 1, 2014, and September 1, 2015.¹¹ We reviewed meeting agendas, minutes, facility-specific strategic plans, planning documents, and data on access to timely primary care appointments, where available.

We conducted this performance audit from February 2015 to March 2016 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

IHS was established within the Public Health Service in 1955 in order to meet federal treaty obligations to provide health services to members of federally recognized AI/AN tribes primarily in rural areas on or near reservations. IHS provides these services directly through a network of hospitals, clinics, and health stations operated by IHS, and also funds services provided at tribally operated IHS facilities or through the PRC program.¹² The federally operated system consists of 27 hospitals, 59

¹¹We reviewed the agendas and minutes of governing board meetings that area offices conducted between January 1, 2014, and September 1, 2015 for all facilities. We also reviewed any information discussed during these meetings that were specifically related to the timeliness of primary care appointments or appointment cycle times.

¹²IHS also provides funding to nonprofit, urban Native American organizations through the Urban Indian Health program to provide health care services to AI/AN people living in urban areas.

Under the Indian Self-Determination and Education Assistance Act, as amended, federally recognized Indian tribes can enter into self-determination contracts or self-governance compacts with the Director of IHS to take over the administration of IHS programs for Indians previously administered by IHS on their behalf. Self-governance compacts allow tribes to consolidate and assume administration of all programs, functions, services, activities, and competitive grants administered throughout IHS, or portions thereof, that are carried out for the benefit of Indians because of their status as Indians. In contrast, self-determination contracts allow tribes to assume administration of a program, programs, or portions thereof. See 25 U.S.C. §§ 450f(a) (self-determination contracts) and 458aaa-3 (self-governance compacts). In 2014, AI/AN tribes administered over one-half of IHS resources through 18 hospitals, 282 health centers, 80 health stations, and 150 Alaska village clinics, and 33 urban health programs.

health centers, and 32 health stations in 33 states and received over 5 million outpatient visits in 2013. (See table 1.)

Table 1: Numbers of Federally Operated and Tribally Operated Indian Health Service Facilities, as of October 2015

Facilities	Hospitals	Health Centers	Alaska Village Clinics	Health Stations
Federal	27	59	NA	32
Tribal	18	284	163	79

Source: Indian Health Service | GAO-16-333

Federally operated IHS hospitals range in size from 4 to 133 beds and are open 24 hours a day for urgent care needs. Health centers offer a range of care, including primary care services and at least some ancillary services, such as pharmacy, laboratory, and X-ray, and are open for at least 40 hours a week. Health stations offer only primary care services on a regularly scheduled basis and are open fewer than 40 hours a week. When services are not available at these facilities, IHS may, in some cases, pay for services provided by external health care providers, including hospital-based and office-based providers through its PRC program. However, if primary care services are not available directly through the IHS, they are unlikely to be covered through the PRC program because IHS pays for higher-priority medical needs first—specifically, services that are necessary to prevent the immediate death or serious impairment of the health of the individual.¹³

IHS oversees its health care facilities through a decentralized system of area offices, which are led by area directors and located in 12 geographic

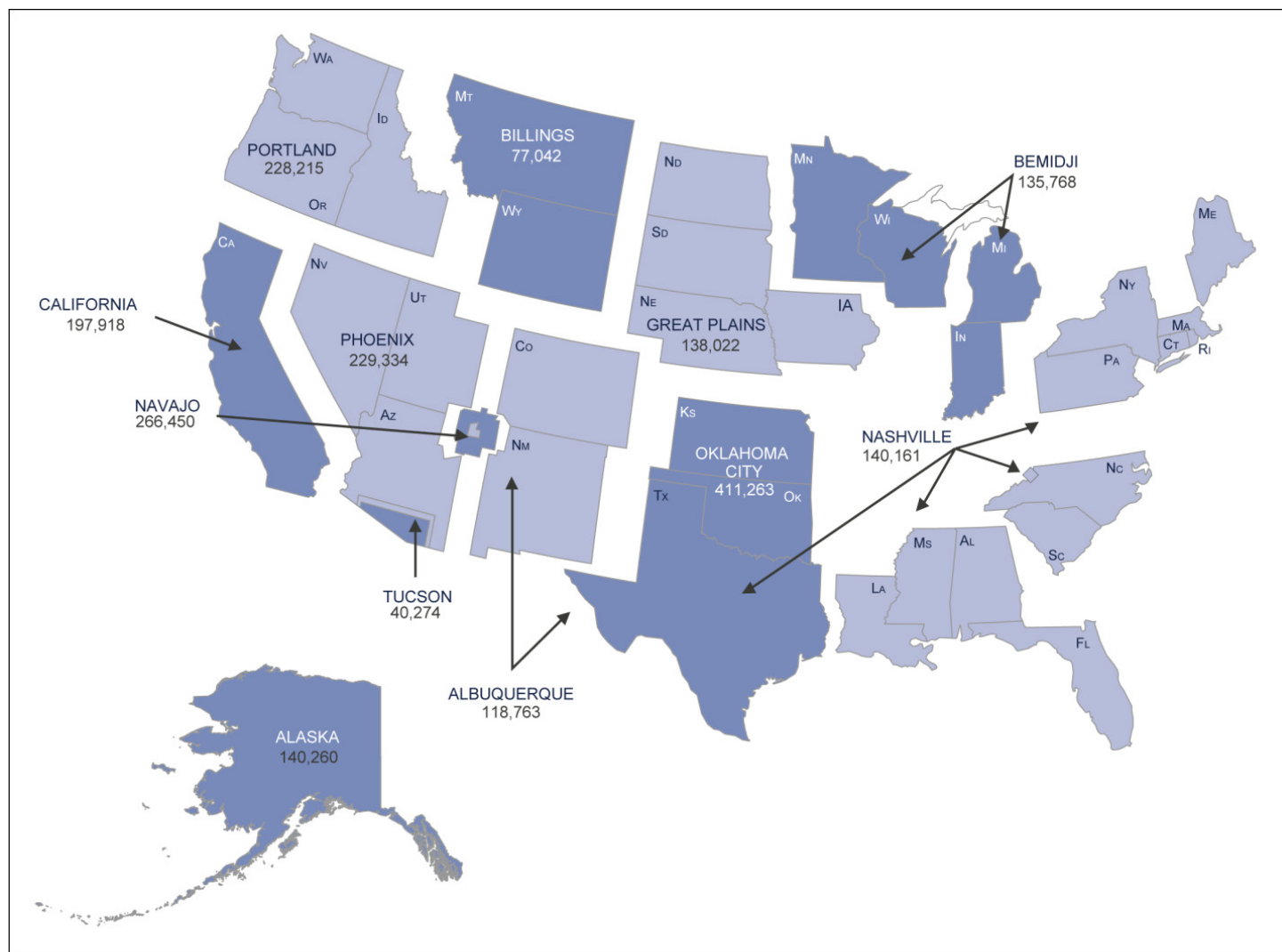
¹³PRC regulations require the ranking of referrals or requests for payment by medical priority when funding is limited. 42 C.F.R. § 136.23(e) (2015). IHS established five categories of care within the medical priority system: (1) emergency threats to life, limb, senses, (2) preventative care services, (3) primary and secondary care services, (4) chronic tertiary and extended care services, and (5) excluded services.

We have noted in past reports that IHS is not able to pay for all eligible health care services—through either direct care services or services funded through the PRC program—leading to an unmet need for health care services. See [GAO-05-789](#); GAO, *Increased Oversight Needed to Ensure Accuracy of Data Used for Estimating Contract Health Service Need*, [GAO-11-767](#) (Washington, D.C.: Sept. 23, 2011); and GAO, *Indian Health Service: Most American Indians and Alaska Natives Potentially Eligible for Expanded Health Coverage, but Action Needed to Increase Enrollment*, [GAO-13-553](#) (Washington, D.C.: Sept. 5, 2013). For a list of related GAO products, see the last page of this report.

areas. (See fig. 1 for a U.S. map showing the IHS patient population by area). Ten of these 12 IHS areas have federally operated IHS facilities—Albuquerque, Bemidji, Billings, Great Plains, Nashville, Navajo, Oklahoma City, Phoenix, Portland, and Tucson.¹⁴

¹⁴The Alaska and California areas do not have any federally operated IHS facilities.

Figure 1: Indian Health Service Patient Population by Area, Calendar Year 2014



Source: Indian Health Service. | GAO-16-333

Note: The Albuquerque, Nashville, and Oklahoma City area offices oversee facilities in Texas.

According to IHS, the headquarters office is responsible for setting health care policy, ensuring the delivery of quality comprehensive health services, and advocating for the health needs and concerns of AI/AN people. The IHS area offices are responsible for distributing funds to the facilities in their areas, monitoring their operation, and providing guidance and technical assistance. (See fig. 2).

Figure 2: Responsibilities of Indian Health Service Headquarters, Area Offices, and Federally Operated Facilities Related to Health Care for American Indians and Alaska Natives



Source: GAO. | GAO-16-333

According to IHS, its agency-wide goal is to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to AI/AN people, and its mission is to raise the physical, mental, social, and spiritual health of AI/AN people to the highest level. According to IHS officials, this mission cascades through every organizational level and individual in the agency and links agency-wide performance to its goal.¹⁵ According to IHS's 2006-2011 strategic plan—the most recent strategic plan available—the agency has established a performance-based culture to carry out its goals at all levels, which is achieved by cascading these objectives to every organizational level and individual and holding them accountable for performing work linked to

¹⁵According to the Indian Health Manual, written performance elements are derived from the IHS Director's performance plan and are cascaded, as appropriate, to all employees. In developing the performance plan, rating officials are required to review and consider the IHS objectives and any other important goals and measures. The manual states that, "the cascaded goals will impact organizational activity as well as individual performance expectations."

those objectives. This cascading method of accountability is often used by health care organizations with a decentralized management structure and is recommended by the Office of Personnel Management (OPM) for agencies with clear organizational goals and objectives.¹⁶ In addition, in 2009 IHS developed four agency-wide priorities that serve as a strategic framework for improvement within the agency. One of these four priorities is to improve the quality of and access to care, and according to Healthy People 2020—HHS’s 10-year national objectives for improving the health of Americans—timeliness is one of four key components of access to health care.¹⁷

IHS established the Improving Patient Care (IPC) initiative in 2006 as a voluntary collaborative program in which its facilities shared best practices by participation in a series of training sessions and webinars, data collection activities, and the formulation and implementation of plans to drive improvement. According to IHS, the aim of the initiative is to “improve quality of care through evidence-based practice, enhance access to care across all ages and chronic conditions, improve patient experience of care, and build a sustainable infrastructure for the spread of innovative improvement.” As part of the IPC initiative, the IPC program has set numerical targets for participating facilities for certain performance goals, including numbers of emergency department and urgent care visits, patient satisfaction, third-next available appointment (TNA), and cycle time. TNA and cycle time are both measures of patient wait time. TNA is a measure of appointment availability for a new patient physical, or a routine or return exam, and represents the average length of time between when a patient requests an appointment and the third-next appointment available. TNA is considered a more accurate measure of access to care than the next available appointment or second-next available appointment because such appointments may have become available due to a cancellation or other event that is not predictable or

¹⁶According to OPM, expectations cascading to all employees must be: (1) aligned with organizational goals; (2) clear, specific, and understandable; (3) reasonable and attainable; (4) measurable, observable, or verifiable, and results oriented; (5) communicated in a timely fashion; and, (6) key in fostering continual improvement in productivity.

¹⁷The four IHS-wide priorities are “(1) To renew and strengthen our partnership with Tribes, (2) To reform the IHS, (3) To improve the quality of and access to care, and (4) To make all our work accountable, transparent, fair and inclusive.” See Department of Health and Human Services, *Fiscal Year 2015 Indian Health Service: Justification of Estimates for Appropriations Committees* (Rockville, Md.: Feb. 6, 2014).

reliable. Cycle time is a measure of the number of minutes that a patient spends at an office visit, beginning at the time of arrival and ending when the patient leaves the facility.

Access to Primary Care for AI/AN People

Central to the IHS mission is the provision of care through hospitals, health centers, and health stations. These facilities are a key source of primary care services for AI/AN people. According to the Agency for Healthcare Research and Quality, individuals are determined to have a primary care provider if they have a health care setting—other than an emergency department—where they go to address new health problems, receive preventive health services, and obtain physician referrals. Having access to a usual primary care provider has been shown to correlate with better continuity of care and, over time, better health outcomes. Although IHS facilities range from full service hospitals located in urban areas and open 24 hours a day to remote health stations with limited hours and staff, they all generally provide primary medical, dental, and vision care.

We have previously reported that the availability of primary care services to AI/AN people largely depended on the extent to which they were able to gain timely access to services funded by IHS—including services obtained through federally operated or tribally operated facilities, or through the PRC program.¹⁸ According to IHS, primary medical care includes a comprehensive first contact and continuing care including identification, diagnosis and management of health problems; health promotion; prevention of disease and disability; health maintenance; rehabilitation; and referral to other providers as appropriate. Primary dental care includes oral examinations, diagnosis and treatment. Primary vision care includes vision examination with diagnosis, treatment of vision disorders, and prescriptions for vision correction. (See table 2 for additional information about services and providers included in primary medical, dental, and vision care, according to the Indian Health Service.)

¹⁸ [GAO-05-789](#).

Table 2: Indian Health Service Primary Care Services

	Services	Providers
Medical	Comprehensive first contact and continuing care including identification, diagnosis and management of health problems; health promotion; prevention of disease and disability; health maintenance; rehabilitation and referral to other providers as appropriate.	Family and internal medicine physicians Pediatricians Nurse practitioners Physician assistants
Dental	Initial or periodic oral exams Restorative treatment of caries Dental x-rays Dental sealants Periodic cleaning Athletic mouth guards Risk assessment Oral hygiene instruction Tobacco cessation counseling Fluoride varnish Dietary fluoride supplements	Dentists Dental therapists Dental hygienists Dental assistants Dental laboratory technicians
Vision	Primary vision examination with diagnosis Treatment of vision disorders Prescriptions for vision correction Consultation of chronic systemic diseases affecting ocular stability Examinations with diagnosis and treatment of ocular disease such as glaucoma	Optometrists Optometric assistants Optometric technicians Ophthalmologists Ophthalmologist technicians/nurses

Source: Indian Health Service | GAO-16-333

IHS Conducts No Systematic, Agency-wide Oversight of Patient Access to Timely Primary Care in Its Facilities and, As a Result, Cannot Ensure Timely Access

IHS has not conducted any systematic, agency-wide oversight of the timeliness of primary care provided in its federally operated facilities and, as a result, cannot ensure that patients have access to timely primary care. IHS has delegated primary responsibility for the oversight of care provided in its facilities to the area offices and has not set any agency-wide standards for how long patients should wait for primary care appointments or for cycle time in their facilities. IHS officials told us that they do not systematically monitor any data on patient wait times for primary care in federally operated IHS facilities or provide systematic written guidance or feedback to facilities on the timeliness of primary care appointments because the agency has higher priorities at this time.

The oversight provided by the area offices has generally occurred during periodic governing board meetings with facility staff.¹⁹ Officials from all 10 of the area offices that oversee federally operated IHS facilities told us that the timeliness of primary care appointments was monitored through these governing board meetings. However, area office officials also told us, and our review of meeting minutes and other relevant documents confirmed, that during these meetings patient wait times were reviewed only (1) if facility staff or tribal representatives raised a concern, (2) in response to patient complaints, or (3) if the facility was participating in the voluntary IPC initiative and the staff chose patient wait times as a focus for improvement. For example, officials from the Portland area office told us that the timeliness of patient care is not a standing agenda item for their governing board meetings with facility staff, but tribal leadership often attend the meetings and may share any concerns they have about patient wait times. In addition, officials from the Phoenix area office stated that they discuss patient complaints during meetings with facility staff because standards and targets for timeliness are not defined across IHS. During our review of the minutes of governing board meetings held since January 2014, we found that, in at least one case the concerns raised were not necessarily addressed, even when a governing board meeting

¹⁹According to IHS, meetings of governing boards, which include senior area office officials and facility staff, focus on quality of care standards. Documentation from all 10 area offices in our review showed variation in the frequency with which the governing boards met with facilities, ranging from 2 to 4 times per year.

included a discussion of patient complaints about the timeliness of primary care.²⁰

Officials from area offices told us they may review data on patient wait times—specifically, TNA and cycle time—during governing board meetings if the facility is participating in the voluntary IPC initiative and the staff chose patient wait times as a focus for improvement. However, IHS headquarters officials told us that few facilities participating in the IPC initiative have chosen to focus on this, and that facilities developed their own approach to reporting patient wait time information to the area offices.²¹ Examples of information reported to area office officials include:

- A graph of a Tucson area facility's monthly TNA from August 2012 through May 2014.
- A table of a Bemidji area facility's TNA for each provider.
- A graph of an Oklahoma City area facility's average yearly cycle time from 2008 through 2014 with specific indications of when the facility implemented changes, such as starting same-day appointments and adding extra appointment slots.
- A list of a Nashville area facility's cycle time by provider and date.
- A graph comparing a Navajo facility's cycle times on two dates about a year apart. This graph specified the facility's average cycle time at specific points in a patient's visit—such as triage, patient registration, time in the exam room, and time at the pharmacy.

²⁰For example, in July 2014, facility staff met with Bemidji area officials and discussed an increase in appointment wait times due to a shortage of providers, as well as patient complaints about problems accessing care. Almost a year later, in June 2015, the facility's clinical director raised the issue again and stated that "most of the comments" on a recent patient survey still involved wait times and insufficient numbers of providers. However, minutes from the meeting do not indicate that the governing board made any recommendations or assigned any staff to be accountable for addressing the issue.

²¹IHS established the IPC initiative in 2006 as a voluntary collaborative program in which its facilities shared best practices by participation in learning sessions and webinars, data collection activities, and the formulation and implementation of plans to drive improvement. According to IHS officials, the overarching goal of the IPC initiative has been to improve the quality of, and access to, care. As part of the IPC initiative, IHS set numerical goals for TNA and cycle time. TNA is a measure of appointment availability for a new patient physical, or a routine or return exam. TNA represents the average length of time between when a patient requests an appointment and the third-next appointment available. Cycle time is the number of minutes that a patient spends at an office visit, beginning at the time of arrival and ending when the patient leaves the facility.

Staff at some facilities have measured patient wait times; however, their efforts have been hampered by an electronic health record system that does not create reports on TNA.²² IHS officials told us that few facilities have focused on improving patient wait times through the IPC program, in part because the scheduling module within the Resource and Patient Management System (RPMS)—IHS’s appointment scheduling and electronic health records system—does not produce reports on TNA. According to IHS headquarters officials and some facility staff, reports on TNA are not created automatically in RPMS and must be calculated manually. IHS headquarters officials stated that this has resulted in a key measure of patient wait times—TNA—being one of the least-reported measures in the IPC program.

Officials from IHS told us the agency has not systematically monitored data related to the timeliness of primary care appointments in its facilities and instead has focused on agency-wide efforts intended to help improve patient access to quality care. These agency-wide efforts have included:

- **Facility accreditation.** IHS has set a goal for its hospitals and outpatient clinics to achieve and maintain accreditation through third-party organizations such as the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission), the Accreditation Association for Ambulatory Health Care (AAAHC) or the National Integrated Accreditation for Healthcare Organizations to ensure the facilities are in compliance with federal regulatory standards for

²²Area office officials also told us that they may review other data indirectly related to the timeliness of patient care—including provider productivity, patient satisfaction, and appointment no-show rates—if facilities present the information to their governing boards.

hospitals.²³ However, the focus of facility accreditation is to ensure the facilities meet nationally accepted standards that ensure quality care and patient safety, for example, by verifying that providers are licensed to practice, and that drugs are stored in a secure manner. Accreditation does not necessarily require facilities to demonstrate that they provide timely access to primary care appointments, in part because the collaborative accreditation process allows hospitals to be partially compliant with the standards and still be accredited.

- **Medical home recognition.** IHS has also encouraged its facilities to obtain designation as patient-centered medical homes through third-party organizations such as AAAHC, the Joint Commission, and the National Center for Quality Assurance, although obtaining this designation is voluntary. According to HHS's Agency for Healthcare Research and Quality, primary care medical homes should deliver, among other things, accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative methods of communication such as email and telephone care. However, this is insufficient to ensure that patients have access to timely primary care appointments because even if a facility met all standards required by a certification organization, it would not

²³The Centers for Medicare & Medicaid Services (CMS) is the agency responsible for certifying that health care organizations meet eligibility standards established by the federal government in order to be certified to receive reimbursement from Medicare and/or Medicaid, known as Conditions of Participation. A health care facility that is accredited for Medicare participation purposes by one of the CMS-recognized national accreditation organizations, such as the Joint Commission or AAAHC, may be deemed by CMS to have met or exceeded Medicare's or Medicaid's standards.

As of December 2015, one IHS facility lost its CMS certification while another has been warned by CMS that they will lose funding if it does not implement an effective corrective action plan. In 2014, CMS identified 45 serious deficiencies at the IHS's Winnebago Hospital in Nebraska that posed an immediate threat to patient health and safety. When IHS failed to adequately address them, on July 23, 2015, CMS terminated the hospital's ability to collect third-party billings from Medicare. On November 27, 2015, CMS cited IHS's Rosebud Hospital for similar safety violations that must be addressed.

necessarily ensure that the facility's patients had access to timely primary care appointments.²⁴

- **Executive performance agreements.** According to IHS, area directors are held accountable for achieving agency-wide goals and specific performance objectives through an appraisal process that also enables these goals and objectives to cascade down to chief executive officers at individual facilities and to all agency employees. Area directors sign performance agreements documenting their accountability. The fiscal year 2015 performance requirements included a provision on access to care that required documentation of: (1) the implementation of at least two activities to improve access to care; (2) goals, measures, and outcomes associated with the activity; and (3) communication of progress and results to staff, patients, and IHS stakeholders. Area officials can choose activities to satisfy this requirement, and the agreement has a list of suggestions, such as participation in the IPC initiative, improved patient safety, facility accreditation, and customer service improvements. IHS officials acknowledged, however, that area directors can satisfy this performance element without addressing timely access to primary care in their facilities.

IHS's lack of systematic, agency-wide oversight of the timeliness of primary care appointments is inconsistent with federal internal control standards, which suggest that agencies should establish and review performance standards and then monitor data to assess the quality of performance over time.²⁵ As stated previously, according to Healthy People 2020, timeliness is one of the four key components of access to

²⁴According to a 2012 analysis by the Urban Institute of ten survey tools used by organizations to designate patient-centered medical homes, less than 4 percent of the standards addressed access to care. Standards that did assess access to care assessed the extent to which practices provide enhanced access to services—such as by leaving time free each day for same-day appointments, or by responding to emails from patients—rather than the timeliness of appointments. R. A. Burton, K. J. Devers, and R. A. Berenson, *Patient-Centered Medical Home Recognition Tools: A Comparison of Ten Surveys' Content and Operational Details* (Washington, D.C.: The Urban Institute, March 2012).

²⁵According to federal internal control standards, effective monitoring should assess the quality of a facility's performance over time and ensure that the findings of audits and other reviews are promptly resolved. Monitoring includes evaluations that may take the form of self-assessments and includes policies and procedures for ensuring that any audit and review findings and recommendations are brought to the attention of management and are resolved promptly. See [GAO/AIMD-00-21.3.1](#).

health care, and improving the quality of and access to care is one of IHS's four agency-wide priorities. HHS has reported that actual or perceived difficulties or delays in getting care when people are ill or injured likely reflect significant barriers to care. By not setting performance standards for timeliness and monitoring facility performance, IHS officials do not know the extent to which primary care services are accessible to AI/AN people, and therefore they do not know if the agency is meeting its own goal to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to AI/AN people. One IHS headquarters official told us that, while agency officials are concerned about patient wait times for primary care appointments, the agency has multiple competing priorities for its resources. This official stated that IHS officials hope to eventually track patient wait times agency-wide.

IHS Staff Reported Modifying Schedules and Improving Communication to Help Ensure Patient Access to Timely Primary Care, but Obstacles Remain

To help improve patient access to timely primary care, staff at IHS area offices and selected facilities in our review reported that facilities have taken steps to modify their appointment scheduling processes and redesign their care delivery models. They also reported improving communication with the tribes in their service area in order to reduce missed appointments and educate patients about the importance of primary care. However, IHS facility staff also told us that staffing vacancies and aging infrastructure and equipment remain ongoing obstacles to ensuring patients' access to timely primary care appointments.

IHS Facility Staff Reported Modifying Appointment Schedules, Redesigning Care Delivery, and Improving Patient Communication to Help Ensure Patient Access to Timely Primary Care

Staff at IHS area offices and federally operated IHS facilities in our review told us that facilities have taken various steps to help ensure that their patients have access to timely primary care. Staff from several facilities told us that, in order to improve access to timely care, they have taken steps to modify their scheduling procedures to increase appointment availability. For example, staff from several facilities told us that they have implemented open access scheduling, which allows staff to schedule a certain portion of appointments in advance and to also keep other appointments open for same-day scheduling.²⁶ Staff from a Navajo area facility told us they set aside a population-based percentage of same day appointments depending on the specialty with about 40 percent open scheduling for internal medicine, 35 percent for family medicine, and 35 percent for dental care. Staff at a Billings area facility also told us that they placed all newly hired providers on a same-day access appointment schedule to demonstrate to existing staff that open-access scheduling increased productivity and decreased no-show rates. All 10 areas reported improving access to timely primary care appointments by expanding their hours of operations or opening new urgent-care or outpatient clinics. For example, Great Plains area office officials told us that one of its facilities expanded its hours to 7 a.m. until 11 p.m. every day. In addition, Phoenix area office officials stated that facilities in their area have started to schedule “nursing only” visits in situations when a patient does not need to see a doctor, such as for a vaccination. Officials told us that more flexible scheduling allowed the facilities to accommodate patients with different scheduling needs and reduced the use of emergency rooms as a source of primary care.

In addition to modifying appointment schedules, IHS facility staff told us that they have taken steps to redesign their care delivery models to improve patient flow through their primary care clinics, so care could be provided to more patients in a single day. Staff at several IHS facilities reported assigning patients to specific providers or teams of providers—

²⁶The goal of open access appointment scheduling is to assure that any patient calling for an appointment can be seen the same day if that is their choice; in other words a TNA of zero. Due to workforce limitations, staff at several IHS facilities told us they were unable to implement 100 percent open access appointments.

referred to as empanelment.²⁷ For example, staff at a Bemidji area facility told us that all of their patients are now empaneled and assigned to color-coded teams that include a primary care doctor and a nurse practitioner, among other support staff. They explained that the color of each team is displayed prominently on their appointment cards and in the scheduling system, and the teams wear color-coded uniforms. They added that providers on different teams will also cover for each other on occasion, for example when a nurse on one team takes the vital signs of a patient for a nurse on another team who may be busy. In addition, documents from a Phoenix area facility that we reviewed showed that staff began to stagger patient appointment times to reduce backups at the registration desk. Staff at two facilities we reviewed in the Navajo area told us that appointments became more efficient when they moved computer terminals into patient exam rooms so providers could refer to and enter information into patients' electronic health records during appointments. Using these and other strategies, staff at one of these facilities told us that, over the course of 2 years, they were able to decrease their appointment cycle time from 2 hours and 54 minutes to 48 minutes. Staff at other facilities also reported using mobile clinics to improve the timeliness of primary care, including mobile mammography and dental clinics, home visiting services for the elderly, and a drive-through flu vaccine clinic.

Staff at several facilities in our review stated that they have also taken steps to improve their communication with their patients as well as with their communities to help improve the timeliness of primary care. For example, to address the issue of appointment no-shows, IHS facility staff told us they made reminder phone calls to patients the day before the appointments, and at one Billings area facility, the staff told us that they used their personal cell phones to conduct these reminder calls.²⁸

²⁷According to the Institute for Healthcare Improvement, empanelment—assigning each provider a set number of patients—is a proven method to create continuity for both patients and providers. In turn, patient continuity is associated with reductions in appointment demand, hospitalizations, referrals, labs and imaging, prescriptions, and no-show rates.

²⁸Staff at some of the facilities we visited told us that appointment no-shows are an ongoing challenge to providing timely care. For example, the chief medical officer of the Navajo area reported a 40 percent no show rate while staff at an Albuquerque area facility told us that between 45 and 50 percent of their patients do not show up for their appointments. The chief dental officer at a Bemidji area facility said that patients in that facility miss 80 percent of scheduled appointments.

According to facility staff, reminder calls have decreased the number of missed appointments. For example, staff from an Albuquerque area facility told us that reminder calls decreased the facility's no-show rate to 16 percent from a high of nearly 50 percent. Staff at all of the facilities in our review told us that they have taken steps to obtain patient comments and feedback. For example, an official who had worked in the Phoenix area told us that facilities there have staff members talk to patients as they leave in order to see if they were satisfied with their care. Further, the IPC program provided participating facilities with a model customer satisfaction survey for patients to provide comments or complaints about their health care experience. In addition, staff at a Navajo area facility told us that they fielded three different surveys to patients and used the information to improve patient satisfaction. Finally, some IHS officials and facility staff told us about facilities' use of different media to improve their communication with their patients—such as tribal newspapers, local radio stations, information tables at powwows, flyers at the post office, and social media.

IHS Facility Staff Stated That Staffing Vacancies and Aging Infrastructure and Equipment Were Obstacles to Ensuring Patient Access to Timely Primary Care

Staff at the seven facilities we visited told us that, although they have taken steps to help improve patient access to timely primary care, they continue to experience obstacles to ensuring access due to extensive staff vacancies and aging infrastructure and equipment.

Staffing Vacancies

IHS officials and facility staff told us that an insufficient workforce was the biggest impediment to ensuring patients' access to timely primary care. According to IHS's 2016 budget justification, there were over 1,550 vacancies for healthcare professionals throughout the system including: physicians, dentists, nurses, pharmacists, physician assistants, and nurse

practitioners.²⁹ The 2016 budget justification reported that the physician vacancy rate was 20 percent—with a particular shortage in primary care specialties. Additionally, a 2011 IHS workforce study, although somewhat dated, showed that nearly 30 percent of the facilities surveyed reported an urgent need for nurses, nurse practitioners, and physicians' assistants, with about a third of respondents saying the shortages compromised access to care. At a Navajo area facility, staff told us that, depending on the availability of family medicine physicians, new patients may wait 6 weeks for an initial exam, whereas new patients in internal medicine may wait 3 or 4 months for an initial exam and between 2 weeks and 2 months for a routine follow-up appointment. In addition, staff from facilities in both the Navajo and Billings areas reported delays of up to a month at some clinics for a routine vision check due to their inability to recruit optometrists. Staff at a Navajo area facility told us that from 2013 to 2014, the facility did not have any permanent physicians on staff and, according to Navajo area office officials, the facility relied on contract physicians to provide care. The Billings area chief medical officer stated that some facilities in the area have been operating in "survival mode" with provider vacancies overworking the remaining staff. IHS officials and facility staff told us that ongoing staff vacancies significantly reduce their ability to ensure that patients receive timely care, and one IHS official in the headquarters office explained that no amount of facility effort can overcome certain external influences, such as staffing deficits.

Facility staff that we interviewed told us that they have been unable to fill some ongoing vacancies due either to salaries and benefits that are not competitive with tribal health centers, other federally funded health programs, or the private sector; or to IHS's lengthy hiring process and the remote locations of some facilities. For example, staff at a Billings area facility told us that an optometrist position that was recently filled had been vacant for 5 years because four previous offers were declined due to inadequate pay. In addition, staff at this facility said that the facility is losing its family physicians because the IHS starting salary is about a third of what the competition can offer. According to Portland area office

²⁹This study also showed that about 38 percent of the facilities surveyed reported an urgent need for dentists, with almost half of respondents saying the shortage of dentists compromised access to care. In addition, according to an IHS Oral Health Survey, approximately 15 to 20 percent of the dentist positions at IHS and tribal health facilities were vacant in 2010. Within IHS, there is 1 dentist for every 2,800 people compared with 1 dentist for every 1,500 people in the general population.

officials, one of their facilities cannot compete with a nearby farmworkers clinic that offers better salaries through a grant from the Health Resources and Services Administration. Furthermore, although IHS facilities offer incentives to assist in the recruitment and retention of health professionals, officials from the Portland area office told us that the Veteran's Health Administration (VHA) is able to offer better salary and benefits and actively recruits IHS staff, especially nurses.³⁰ According to IHS's 2016 budget justification, while IHS's school loan repayment program helps to alleviate problems in recruiting and retaining providers, in fiscal year 2014 the agency denied over 500 applications for loan repayment—from both employees and prospective employees—due to limited funds. In addition, staff at a Billings area facility told us that they need to be creative when trying to offer incentives to providers to choose their facility, including asking tribes to provide incentives such as free fishing and hunting licenses. According to Portland area office staff, the federal hiring process takes so long that potential new hires may accept other job offers before IHS can hire them. Staff from one Navajo area facility analyzed the facility's ten most recent hires and found that their hiring process took between 13 and 783 days with an average of 190 days. Staff told us that it typically takes about 6 months from posting the position to when a new provider starts work. Finally, facility staff told us that the remote locations of certain IHS facilities, limited housing, and a lack of employment opportunities for providers' spouses are also among the obstacles to recruitment efforts. For example, staff from a facility in the Bemidji area told us that they focus their recruitment efforts on providers from Northern Minnesota because the remote location and harsh winters tend to deter people from other areas. Staff from this same facility also stated that they need to rely on recruiting providers who specifically want to provide health care to the underserved AI/AN population.

Aging infrastructure and equipment

Facility staff told us that aging infrastructure and equipment in IHS facilities are obstacles to ensuring that patients have access to timely primary care. According to IHS's 2011 Facilities Report to Congress, the average age of federally operated IHS facilities is 31 years, and fourteen of the 35 IHS hospitals and 22 of the 61 IHS health centers are older than 40 years. In contrast, the average age of private-sector hospitals is 9 to

³⁰IHS officials told us they are working with OPM regarding how to make IHS's personnel authorities more competitive with the VHA.

10 years.³¹ IHS officials and facility staff told us that several IHS facilities lack sufficient physical space to increase the number of available appointments, and stated that, even if they could recruit sufficient providers, there would be insufficient physical space or equipment with which the additional staff could work.³² For example, staff at a Billings area facility who hired an optometrist after a 5-year vacancy told us that they were unable to request equipment for this provider until the start of the new fiscal year when additional funds would be available. In addition, staff at a Bemidji area facility told us that, even though they had an insufficient number of providers, they were unable to hire any additional providers until they completed construction on a new facility because of a lack of space in the current facility. According to a 2011 IHS analysis, all areas have reported a significant backlog of essential maintenance, alterations, and repair.³³

Facility staff also told us that aging medical and telecommunications equipment have created challenges in providing timely primary care. According to IHS, medical and laboratory equipment, which has an average useful life of 6 years, generally is used at least twice that long in Indian health care facilities.³⁴ Documents provided by a facility in the Great Plains area stated that its mammography equipment is outdated but, in order to upgrade to digital mammography equipment, the facility would need to remodel its radiology room. In addition, staff at a Billings

³¹This report was required under 25 U.S.C. § 1631.

³²In a 2011 report to Congress, IHS reported that “maintaining reliable and efficient buildings is increasingly challenging as existing facilities age and the demands of providing modern healthcare services strain the infrastructure. Many of IHS and Tribal facilities are old, overcrowded, and not designed to be utilized efficiently in the context of modern healthcare delivery. As existing health care facilities continue to age, the healthcare delivery system tends to become less efficient and the operational and maintenance costs for the facility increase.” See Indian Health Service, *Report to Congress on Estimated Need for Tribal and Indian Health Service Health Care Facilities*. (Rockville, Md.; Mar. 23, 2011).

³³According to IHS, typical maintenance needs include meeting building codes and standards, maintaining or repairing the physical condition of health care facilities, and modernizing existing health care facilities to meet changing health care delivery needs, and implementing mandated requirements. See *Department of Health and Human Services: Fiscal Year 2015 Justification of Estimates for Appropriations Committees*. Indian Health Service (Rockville, Md.; Feb. 6, 2014).

³⁴Indian Health Service Factsheets, *Health Facilities Construction*, accessed Feb. 1, 2016, <https://www.ihs.gov/newsroom/index.cfm/factsheets/healthfacilitiesconstruction/>.

area facility told us that they have not used their radiology equipment since 2000 because it needs to be upgraded to digital technology. Documentation from a governing board meeting in 2014 showed that another Great Plains area facility was unable to upgrade any of its technology until the building was completely rewired. In addition, IHS facility staff reported challenges in providing timely primary care because of aging or outdated telecommunication systems. For example, staff at multiple facilities reported having a limited number of telephone lines, making it difficult for patients to make appointments and for staff to make reminder calls or provide services through telemedicine. Staff at a Billings area facility stated that the facility had only three telephone lines, so if a doctor and a pharmacist were on separate calls, there would only be one line left available for patients to call for appointments. As a result, some staff reported receiving complaints from patients unable to schedule appointments. The scheduling staff at this facility told us that they used their personal cellphones to call or text patients to remind them of their appointments so they did not occupy a phone line. In addition, the CEO of this facility told us that their telephone system was so outdated that they could no longer purchase new replacement phones or parts. As a result, she said that she spends time searching the internet for replacement parts to fix their phones.

Conclusions

American Indians and Alaska Natives continue to die at higher rates than other Americans from many causes, including preventable diseases—such as cirrhosis of the liver and lower respiratory infections—that can be mitigated through access to timely primary care services. Based on our past work, patient wait times have historically been a problem for some IHS facilities—particularly those located in poor, rural areas—but staffing vacancies and aging infrastructure and equipment have created obstacles for facilities working to provide timely primary care. While IHS has an agency-wide goal to ensure that health services are available and accessible to AI/AN people, and individual facilities have taken steps to help improve patient wait times, IHS has not monitored the timeliness of patient care on an agency-wide scale, which is inconsistent with federal internal control standards. Whether the agency has made any progress in improving access to care in its facilities is indiscernible due to a lack of agency-wide information on a key indicator of patient access—how long patients wait to see primary care providers. Until IHS develops and communicates agency-wide standards for the timeliness of primary care and begins to monitor patient wait times in its facilities, it cannot know whether it is providing sufficient primary care needed to raise the health status of the AI/AN population.

Recommendations for Executive Action

To help ensure that timely primary care is available and accessible to AI/AN people, the Secretary of HHS should direct the Director of IHS to take the following two actions:

1. Develop and communicate specific agency-wide standards for patient wait times in its federally operated facilities. As part of its process, IHS should review its experience with the timeliness goals it set as part of its Improving Patient Care program.
2. Monitor patient wait times in its federally operated facilities and ensure corrective actions are taken when standards are not met.

Agency Comments and Our Evaluation

We provided a draft of this product to the Department of Health and Human Services (HHS) for comment. In its written comments, reproduced in appendix I, HHS stated that it agreed with the need to improve patient wait times at IHS federally operated facilities to ensure timely primary care is available and accessible to AI/AN people. Regarding our findings and recommendations, HHS agreed that setting quality standards and monitoring against those standards is a key strategy for improving patient care.

In its response, HHS stated that IHS is implementing a plan to establish an agency-wide Office of Quality Management, which will implement a data analytics function to increase the agency's capacity for centralized monitoring, training, and technical assistance coordination and improve tracking and monitoring of metrics, deficiencies, and corrective action plans. HHS also stated that IHS will consider how setting specific agency-wide standards for patient wait times could be incorporated into the data analytics plan, but that the agency also needs to continue to work to address the underlying challenges that are at the root of the issue of patient wait times, such as staffing shortages. HHS also noted that, in 2016, IHS will change its annual Senior Executive Service performance standards to include implementation of "at least two activities to improve wait times and access to quality health care for patients that are based on enhanced implementation of current quality initiatives or new quality initiatives and that have measurable goals, measures and outcomes", and will require improvements to be documented at the IHS headquarters, area office, and facility levels.

Despite the underlying challenges that remain and any new or ongoing IHS initiatives to improve patient wait times, it is essential for IHS to develop and communicate agency-wide standards for the timeliness of primary care and for the agency to begin monitoring patient wait times in

its facilities in order to determine whether it is providing sufficient primary care needed to raise the health status of the AI/AN population.

We are sending a copy of this report to the Secretary of the Department of Health and Human Services. As arranged with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution of it until 30 days from the report date. In addition, the report will be available at no charge on GAO's website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or kingk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.



Kathleen M. King
Director, Health Care

Appendix I: Comments from the Department of Health & Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

MAR 04 2016

Kathleen King
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. King:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, *"Indian Health Service: Actions Needed to Improve Oversight of Patient Wait Times"* (GAO-16-333).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in cursive script, reading "Jim R. Esquea", is positioned above the printed name and title.

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN
SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO)
DRAFT REPORT ENTITLED: INDIAN HEALTH SERVICE: ACTIONS NEEDED TO
IMPROVE OVERSIGHT OF PATIENT WAIT TIMES (GAO-16-333)**

The U.S. Department of Health and Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report.

GAO Recommendation

To help ensure that timely primary care is available and accessible to American Indians/Alaska Natives (AI/AN) people, the Secretary of HHS should direct the Director of the Indian Health Service (IHS) to take the following two actions:

1. Develop and communicate specific agency-wide standards for patient wait times in its federally operated facilities. As part of its process, IHS should review its experience with the timelines goals it set as part of its Improving Patient Care program.
2. Monitor patient wait times in its federally operated facilities and ensure corrective actions are taken when standards are not met.

IHS Response

HHS concurs with the need to improve patient wait times at IHS federally operated facilities to ensure timely primary care is available and accessible to AI/AN. The IHS mission is to “raise the physical, mental, social, and spiritual health of AI/AN to the highest level.” HHS is committed to improving patient care in accordance with the Agency mission. HHS appreciates the GAO’s recommendations and agrees that setting quality standards and monitoring against those standards is a key strategy for improving patient care.

IHS is actively implementing a plan to establish an Office of Quality Management in IHS Headquarters. The goal of this office will be to provide for national policy and oversight of critical quality improvement strategies and ensure their success and accountability. Consistent with that goal, the Office of Quality Management will implement a data analytics function, which will increase overall capacity for centralized monitoring, training and technical assistance coordination and improve tracking and monitoring of metrics, including quality metrics, deficiencies and corrective action plans to ensure critical program standards are consistently met and sustained. As part of this data analytics function, IHS is committed to considering how setting specific agency-wide standards for patient wait times in federally operated facilities could be incorporated into the data analytics plan that it is currently being developed. While establishing and monitoring metrics is important, achieving improvement in access to timely primary care requires IHS to continue to work to address a number of complex underlying challenges that are at the root of the issue of patient wait times, including staffing shortages and other areas of focus for quality improvement. IHS will enhance short-term and long-term efforts in medical provider recruitment and retention and make additional quality improvements that will address patient wait times.

In 2016, IHS is cascading annual Senior Executive Service performance standards that specifically address improving access to patient care by establishing accountability for all senior managers to “implement at least two activities to improve wait times and access to quality health care for patients that are based on enhanced implementation of current quality initiatives or new quality initiatives and that have measurable goals, measures and outcomes”, and requiring improvements to be documented at Headquarters, Area Office and facility levels.

Appendix II: GAO Contact and Staff Acknowledgements

GAO Contact

Kathleen M. King, (202) 512-7114 or kingk@gao.gov

Staff Acknowledgements

In addition to the contact named above, Kristi Peterson, Assistant Director; Kelly DeMots; Anne Hopewell; Laurie Pachter; Michael Rose; and Jennifer Whitworth made key contributions to this report.

Related GAO Products

Indian Health Service: Opportunities May Exist to Improve the Contract Health Services Program. [GAO-14-57](#). Washington, D.C.: December 11, 2013.

Indian Health Service: Most American Indians and Alaska Natives Potentially Eligible for Expanded Health Coverage, but Action Needed to Increase Enrollment. [GAO-13-553](#). Washington, D.C.: September 5, 2013.

Indian Health Service: Capping Payment Rates for Nonhospital Services Could Save Millions of Dollars for Contract Health Services. [GAO-13-272](#). Washington, D.C.: April 11, 2013.

Medicaid Expansion: States' Implementation of the Patient Protection and Affordable Care Act. [GAO-12-821](#). Washington, D.C.: August 1, 2012.

Indian Health Service: Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program. [GAO-12-446](#). Washington, D.C.: June 15, 2012.

Indian Health Service: Increased Oversight Needed to Ensure Accuracy of Data Used for Estimating Contract Health Service Need. [GAO-11-767](#). Washington, D.C.: September 23, 2011.

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Medicare and Medicaid: CMS and State Efforts to Interact with the Indian Health Service and Indian Tribes. [GAO-08-724](#). Washington, D.C.: July 11, 2008.

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