WINNEBAGO TRIBE OF NEBRASKA

P.O. Box 687 * Winnebago, Nebraska 68071 * PH: 402-878-2272 * Fax: 402-878-2963

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March 10, 2016

Good afternoon Mr. Chairman and Members of the Committee:

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.

I would like to begin by thanking the Members of this Subcommittee for your immediate response to our recent, and still on-going, health care crisis at the Winnebago IHS Hospital. A crisis which led to the IHS operated hospital to lose its Medicare/Medicaid Provider Certification. I would also like to note that while progress has been made to address the situation, much work remains to restore the Hospital to the operating standards required by federal law. The Winnebago Tribe believes strongly that this Subcommittee needs to play a direct role in overseeing these improvements because our recent experience has taught us that the problems I am about to describe will not be solved, unless and until, the Congress ties IHS's receipt of funds to its efforts to address the current situation.

The Winnebago Tribe is located in rural northeast Nebraska. We are served by a small thirteen (13) bed Indian Health Service (IHS) operated hospital, clinic and emergency room located on our Reservation. This hospital, which was funded by this very Subcommittee, provides services to members of the Winnebago, Omaha, Ponca and Santee Sioux Tribes. It also provides services to a sizable 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.

While it would be impossible to cover every finding which led the Center for Medicare and Medicaid Service's (CMS) to terminate its certification of the facility, I will make an effort to summarize just a few of the very disturbing things that these outside investigators uncovered. Many of these are problems that the Winnebago Tribe has been pointing out for years, and most are not unlike the problems described by other tribes in the Great Plains IHS Service Area in testimony before this very Subcommittee.

Since at least 2007, the Winnebago Hospital has been operating with demonstrated deficiencies which should not exist at any hospital in the United States. I am not talking about unpainted walls or equipment that is outdated. I am talking about a facility which employs emergency room nurses who do not know how to administer basic drugs such as dopamine; employees who did not know how to call a Code Blue; an emergency room where defibrillators could not be found or utilized when a human life was at stake; and a facility which has a track record of sending patients home with aspirin and other over-the-counter drugs, only to have them airlifted from our Reservation in a life threatening state. I am also talking about a Hospital which had at least five documented "unnecessary deaths," including the death of a child under the age of three. These are not our findings, they are the findings of the federal government's own agency, CMS.

In fact, the CMS uncovered deficiencies which were so numerous and so life threatening that this last July 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 quick 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.

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. This is why the oversight of this Subcommittee is so important to us.

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 our 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.”

Mr. Chairman and Members of the Committee, I know that each of you have families and close friends, and I assume that most of you have also suffered a loss or know someone who has. It is a profoundly painful experience. Now, imagine going through that pain only to learn a year or more later, through some government report, that the death might have, or even should have, been avoided. It’s time to put an end to this and I call upon this subcommittee to use its funding authority to make sure that this actually happens. There are a number of fine employees in the IHS but many of them are scared to speak up. The Senate Indian Affairs Committee can provide you with the names and contact information for the IHS Winnebago Hospital employees who have sought and received federal whistleblower protection and of others who have been specifically told not to file reports of improper hospital practices on the HHS Web incident reporting system. This is outrageous, its illegal and it is threatening people’s lives.

In the interim, I am here to ask for your assistance in assuring that our hospital does not lose services or staff because of its loss of Medicare/Medicaid third party income. We have IHS employees who are suggesting that it may not be "cost effective" to fix some of our hospital's current problems or even to run hospitals in the Great Plains Area. So, the IHS leaves us with an underfunded, undertrained staff, and now it wants to use the very situation that it created as an excuse for saying that it's not "cost effective" to save an Indian, or to provide an Indian with medical services within a reasonable distance of their home. This is outrageous, it is a flagrant violation of our treaty and of the federal government's trust responsibility and quite frankly it is inhuman.

I am also asking for your help in assuring that the Great Plain IHS Service Area has all of the Referred Care dollars that it now requires because of this crisis. Since our hospital lost its CMS certification, and since the CMS certification of the Rosebud Hospital's Emergency Room and the Pine Ridge Hospital is now being threatened as well, the IHS has been sending an ever increasing number of patients from these three facilities to third party providers. In some instances this has been helpful, and in other instances we believe that it is being done just to avoid another set of CMS findings. While we are glad that our people are receiving care, we are worried about where the funding is going to come from to pay those referred care bills. The Great Plains IHS Service Area has long been operating on a priority one basis, and despite that limitation, it has often run out of referred care dollars well before the end of the fiscal year. So, unless the IHS has not been truthful about its budget in past years, we fear that the Aberdeen Area will not have enough money in its referred care budget to cover these added costs in FY 2016 and 2017. If this is true, every tribe in the Great Plains Service Area will suffer and our Winnebago people will suffer yet another injury when they receive thousands of dollars of unexpected medical bills a few months from now. Please do not let that happen.

Mr. Chairman, the Winnebago Tribe has submitted a series of recommendations for improvements in the Indian Health Service to the Senate Indian Affairs Committee and the House Natural Resources Committee. I am attaching a copy of those recommendations to my testimony. We know that many of you serve on other Committees which can help us get some of those recommendations enacted and we ask for your help in doing that.

The Winnebago Tribe knows how hard this Subcommittee has fought to preserve the IHS budget during these tight fiscal times, and we appreciate those efforts very much. It is my sincere hope that you can use my testimony to show your colleagues that their decisions about Indian Health Care Funding have consequences, and that the wrong decisions can lead to very real harm. Thank you for this opportunity to address you today. I will be happy to answer any questions you may have.