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HUMAN RESOURCES
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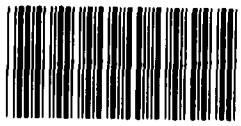

The Honorable Richard S. Schweiker
The Secretary of Health and
Human Services

Dear Mr. Secretary:

Subject: Opportunity to Avoid Construction at Certain IHS Hospitals (GAO/HRD-82-122)

The Indian Health Service (IHS), a component of the Department of Health and Human Services (HHS), is responsible for providing comprehensive health services to American Indians and Alaskan Natives. In carrying out this responsibility, IHS operates 49 hospitals, 102 health centers, and 300 smaller health stations and satellite clinics. To supplement its health delivery system, IHS also obtains health services through contracts with community hospitals, private physicians, and other health professionals. In fiscal year 1982, IHS planned to spend about $397 million to operate its direct health delivery system and another $118 million to purchase health services through contracts.

We reviewed the factors that contributed to the low utilization of inpatient services of nine small IHS hospitals and evaluated whether other cost-effective alternatives existed. At the time of our review, HHS plans called for significant capital expenditures to replace or modernize the facilities we reviewed. The results of our review are presented below.

CONCLUSIONS AND RECOMMENDATIONS

At the nine hospitals we reviewed, the inpatient workload was low, and the services offered were limited when compared to those generally available at nearby community hospitals. Because of limited IHS inpatient services, a portion of the inpatient workload at the hospitals reviewed is now being referred to nearby community hospitals, which generally have the capacity to absorb the nine hospitals' total inpatient workload.

HHS plans to replace or modernize seven of the nine hospitals reviewed at a total estimated cost of $66 million. In addition, an estimated $6 million is planned to correct structural deficiencies at all nine hospitals, and $15 million is planned for construction of personnel quarters at four of them.

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We believe that some of the planned capital expenditures could be avoided by (1) limiting expenditures to those required to maintain outpatient and emergency care facilities at the nine locations and (2) obtaining inpatient care under contract from nearby community hospitals. Because IHS' cost accounting system did not precisely identify inpatient costs, we could not do an indepth analysis of the relative operating costs of the nine hospitals reviewed and the nearby community hospitals. However, available cost data suggest that obtaining inpatient care for IHS beneficiaries from the community hospitals could be less costly.

We recognize that discontinuing inpatient care at these nine hospitals may raise concern or opposition from tribal officials. However, Pawnee tribe members recently began receiving all of their hospital care under contract with community hospitals, and they seem to be satisfied with this arrangement. While there may be some transition difficulties, phasing out IHS inpatient care at the hospitals we reviewed by making greater use of community hospitals appears feasible as long as adequate funds for contract health care are available.

Accordingly, we recommend that the Secretary of HHS require the Director of IHS to:

--Reevaluate the hospital construction plans for each of the nine hospitals reviewed and justify any capital expenditures beyond those necessary to provide outpatient and emergency care facilities. IHS' justification should include a determination of (1) the use of nearby community hospitals as a cost-effecive alternative to IHS direct care and (2) the impact of using community hospitals on the quality of Indian health care.

--Where use of nearby community hospitls is a cost-effective alternative, phase out the provision of IHS inpatient services by making greater use of nearby community hospitals. The phaseout period should be long enough to assure IHS and tribal officials that inpatient care from nearby community hospitals will be both available and acceptable.

We also recommend that the Secretary assure that IHS has sufficient contract health care funds available for inpatient care at community hospitals at locations where IHS inpatient care is being phased out or has been discontinued.

Views of IHS program officials on discontinuance of IHS-delivered inpatient care

IHS program officials agreed that the continued operation of inpatient services at the nine hospitals in our review warrants close examination. The IHS officials generally believed that IHS-delivered inpatient care is cost-effective in comparison to contract health care. However, they acknowledged that the cost-effectiveness of providing IHS inpatient care is diminished at small, isolated facilities where wide geographic dispersal of beneficiaries precludes the availability of a sizable inpatient workload. They said that each facility we reviewed should be analyzed thoroughly before any action is taken to phase out IHS-delivered inpatient care.

OBJECTIVES, SCOPE, AND METHODOLOGY

In 1981, the American Hospital Association (AHA) reported that the number of small community hospitals (6 to 24 beds) in the United States declined from 397 in 1970 to 259 in 1980. This report discusses nine small IHS hospitals, of which seven were built before 1945 and eight averaged fewer than nine inpatients per day in fiscal year 1980. Our objectives were to:

--Determine the reasons or factors that contributed to the hospitals' low utilization.

--Evaluate the acceptability and availability of community facilities within a reasonable distance of the IHS facilities.

--Compare the costs of hospitalization at IHS facilities with those at community hospitals.

Our review was made at IHS headquarters, Rockville, Maryland; IHS area offices in Aberdeen, South Dakota; Albuquerque, New Mexico; Billings, Montana; Oklahoma City, Oklahoma; Phoenix, Arizona; and Portland, Oregon; and the Bemidji, Minnesota, IHS program office. The nine IHS hospitals reviewed were at Cass Lake, Minnesota; Clinton, Oklahoma; Harlem, Montana; Mescalero, New Mexico; Owyhee, Nevada; Parker, Arizona; Schurz, Nevada; Winnebago, Nebraska; and Ft. Yuma, Arizona. We selected these hospitals on the basis of their small number of beds, their limited inpatient utilization experience, and the availability of community hospitals in their general area.

For each IHS hospital reviewed, we obtained data on bed capacity, inpatient service availability, patient utilization, and hospitalization costs. We obtained similar inpatient data

from community hospitals located near the IHS facilities. We compared inpatient costs reported by IHS with average daily costs of community hospitals in the general vicinity of the IHS hospitals that were already treating inpatients referred by IHS.

The IHS cost accounting system in use through fiscal year 1980 did not precisely identify IHS hospital inpatient costs, and therefore we were not able to make a detailed cost comparison with nearby community hospitals. However, we estimated average daily patient costs derived from inpatient days and hospital operational cost data as reported by IHS. The community hospital inpatient cost data were obtained by telephone contacts with 24 community hospitals located within 50 miles of the IHS hospitals reviewed.

We also obtained the views of tribal officials regarding using community hospitals for inpatient care in lieu of receiving such care at IHS hospitals.

In addition, we have discussed the matters in this report with IHS program officials and have considered their comments where appropriate.

Our review was made in accordance with the Comptroller General's "Standards for Audit of Governmental Organizations, Programs, Activities, and Functions."

OPPORTUNITIES TO MAKE GREATER USE OF COMMUNITY HOSPITALS FOR INPATIENT CARE

Many IHS hospitals are old, inefficient, and understaffed. Of the 49 IHS hospitals, 21 were built during 1912-39, 3 during 1940-54, and 25 since 1955. In April 1980, HHS submitted a plan to the Congress for improving the health care provided to American Indians over the 4-year period ending fiscal year 1984. HHS estimated that about $828 million would be needed to construct new or replacement hospitals, to build personnel quarters, and to correct known deficiencies at existing IHS hospitals. The portion of the costs applicable to the nine hospitals reviewed totaled about $87 million.

As discussed below, at the IHS hospitals we reviewed, the inpatient workload was low, and the available facilities and services were limited. More comprehensive inpatient services were generally available and accessible in nearby community hospitals. A portion of the IHS workload was already being referred to these community hospitals, and they had the capacity to absorb the total IHS workload.

Inpatient workload at IHS hospitals was low

The inpatient workload at the nine IHS hospitals reviewed was below the existing IHS criteria for justifying the construction of new facilities. Currently, IHS criteria provide that an inpatient facility should not be constructed unless it can open at 75 percent of its operating capacity--a minimum of 7,500 inpatient days a year or about 20 inpatients a day. The inpatient workload of each facility reviewed is shown below.

Inpatient Workload Data for Hospitals Reviewed for Fiscal Year 1980

IHS hospital	Average daily census	Average daily occupancy rate	Average length of stay	Number of inpatient days
Cass Lake	7.5	31	3.5	2,732
Clinton	8.6	61	4.7	3,160
Harlem	6.6	37	3.8	2,409
Mescalero	5.8	39	3.9	2,125
Owyhee	3.7	25	5.7	1,358
Parker	6.6	33	6.5	2,401
Schurz	4.1	29	6.6	1,494
Winnebago a/	7.0	28	3.7	2,555
Ft. Yuma	10.3	61	6.6	3,757

a/Excludes the alcoholism treatment program, which uses 16 hospital beds as a domiciliary for patients who do not require hospitalization.

According to IHS data, the number of inpatient days at seven of the nine hospitals has declined by more than 2,500 days since fiscal year 1978. As discussed below, the limited capabilities of these facilities to provide inpatient care contributed substantially to the low inpatient workload.

Availability of facilities and inpatient services

Facilities and services for inpatient care at the nine IHS hospitals we visited were limited. Each of these hospitals reported having an outpatient department, a full-time pharmacy, and emergency room service, and all but one reported having a pediatric inpatient service. However, none routinely performed

surgery or provided obstetrical care. One hospital that reported having an intensive care unit did not have a cardiac monitor or staff qualified to interpret X-rays. The following table shows the extent to which inpatient services and/or facilities were available at the nine hospitals. 1/

Inpatient facility or service	Number of IHS hospitals with facility or service
Alcohol/chemical dependency service	1
Blood bank	2
Diagnostic radioisotope facility	-
Intensive care unit (cardiac)	-
Intensive care unit (mixed)	1
Occupational therapy	-
Pathology laboratory	-
Physical therapy	-
Premature nursery	2
Psychiatric unit	-
Respiratory therapy	-
X-ray therapy	-

According to IHS hospital officials, the limited capabilities often result in many individuals who need inpatient care being referred to community facilities.

Inpatient care in community hospitals generally available and accessible

Inpatient services at community hospitals were generally accessible and available to patients served by the IHS hospitals reviewed. As shown in the table on the following page, 24 community hospitals were located within 50 miles of eight of the IHS facilities reviewed.

1/ The 1980 AHA publication, "Guide to the Health Care Field," provided the information on inpatient facilities and services available at the hospitals reviewed.

IHS hospital	Miles to nearest community hospital	Number of community hospitals within 50 miles
Cass Lake	17	3
Clinton	same community	6
Harlem	43	2
Mescalero	19	2
Owyhee	100	0
Parker	same community	3
Schurz	25	3
Winnebago	18	4
Ft. Yuma	same community	1

In the case of the Owyhee hospital, at the time of our review, all specialty inpatient care was obtained from community facilities located about 100 miles away. As shown in the table on page 9, 41 percent of the patients seeking inpatient care at the Owyhee facility were referred to these community facilities.

Overall, the nine hospitals reviewed were similar to other IHS hospitals in terms of their proximity to the nearest community facilities, as shown below.

Miles to nearest community hospital from IHS hospital (note a)	Total number of IHS hospitals
Located in same community	15
1 to 25	9
26 to 50	13
Over 50	b/12
Total	49

a/Currently, IHS construction criteria for new facilities allow a 90-minute travel time factor from a beneficiary's residence to the hospital.

b/Five of these 12 are in Alaska.

In general, the 24 community hospitals within 50 miles of the nine IHS facilities in our review offered a wide range of inpatient services, as shown in the table on the following page.

Inpatient facility or service (note a)	Number of community hospitals with facility or service
Alcohol/chemical dependency service	1
Blood bank	18
Diagnostic radioisotope facility	10
Emergency room service	22
Intensive care unit (cardiac)	7
Intensive care unit (mixed)	13
Occupational therapy	2
Pathology laboratory	6
Pediatric inpatient service	12
Pharmacy with full-time pharmacist	12
Physical therapy	20
Premature nursery	4
Psychiatric unit	4
Respiratory therapy	20
X-ray therapy	4

a/1980 AHA Publication, "Guide to the Health Care Field," provided the information on available inpatient facilities and services for the community hospitals.

All of the community hospitals were certified for participation in Medicare, and 13 were accredited by the Joint Commission on Accreditation of Hospitals.

Inpatient workload already being referred to community hospitals

As discussed on page 6, the limited inpatient capabilities at the nine IHS hospitals reviewed necessitate that many patients be hospitalized at community facilities. The following table shows by hospital the number of patients hospitalized by IHS and community hospitals in fiscal year 1980.

IHS hospital	Number of patients admitted by IHS	Number of IHS patients admitted by community hospitals	Percent of total admissions at community hospitals
Cass Lake	774	220	22
Clinton	673	197	23
Harlem	631	285	31
Mescalero	547	334	38
Owyhee	239	168	41
Parker	369	90	20
Schurz	226	350	61
Winnebago	694	183	21
Ft. Yuma	569	123	18
Total	4,722	1,950	31

Officials we contacted at community hospitals currently serving IHS beneficiaries generally agreed that they could handle the total average daily inpatient workload of the nine IHS hospitals. In the case of the Bemidji, Minnesota, Community Hospital, officials told us that a space problem might occur during peak patient loads if all of the IHS inpatients at Cass Lake were sent there. The average daily availablity of beds at the community hospitals in the IHS areas we reviewed during fiscal year 1980 is shown below.

IHS hospital	IHS average daily patient load	Community hospitals (note a)		
		Total number	Total beds	Average number of empty beds
Cass Lake	8	3	253	58
Clinton	9	6	329	169
Harlem	6	2	149	74
Mescalero	7	2	117	45
Owyhee	4	-	-	-
Parker	7	3	152	77
Schurz	4	3	119	58
Winnebago	7	4	963	274
Ft. Yuma	10	1	208	67
Total	7	24	2,290	822

a/Located within 50 miles of IHS hospital.

INPATIENT CARE AT COMMUNITY HOSPITALS APPEARS LESS COSTLY THAN AT IHS HOSPITALS

Based on available information, it appeared more costly to provide inpatient care at some of the IHS hospitals reviewed than at nearby community facilities. In 1981, AHA reported that the average cost per inpatient day in 1980 at community hospitals was $245. For small hospitals (6 to 24 beds), which generally offer a smaller range of specialized inpatient services, the average cost per inpatient day was $203. In contrast, using IHS-reported cost data, we estimated that the average cost per inpatient day at the nine hospitals reviewed was $280. At the time of our review, IHS' accounting system did not precisely identify inpatient costs and therefore we could not do an indepth analysis of IHS' operational costs. However, a comparison of the IHS-reported cost per inpatient day at eight of the nine hospitals reviewed to the highest average inpatient cost per day at the nearby community hospitals showed that four of the IHS hospitals appeared to have higher costs.

	Average cost per inpatient day	
IHS hospital	IHS hospital	Community hospital
Cass Lake	$300	$221
Clinton	237	247
Harlem	308	231
Mescalero	417	312
Owyhee	268	(a)
Parker	211	465
Schurz	419	295
Winnebago	256	270
Ft. Yuma	115	275

a/There were no community hospitals within 50 miles of Owyhee.

HOSPITAL REPLACEMENT AND MODERNIZATION COSTS

The April 1980 HHS "National Plan" for improving health care to Indians estimated that $828 million would be needed over the 4-year period ending fiscal year 1984 to meet Indian health facility construction needs.

As shown on the following page, seven of the nine hospitals we reviewed were included in that plan as requiring replacement or modernization, at a total estimated cost of $66 million.

Proposed Hospital Projects

IHS hospital	Type of project	Total estimated cost
		(000 omitted)
Cass Lake	Modernization	$10,396
Clinton	Modernization	10,480
Harlem	Replacement	7,172
Parker	Replacement	9,971
Schurz	Replacement	8,373
Winnebago	Replacement	11,194
Ft. Yuma	Replacement	8,202
Total		$65,788

In addition to the foregoing projects, HHS' plan calls for expending substantial amounts to correct life safety and other deficiencies identified by Medicare surveys or the Joint Commission on Accreditation of Hospitals. The total estimated cost of correcting these deficiencies at the nine hospitals reviewed was about $6 million, as shown below.

Estimated Costs to Correct Identified Facility Deficiencies

IHS hospital	Estimated cost
	(000 omitted)
Cass Lake	$ 239
Clinton	1,193
Harlem	1,983
Mescalero	372
Owyhee	90
Parker	719
Schurz	362
Winnebago	935
Ft. Yuma	174
Total	$6,067

The HHS plan also included about $15 million to construct personnel quarters at four of the hospitals reviewed, as shown on the following page.

IHS hospital	Number of units	Estimated cost per unit	Total estimated construction cost
			(000 omitted)
Harlem	32	$ 65,000	$ 2,080
Parker	77	"	5,005
Schurz	86	"	5,590
Winnebago	41	"	2,665
Total			$15,340

CONCERN OVER USE OF CONTRACT CARE AS ALTERNATIVE TO DIRECT CARE

Over the years, the provision of health care services under contract has become a major element of IHS' health delivery system. According to IHS data, total hospital admissions to contract facilities increased from 7,381 in 1955 to 31,155 in 1979.

IHS hospital officials we contacted generally acknowledged that patients requiring hospitalization are often sent to community hospitals because the IHS facilities lack the necessary staff and equipment to treat these patients. In some cases, the IHS officials said that patients prefer to go to the community hospitals because of the known limitations of the IHS facilities. Officials from tribes located near these hospitals expressed concern about or opposition to discontinuing inpatient care at IHS facilities. However, other tribal members who now obtain inpatient care from community hospitals preferred this arrangement once it was established. Therefore, while there may be some transition difficulties, making greater use of community hospitals for inpatient care appears feasible as long as adequate contract health care funds are available for inpatient care from community hospitals.

Studies on IHS facilities and health care programs

Since 1979, several studies have been made to evaluate certain IHS health care facilities and various aspects of contract health services, including cost effectiveness. The results of these studies are discussed in the following sections.

Congressional study of IHS facilities and programs

In February 1979, the House Appropriations Committee reported on its study of selected IHS health care facilities and programs. The study noted that building a modern, well-equipped hospital in isolated areas fails to meet IHS objectives of providing effective and efficient health care to IHS beneficiaries. According to the study, IHS should be encouraged to pursue its objective of providing health care services through greater emphasis on constructing clinics, health centers, and stations rather than hospitals. The study noted that on the basis of economics, a number of health facilities strategically located and more readily accessible to patients could be constructed for the cost of one hospital. Although that study concluded that contract services appeared more costly than direct care provided by IHS, it noted that under certain circumstances involving infrequent demand and the need for specialization, contract services may be cost effective.

Western Nevada Health Delivery Systems Study

In 1979, a tribal task force, representing nearly all the Indian tribes of western Nevada, awarded a contract to a consulting firm to assess and develop a strategy aimed at improving the system of health care delivery to these Indians. The study, completed in September 1980, stated that:

> "* * * There is a general lack of availability of health care resources in most aspects of health services.
>
> "The IHS health care resources that are available are geographically inaccessible, housed in inadequate facilities and insufficient in quantity. * * *"

According to the study, IHS' Schurz Hospital (included in our review) "is inadequate, understaffed, overcrowded and geographically inaccessible." The study recommended that inpatient services at this hospital be discontinued and obtained on a contract basis with existing community facilities. According to the study, obtaining inpatient care at non-IHS hospitals was preferred to direct IHS care because:

> "* * * The cost will be lower.
>
> "Any hospital built in Western Nevada to serve the Indian population would be inaccessible to a large percentage of the population because of the geographic dispersion of the Tribes.

"The current travel burden on patients and their families would be eased.

"Continuity of care will likely increase because it will be easier for IHS primary care physicians to monitor patient progress in nearby hospitals. * * *"

The study pointed out that ambulatory services should continue at the Schurz hospital and that projected acute inpatient care would require a major expansion of the present facility or construction of a new one.

Study on Pawnee Benefit Package Program

The Pawnee Benefit Package Program (as the project is known) was authorized by the Congress in fiscal year 1981. Under the program IHS beneficiaries in the Pawnee, Oklahoma, area received inpatient and emergency care from the hospital of their choice and IHS reimbursed community health care providers for comprehensive inpatient hospital, nursing home, and rehabilitative care and for specified outpatient services. Obsolesence of the Pawnee IHS facility, overcrowding at the IHS facility nearest to the Pawnee facility, and the projected cost of constructing and staffing a new hospital at Pawnee were among the factors used as reasons for seeking an alternative means of providing health services to eligible Pawnee IHS beneficiaries.

In March 1982, IHS submitted a 6-month progress report on a demonstration project of health care delivery to the Indians using the Pawnee hospital.

The report noted that the program (1) greatly improved the availability of hospital inpatient and emergency services to its beneficiaries and (2) had widespread acceptance among patients and providers. According to the report, the program appeared to be a cost-effective alternative to constructing and staffing a new hospital. The report stated that allowing beneficiaries to choose their providers of inpatient and emergency services resulted in having all beneficiaries living within 20 miles of a community facility, whereas using the Pawnee IHS facility required a 75-mile drive for most IHS patients.

Tribal concerns of possible discontinuance of IHS inpatient services

Tribal officials at most IHS hospital locations we reviewed expressed concern over the possible closure of their inpatient facilities. In several instances tribal leaders had requested

IHS funding for constructing new hospitals. For example, tribal leaders in the Clinton, Oklahoma, hospital area proposed construction of a new hospital estimated to cost $10.5 million, even though the average daily patient load in 1980 was about nine patients and a 75-bed community hospital had been constructed in Clinton in 1976.

Tribal responses to the suggestion that inpatient care could be obtained from community hospitals rather than IHS facilities are summarized below:

--Elderly Indians prefer the IHS hospital and would not go for medical care if it was contracted out.

--It would be necessary to travel long distances for service if hospital inpatient care was contracted out.

--Contract health service funding runs out before the end of the fiscal year.

--Tribal members employed at the IHS hospitals would lose their jobs.

--Discontinuance of inpatient services would be a step toward closing the IHS facility.

To overcome tribal concerns IHS must assure that adequate contract health care funds are available to obtain needed inpatient care from community hospitals. In addition, because shifting the provision of inpatient care to community facilities from IHS hospitals is a sensitive issue, sufficient transition time and careful IHS oversight will be needed.

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As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

We are sending copies of this report to the four Committees mentioned above, the Senate Committee on Labor and Human Resources,

and the House Committee on Energy and Commerce. Copies are also being sent to the Directors, Office of Management and Budget and IHS.

We appreciate the cooperation and courtesy given our staff during this review and welcome the opportunity to discuss the above matters with you or your staff.

Sincerely yours,

Gregory J. Ahart
Director