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Quality Management

in the Indian Health Service

*Enhancing Our Ability To Raise
The Health Status of American Indians
And Alaska Natives*

Status Report
April 1990

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Indian Health Service

I. INDIVIDUAL QM PROJECT UPDATES

This section of the status report provides progress updates for each of the six on-going QM projects. Work groups are on-going for the following projects:

- Responding to External Authorities
- Managing Contract Health Services
- Managing Third Party Resources
- Developing Human Resources
- Managing Area & Associate Directors
- Restructuring Materiel Support

Two additional Work Groups have been appointed, but have not yet begun to meet. They will focus on 1) the implementation of the 638 regulations and 2) improvements in budget operations. Progress on these groups will be contained in the next report.

QM Work Groups are the tactical nucleus of QM activities. They use a four step process. They define the problem, find the facts, prioritize and decide solutions, and implement. They have a limited time, usually six months, to complete their charge. The Director of Quality Management and the Director, IHS provide a high level of support and visibility to these Work Groups and assure access to any staff assistance that they require.

Each Work Group knows the need to establish baselines upon which to measure progress; and although all the results are far from in yet, there is evidence in the Work Group implementation plans that change will be substantive and immediate.

A high level of energy and enthusiasm from each of these groups is producing similar optimism and commitment in other parts of IHS. We are pleased with this, but some barriers are being encountered as we move into implementation. These barriers take many forms, i.e. legislative, regulatory, managerial. The second section of this report will discuss the change strategy necessary to meet and overcome some of these barriers.

HIGHLIGHTS

IHS Quality Management

MANAGING CONTRACT HEALTH SERVICES

- **CHARGE: IMPROVE FINANCIAL MANAGEMENT OF CHS**
- **Corrective actions for a Material Weakness**
- **Processing difficulties led to fund control problems**
 - Propose simplify/accelerate processing flows (eliminate excessive handling)
 - Increased use of FI automation capacity
 - Enhance CHS software and revise paper handling processes
- **More disciplined fund control by HQ, Areas, Service Units**
 - Restrict requests for additional funding (make it very difficult)
 - Biweekly monitoring of funds status
 - New internal controls - manual issuances, circulars, performance standards
- **Managed Care Concepts**
 - Aggressively managed contracts, costs, pricing
 - Utilization Review, Quality Assessment (Some restrictions save \$ without sacrifice)

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DISCUSSION

The management of contract health services has been cited as a material weakness by the Director, Office of Management, OASH. This Work Group, chaired by Dr. Terry Batliner, Portland Area Director, has developed the corrective actions necessary to remove this citation.

The immediate changes have corrected some processing difficulties that lead to fund control issues. Revision to the scope of work in the contract with the fiscal intermediary will provide more timely information to the service units. In addition providers will be paid on a more timely basis reducing the frustration experienced by all concerned.

Software enhancements are being made by the staff of the Office of Information Resource Management at Billings and Portland Area test sites.

Bi-weekly reporting of expenditures by every service unit to the area, and in turn by the area to headquarters on a monthly basis, is required for more disciplined fund control. The internal control procedures are completed. Several draft documents, including suggested performance standards for managers, are ready for issuance.

Future directions for this work group, or its successor, lead the agency into as yet unplowed ground for IHS. In order to meet the ever growing demands for service within limited resources, IHS must look to the tools available to other health systems in America, such as those used in Managed Care. This work group has proposed that IHS immediately undertake such planning and develop the organizational skills and structure to so operate. The CAAD has approved moving in this direction, and plans are underway.

HIGHLIGHTS

IHS Quality Management

MANAGING THIRD PARTY RESOURCES

- **CHARGE: ASSURE APPROPRIATE COLLECTIONS AND EXPENDITURE OF 3RD PARTY RESOURCES**
- **3 Elements: Revenue Collections, Expenditures, Broad Policies**
- **Update on legal authorities**
- **Assessment of expenditure practices is on-going**
- **Proceeding with 11 High Priority Actions:**
 - **Provider status for Freestanding clinics**
 - **Assess/Reduce 638 contractors vulnerability**
 - **Pursue billing of multispecialty visits**
 - **Pursue billing for IHS services outside IHS facilities**
 - **Replace flat fees with "Tortuously Liable Rate"**
 - **Return PI Collections to Areas for Incentives**
 - **Revise M&M Finance Reports**
 - **Establish "Business Offices"**
 - **Improve eligibility PR data**
 - **Install Billing/Coding software**
 - **Immediate training in billing PI**

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DISCUSSION

There are two priorities for this work group, chaired by Michel Lincoln, Navajo Area Director. First, to improve performance in collecting Medicaid and Medicare revenues, and second, to assure that expenditures of such collections comply with existing laws and regulation. Three subcommittees analyzed differing components affecting performance: a) the broad policies and legislative requirements related to this increasing important source of IHS funding, b) systems and policies affecting revenue collections, and c) the planning for and importance of expenditures.

The 11 priority actions, listed above, address the IHS ability to increase revenue by assuring provider status, more accurately billing for services rendered, correcting inadequate fee schedules, and instilling a businesslike attitude into the service units.

Some of these projects will require a long lead time until the results are measurable. Several years will be required to fully transform service unit administrative staff and procedures into strong business offices. Other efforts, like the revision of computer matching routines that identify IHS patients that are eligible for state medicaid benefits, are beginning to produce results immediately. The processes needed to achieve these short and long term results will be undertaken immediately.

HIGHLIGHTS

IHS Quality Management

MANAGING SENIOR OFFICIALS

- **CHARGE: INSTALL A PROCESS TO EFFECTIVELY MANAGE SENIOR AGENCY MANAGERS**
- Restructured CAAD as an IHS Governing Board
- Developed an improved system for managing senior officials
 - Improved communication between field and HQ
 - Implemented periodic reporting systems for Area Directors
 - Redesigned the system for monitoring and evaluating Area performance
- Developed an orientation program for new Area Directors and executive staff

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DISCUSSION

The key message of this work group is increased accountability of senior officials. Three approaches are used:

- o Transforming the role of the CAAD,
- o Redesigning the communication and evaluation systems used to manage senior officials
- o Improving senior managers understanding of their authorities and responsibilities.

The responsibility for seeing that senior agency officials maintain excellent standards of performance and provide the level of professional advice and decision-making assistance to the Director remains with the Director, IHS. He, therefore, is the chairperson for this group. The Council of Area and Associate Directors comprise the governing body, designated by the Director to provide this advice to his decisions. IHS has issued a new charter defining CAAD responsibilities and has conducted its first meeting under the new charter. An evaluation of the progress is underway.

Three instruments have been refined or introduced to give the Director the information he needs for assuring accountability with the Area Directors and to improve his ability to communicate with Area Directors. They are more precise performance plans including FMFIA responsibilities, redesigned program and administrative reviews, and development of management indicators and a periodic reporting system from areas to headquarters.

It is critical to provide new Area Directors and Executive staff with the orientation and training that they need to effectively perform their jobs. Such an orientation program is now in design. It will be pretested in the Bemidji Area where a new Director has been recently appointed.

HIGHLIGHTS

IHS Quality Management

RESTRUCTURING MATERIEL SUPPORT

- **CHARGE: REORGANIZE AND IMPROVE MATERIEL SUPPORT**
- **PHASE 1: Transfer Perry Point SSC from HRSA to IHS**
 - 60% of business is from IHS
 - Has strong influence on our costs - transfer will give IHS greater control over costs
 - PPSSC is not structurally deficient, but costs exceed VA and some other suppliers
 - New Division of Materiel Support established in IHS
 - 42 FTE / No new funding / Staff transferred from HRSA
- **PHASE 2: Restructuring Materiel Support Systems**
 - IHS has \$100M materiel costs, costs are \$43 per P.O., \$1M in P.O. costs
 - There are variances in purchase costs, service, distribution, on-site inventories.
 - Coordinated supply has advantages for all IHS operations
 - Use Computer Modeling of supply points, flows, distribution costs, inventories, etc.
 - Use revolving service supply fund (no direct appropriations), pay its own way
 - Establish regional networks: Service time, throughput, and bulk buying are key

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DISCUSSION

This activity is divided into two phases. The first phase, under the leadership of Glenn Farmer, Chief, Supply Management Branch, focused on the transfer of the Perry Point Supply Center from Health Resources and Services Administration (HRSA) to IHS. These plans are now completed and decision package and Federal Register notice requesting the Secretary's signature will be forwarded to you in the immediate future. Dr. Rhoades and Dr. Harmon have each signed off on this document.

The second phase will be lead by Dr. Robert Harry, Oklahoma Area Director. This phase will address restructuring the materiel support systems in IHS. This is a massive undertaking requiring several years for full implementation.

Significant savings may result if coordinated and consolidated supply systems are in place for all IHS operations as they are now in some areas. In addition, an automated financial and inventory management system, named ARMS, is now under development at Albuquerque and will be installed throughout the system. This information will allow IHS to analyze and manage such factors as supply points, distribution costs, and inventory controls.

HIGHLIGHTS

IHS Quality Management

RESPONDING TO EXTERNAL AUTHORITIES

- **CHARGE: INSTALL A PERMANENT CAPACITY TO EFFECTIVELY RESPOND TO EXTERNAL ORGANIZATIONS**
- Attention to customers is an essential part of our business. We are judged by our paper and our personal contacts.
- Quality products is the expectation, not the exception.
- Major effort is at HQ with Exec. Sec. Focus on coordination of controlled correspondence. New software for tracking is planned.
- Significant effort to build bridges and personal contacts with outside (Congress, OIG, Department)
- Special emphasis on routine recurring reports.
- Develop standards of responsibility, performance, timeliness, and quality that defines effective responses.
- Communications is vital in efforts to improve "PR".

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DISCUSSION

The success of this effort is measured by the feedback that IHS receives about its performance from those persons and organizations with whom it does business. The objective is for IHS to be recognized for timely, responsive and quality materials.

The members of this Work Group, chaired by Michel Lincoln, Navajo Area Director, examined the types of recurring demands on IHS. They have completed the systems analysis and developed guidelines for all IHS staff who have responsibility for the preparation of such documents. These include preparation of regulations and the required Federal Register notices, and internal control review reports.

The design of an automated tracking and management information system is near completion in Executive Secretariat.

HIGHLIGHTS

IHS Quality Management

DEVELOPING HUMAN RESOURCES

- **CHARGE: ASSURE ADMINISTRATIVE MANAGERS POSSESS THE KNOWLEDGE AND EXPERTISE TO EFFECTIVELY MANAGE**
- **Concentrating on administrative functions:**
 - Procurement/Contracting
 - Financial Management
 - Personnel
 - Supply
- Pockets of excellence, but largely for clinical functions.
- Pilot test training from AMA for senior managers
- Examining personnel qualifications and standards

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DISCUSSION

The Work Group, chaired by Eleanore Robertson, Tucson Area Director, has focused its efforts on analyzing the training needs for administrative managers and suggesting ways for meeting these needs. The Work Group has determined that training for agency procurement staff is the first order of business, with training for other functions to be developed using the same model as used for procurement.

In addition, a program for senior managers offered by the American Management Association has been tested in April to see if such programs are applicable to IHS managers. Preliminary reports are positive.

IHS recognizes that the magnitude of meeting its responsibilities for training and development will require extensive efforts beyond those of this work group. Planning to meet the staffing needs in the next decade, and to provide the infrastructure to accomplish this, is now underway within the immediate Office of the Director.

HIGHLIGHTS

IHS Quality Management

COMMUNICATIONS ADVISORY GROUP

- **CHARGE: DESIGN AND MAINTAIN A COMPREHENSIVE COMMUNICATIONS METHODOLOGY FOR IMPLEMENTATION OF QM**
- Tailor methods to effectively communicate QM to various audiences of the IHS
- IHS audiences include employees and their families, tribal members, health professionals, the media, and Congressional offices
- Highlight the results of change not just the process of change
- "Quality Management means Quality Service"

April Quarterly Report

DISCUSSION

The Communications Advisory Group (CAG), chaired by Patricia DeAsis, Director of Communications, is different from the other QM Work Groups. This is because it is established as an Advisory Group. The CAG will operate throughout the QM effort as long as Work Groups are active. As the QM process evolves and changes, so will the CAG. The communications programs put in place during the QM process will continue after the QM process becomes absorbed into the management culture of IHS.

The communications strategy for QM is developed and implemented in phases. The initial phase has begun with the development of an orientation packet. This packet will assist senior officials in conducting orientation briefings on QM.

The orientation packet consists of summary descriptions of key features of QM, as well as a video presentation by the Director of IHS, the Director of QM, and excerpts from Work Groups products. These information materials will be completed before the next CAAD meeting scheduled in August.

II. OASH ASSESSMENT OF IHS MANAGEMENT SYSTEMS

In keeping with the Plan for Quality Management in the Indian Health Service, OASH conducted and completed its assessment during this quarter. The report was sent to IHS in March. Each of the sections of the report has been carefully reviewed. Our staff met with the Director, Office of Management, and concurred in general with the report.

There are some very serious problems outlined. In particular, two functions are noted as material weaknesses: Contract Health Services and the IHS Scholarship program. As pointed out in the status report of the Contract Health Services Work Group (see section one of this report), the objective of this work group is to complete the corrective action plan for this program, and in fact, to implement the steps necessary to have the citation removed. Many of the areas reviewed by OASH are currently matters that are being actively addressed by QM Work Groups and managers in IHS. For example, many of the findings about management of Medicare & Medicaid reimbursements are the subject of correction and improvement projects that are already well advanced. Others required additional attention.

The Director, IHS, has appointed Mr. James Meredith, reporting to Mr. Marsland, to manage development of the Improvement Plan based upon the OASH report and to develop the tracking system to monitor agency progress. IHS will provide you with this plan by June 30, 1990.

III. MANAGING CHANGE IN IHS

The scope and multiplicity of activity now going on in IHS administrative management is explosive. It is staggering to list the major management systems that IHS is revamping at this time:

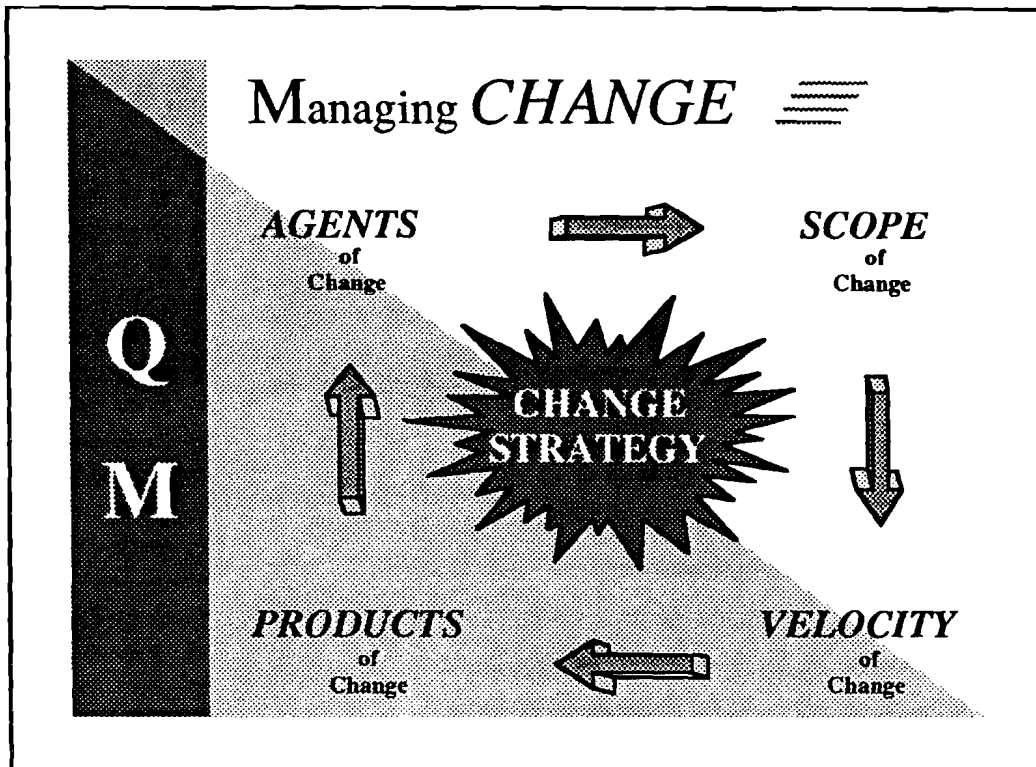
- implementation of FMFLA
- management of senior officials
- contract health services
- Medicaid, Medicare, and private insurance billing
- executive secretariat functions
- supply management systems
- human resources development
- quality assurance systems
- transforming program and administrative reviews
- implementation of 638 contracting regulations
- budget formulation and execution processes
- internal/external communications

When this is combined with the need to continue to meet its operational responsibilities and also make the changes needed to meet the requirements of the OASH Assessment, one can see that IHS is facing pressures throughout the agency that few other agencies have encountered.

All of the activities are additive. Staff are challenged to change the way in which IHS conducts business, take on additional duties, and remedy omissions and imperfections.

In order to direct energies in constructive ways, IHS must now develop and undertake a strategy to manage change on a massive scale. We have begun this effort by attempting to refocus the diffuse concern and uncertainty of IHS managers into discreet, more understandable chunks. We have outlined the elemental components of change in numerous meetings with Area and Associate Directors, Area Administrative Officers, and at a national conference of IHS Service Unit Directors. The agency will continue to outline these changes at each opportunity available, i.e. national professional meetings, tribal consultation meetings, meetings with external authorities and interested organizations.

HIGHLIGHTS



DISCUSSION

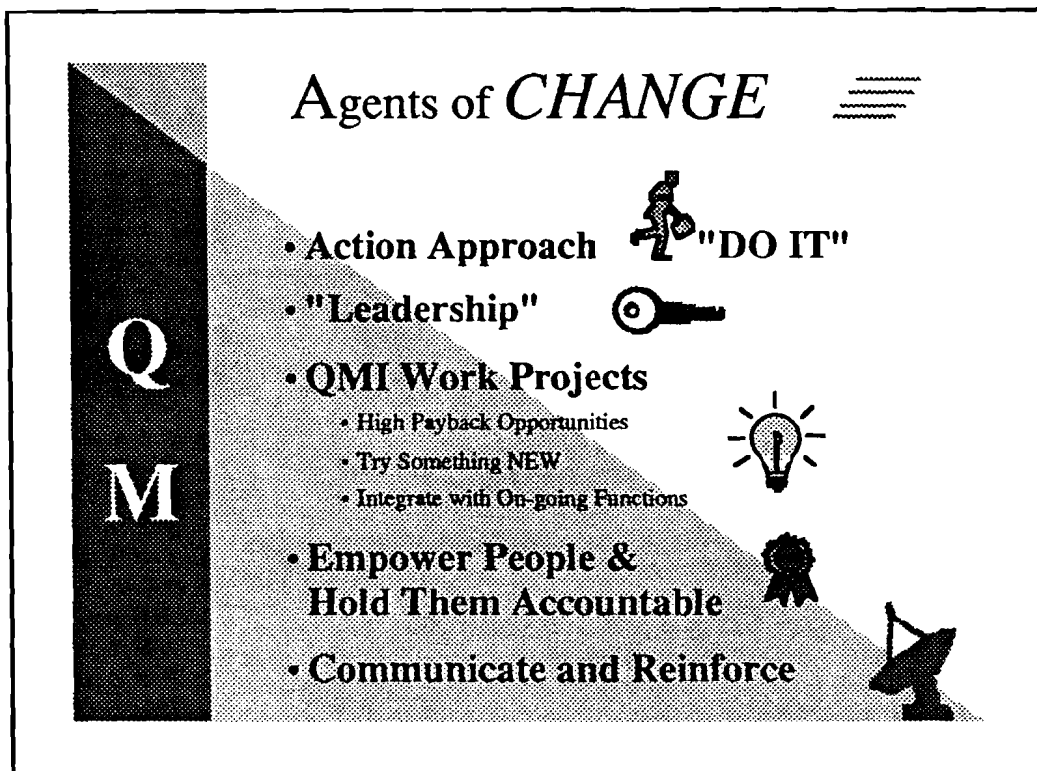
QUALITY MANAGEMENT is all about change. IHS has undertaken changing an entire agency. Such a process is enormous; it is difficult, time consuming and slow. It will not happen by itself; it needs to be managed.

IHS proposes a change strategy that breaks down the complexity of change into manageable chunks and deals with each of these individually and then integrates them into a whole.

The IHS strategy identifies:

- o Agents of change
- o Scope of change
- o Velocity of change
- o Products of change

HIGHLIGHTS



DISCUSSION

The change AGENTS begin with QUALITY MANAGEMENT itself. It is action oriented. We not only study it, we DO it.

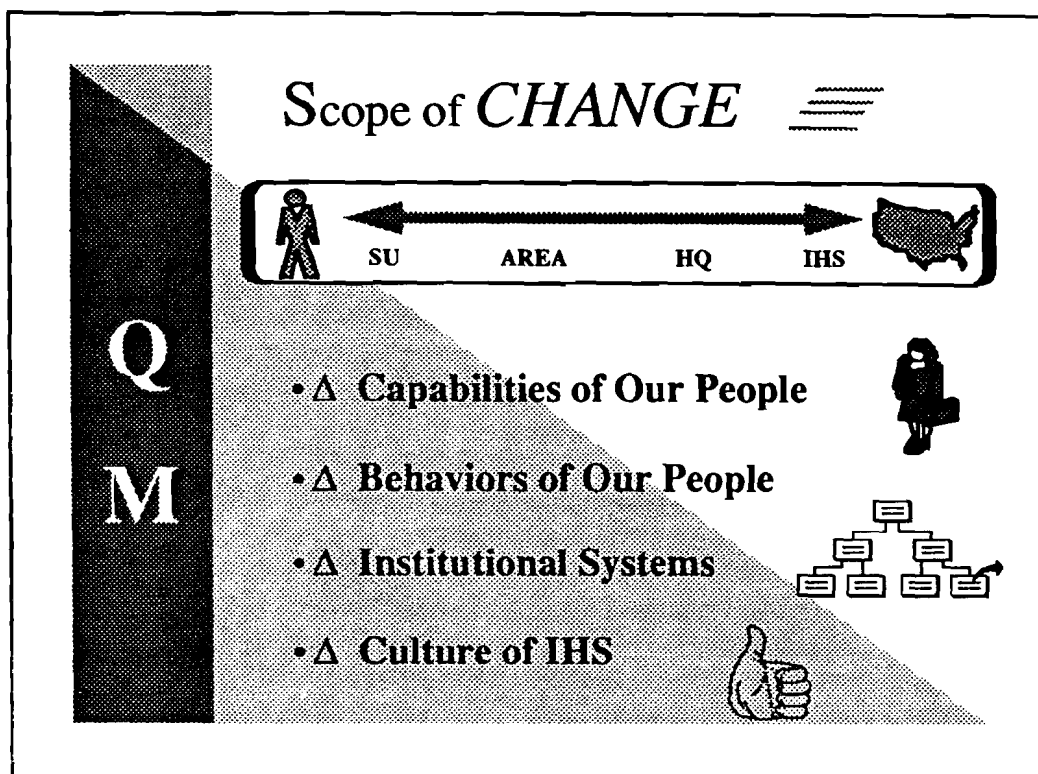
The top management role is visible and defined. Beginning with Dr. Rhoades, the key leadership throughout IHS is actively participating in QM. All Area and Associate Directors as individuals and as members of the CAAD lead or support the Work Groups tackling the issues facing IHS. Several influential managers in all levels of the agency are representing change in their respective environments.

The project oriented Work Groups in QM provide high payback. They give members the latitude/responsibility to try something new. The creativity and energy of the Work Groups spreads to others with whom the members come into contact.

Change relies on people. QM gives people the opportunity, the tools and the accountability for personal performance.

All of these agents are needed to get the message to people.

HIGHLIGHTS



DISCUSSION

Scope varies along a continuum from one individual to the entire 12,000 people who make up the whole agency. Several kinds of change are underway affecting many different facets of IHS staff and different numbers of them at any one time. They are:

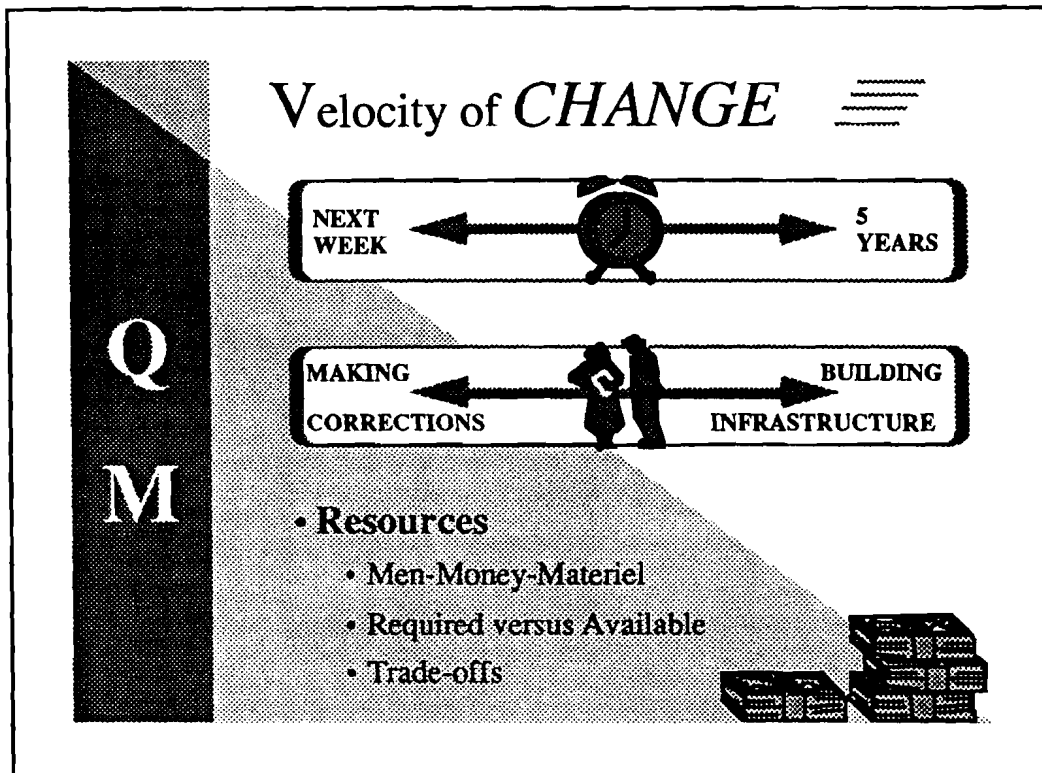
Changing staff CAPABILITIES. This includes recruiting talent, developing skills and providing tools, such as training, education and credentials.

Changing staff BEHAVIOR. Management practices such as incentives for performance, accountability, and better decisions influence the rate of change.

Changing agency SYSTEMS. When policies, regulations, organizational structure, delegations, procedures impede change that is needed, they must be revised.

Changing agency CULTURE. The goal is shared attitudes and motivations towards professionalism and ethical standards. This requires continued reinforcement of our commitment. We intend to institutionalize a CAN DO culture based upon performance and confidence.

HIGHLIGHTS



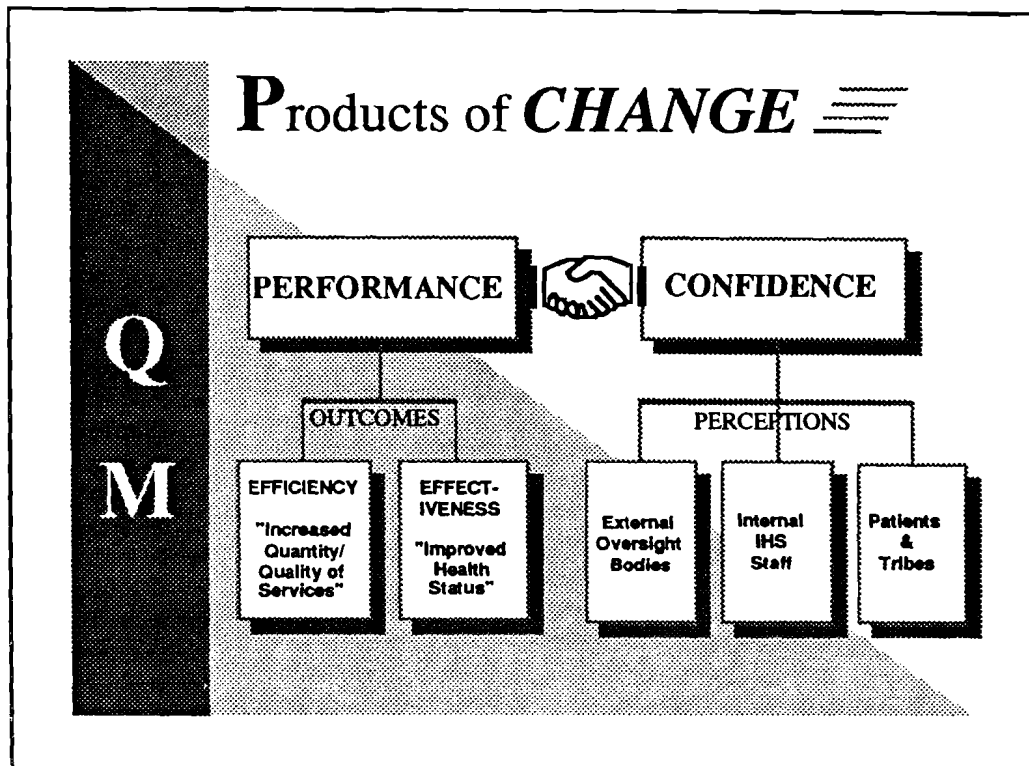
DISCUSSION

Change in organizations is difficult and can be slow. IHS recognized the requirement for long-term commitment in the design of QUALITY MANAGEMENT. Up to five years is a realistic time-frame to realize a range of outcomes.

Velocity of change is also related to the scope of change. Some corrections for relatively simple things can be made immediately. We are doing some of these, such as revised performance plans, changes in contract scope of work, reporting systems. At the same time basic changes to our organizational infrastructure and culture have a much longer time line.

Velocity will also relate to the resources that we are able to put to the task. The amount of manpower and money available will affect the rate of accomplishment. Trade-offs are inevitable, but the return on investment is promising in QM.

HIGHLIGHTS



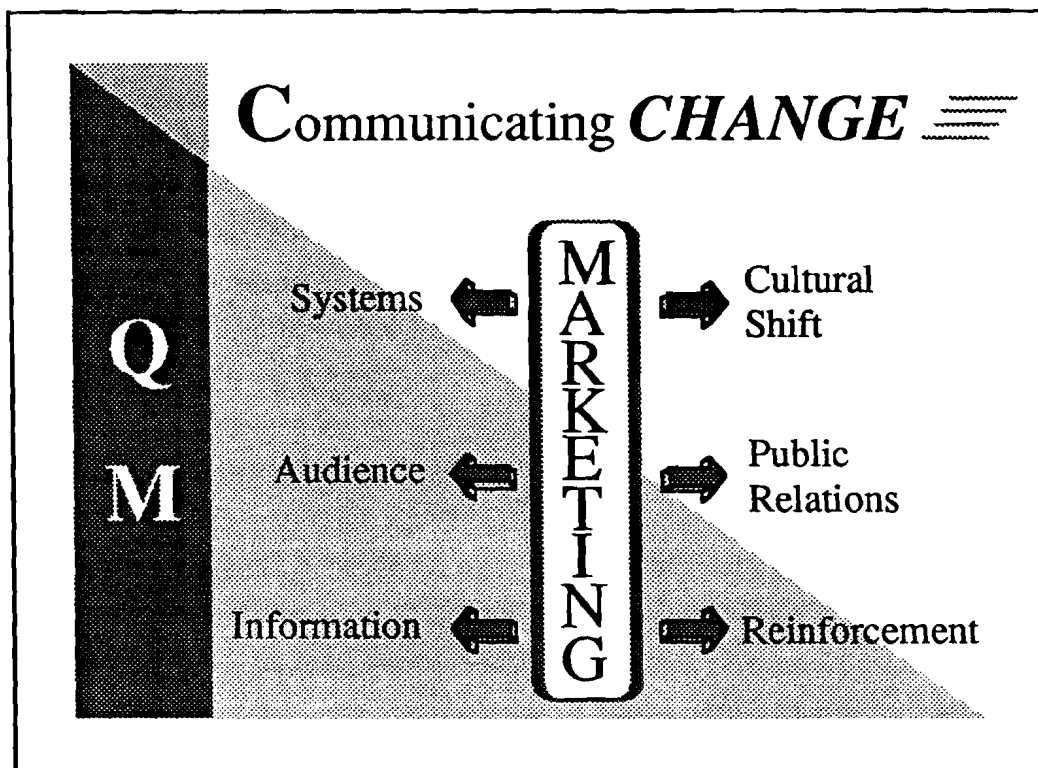
DISCUSSION

We measure success with two fundamental payoffs.

IMPROVED PERFORMANCE Ultimately the QM effort must be judged on its effects on outcomes. We include both the "efficiency" measure of quantity and quality of services provided compared to the resources used and the "effectiveness" measure that relates to improved health status of Indian people.

IMPROVED CONFIDENCE While health outcomes may be difficult to quantify and measure, the perceptions of our customers (oversight bodies, patients, tribes and IHS staff) will be more immediately apparent. If we do the job planned, then we will have an IHS that is recognized both for performance and accountability.

HIGHLIGHTS



DISCUSSION

QUALITY MANAGEMENT is about a continuum of change. This continuing process requires a comprehensive and consistent approach to communicating the change throughout the agency.

A strategy of systematic communications must be an integral part of the organizational change. Strategies and actions that require the support and inter-action of an audience that will implement these changes, necessitates that this audience be informed in a manner that is clear and acceptable to them.

Reinforcement to employees for successes must be immediate, and these same successes must be shared by the organization through responsive communications.

IV. PROGRESS IN QM COMMUNICATIONS

The purpose of the previous sections of this report was to comprehensively survey the many QM activities that IHS is currently conducting and to report on the progress of each. In addition, a transformation in the attitudes of IHS staff must accompany any broad based change in the IHS management culture. We have attached interviews from two members of QM Work Groups who were asked to talk about their personal experiences. Excerpts from these discussions are contained in the attachment *QUALITY MANAGEMENT: TWO PERSONAL PERSPECTIVES*.

This document also exemplifies one of the various communications initiatives that have been developed in concert with the QM effort. In recognition of the need to communicate the QM effort at personal level with all IHS employees, we have created a periodic feature entitled *QM FACE-TO-FACE*. This issue contains the personal reflections of Joe Cash, M.D., a member of the Contract Health Services QM Work Group and Ms. Karen O'Steen, a member of the External Authorities Work Group. This document has been widely distributed to all IHS programs and areas including all of the services units.

QUALITY MANAGEMENT: TWO PERSONAL PERSPECTIVES

About six months ago, IHS inaugurated Quality Management (QM), a results-oriented initiative to improve management throughout the agency. At that time several QM workgroups were established and charged with making significant improvements in a specific area of IHS activity within six months. As several of the workgroups are about to complete their six-month commitments, we decided to ask a few workgroup members to talk about their experiences with the QM effort. The following are excerpts of two of our discussions.

Joe Cash, M.D., Contract Health Services Workgroup. Dr. Cash is a board-certified internist at the Rapid City Service Unit in the Aberdeen Area. He is a member of the PHS Commissioned Corps. The Contract Health Services Workgroup, which is chaired by Dr. Terry Batliner, Director of the Portland Area, was charged with developing a system for managing the costs of the contract health program and maximizing the purchasing power of IHS's contract health dollars.

QM: Dr. Cash, why do you think you were chosen to serve on a QM workgroup, and why, specifically, the Contract Health Services Workgroup?

Dr. Cash: Not long ago, I served as head of the Contract Care Committee at the Rapid City Service Unit at the same time that Dr. Terry Batliner was the Director of that service unit. As a result, Dr. Batliner and I developed a close working relationship, and he became very familiar with my knowledge and ideas in the contract health care area.

I also think I was chosen because I have extensive service unit experience and a medical staff perspective on contract care issues. This perspective was needed to balance out the workgroup, because many of the other members have administrative, not medical, perspectives.

QM: It appears that multiple perspectives and balance were sought in assembling all of the QM workgroups, and the Contract Health Services Workgroup was no exception. . . . Given the heavy demands on your time as a service unit physician, why did you agree to serve on the workgroup?

Dr. Cash: One reason is that I felt that I could make a specific contribution to the workgroup. The other is that I have a great deal of respect for Dr. Batliner. I know him as someone who is capable of getting things done, so I knew it would be a productive experience.

Dr. Joe Cash

"When IHS pays at 100 percent of billed charges, we subsidize the losses that the providers incur in these other aspects of their business. This process is known as 'cost-shifting.'"

"Contracting is the cornerstone of managed care. IHS needs to do a better job of contracting so that we can avoid cost shifting and stretch out our dollars."

QM: *What special issues or problems have you concentrated on while serving on the workgroup?*

Dr. Cash: I was asked to do a few specific things. I went to headquarters and worked on policies and procedures to streamline the appeals process. I also worked extensively on converting IHS to a managed care system.

QM: *Could you talk a little about a "managed care system?"*

Dr. Cash: What "managed care" means is tightly managing the contract health services budget. Currently, much of the IHS contract health dollar goes to pay physician and hospital providers at 100 percent of billed charges. Few other third-party payers pay these providers at such a high rate. For example, insurance companies may pay according to a fee schedule, Medicare pays by DRGs, and Medicaid usually pays a low percentage of billed charges. In addition all of IHS's contract providers have some patients who pay nothing. When IHS pays at 100 percent of billed charges, we subsidize the losses that the providers incur in these other aspects of their business. This process is known as "cost shifting."

IHS is extremely vulnerable to cost shifting because we do not manage our contract care budget as tightly as the other large payers do. We now want to do so, so that we can stretch the dollars out further and buy more care for our beneficiaries.

QM: *Has your workgroup made any progress in this area?*

Dr. Cash: Yes, a great deal of progress. We have developed a multifaceted plan to convert IHS to a managed care environment. IHS providers are extremely diverse, and every local medical market is different. Patients are spread out in huge geographical areas. Therefore, for us to make a blanket policy that applies to everybody probably would not work. So we're going to have a diverse approach to match the diverse environment in which we operate.

The first thing that we're going to try to do is improve contracting. Contracting is the cornerstone of managed care. IHS needs to do a better job of contracting so that we can avoid cost shifting and stretch out our dollars.

We're going to implement policies and procedures to give the area offices and the service units the expertise to review the contracts that IHS has in place with providers and to develop strategies for negotiating contracts that are mutually beneficial. It's conceivable that in some medical markets our contracts will be on a DRG basis, in others on a percent-billed-charge basis. We may ultimately use different DRGs. For example, the Defense Department's CHAMPUS program has developed DRG coding that may be more financially beneficial to us than the current Medicare DRG coding.

Dr. Joe Cash

"In the private insurance industry, it is estimated that eight dollars are saved for every one dollar spent in setting up a managed care program."

We also hope to develop a strategy through which we aggressively market those providers with whom we do not currently have contracts in order to increase the percentage of our providers under contract.

We want to fund a medical contracting officer in each area office. Trained in modern medical contracting strategies, these officers would be backed up at the area level by committees, which include service unit representatives. At the national level, we are asking for funding to support a Managed Care Advisory Committee to oversee IHS-wide implementation. We are also asking for a director for managed care implementation, preferably a medical doctor, to supervise the implementation nationwide, to assist the area offices in negotiations with individual hospitals and physicians, and to give feedback to the Managed Care Advisory Committee.

QM: *This will involve the expenditure of a considerable amount of money. Will the payoff be worth it?*

Dr. Cash: Managed care is one of those things in life where you have to spend money to save money. In the private insurance industry, it is estimated that eight dollars are saved for every one dollar spent in setting up a managed care program. We have indications from the upper levels of management at IHS headquarters that they generally support assuming the start-up costs. Although the start-up costs will be significant and the benefits may not be seen for a few years, we expect ultimately to save millions, if not tens of millions, of contract health dollars through a full-fledged managed care plan.

IHS has always used some of the principles of managed care, and the system has been slowly evolving toward a more complete approach. Our workgroup is speeding up that process.

QM: *One of the issues that other workgroups have been confronted with is how to explain QM and the changes it is making to the Congress and the tribes — changes that will cost money that could go directly into health care. What about your workgroup?*

Dr. Cash: The first task for our workgroup has been to sell these changes to people *within* IHS. Dr. Batliner has been very conscious of this. We have met with two field organizations: service unit directors and area contract health officers. We also presented our managed care proposal to Dr. Rhoades and the Council of Associate and Area Directors. We've received an enthusiastic response from all of these groups.

We have not yet had the opportunity to talk to Congress. But our effort should be well received by Congress when they learn of it. The studies of IHS done by the Office of the Inspector General and the Assistant Secretary for Health have consistently found problems with the way IHS manages its contract health money, and our workgroup is addressing those concerns directly.

Dr. Joe Cash

"We're not in QM just to make recommendations. We're in it to make real changes in the way IHS operates."

"The support from Dr. Rhoades, Mr. Marsland, and Dr. Porvaznik has been excellent. They recognized that contract health services needed a close look and some changes, and they had confidence in us to come through with far-ranging policy changes."

We have not taken our proposal to the tribes, but they should be supportive when they find that managed care will allow us to have more contract health resources available. That's what it's all about. The tribes want more health care for Indian people, and so do we. Managed care is the way to do that.

QM: *Is there anything special about your QM workgroup that has made it easier to deal with improving contract health care? In other words couldn't some other IHS task force or IHS office have taken this on with equal success?*

Dr. Cash: The QM workgroup has much more clout than the traditional mechanism for implementing change in IHS. Generally in IHS and other governmental organizations, one recognizes the problem, one studies it, and one sends recommendations up the chain of command. These recommendations may or may not be implemented based on financial or other considerations. This is an extremely slow process, and a committee can only make recommendations. The difference with QM is that the workgroup has the ability not only to study a problem but also to change policy. We're not in QM just to make recommendations. We're in it to make real changes in the way IHS operates.

QM: *Have you experienced support for that approach up to this point?*

Dr. Cash: We've run into no roadblocks in terms of implementing our ideas. In fact, the support from Dr. Rhoades (Director of IHS), Mr. Marsland (Deputy Director for Headquarters Operations), and Dr. Porvaznik (Associate Director, Office of Health Programs) has been excellent. They recognized that contract health services needed a close look and some changes, and they had confidence in us to come through with far-ranging policy changes.

QM: *What else would you say has contributed to the success of your QM workgroup?*

Dr. Cash: The people involved in the workgroup, and an exceptionally capable, thoughtful, and thorough workgroup chairperson. This has made all the difference.

QM: *Your workgroup is about to complete its work, isn't it? The workgroups were intended to get in there, make some changes, and then get out. Is that how it's working out with your group?*

Dr. Cash: Our workgroup got divided into two main projects: one to improve the flow of data among service units, area offices, and the fiscal intermediary, and the other to develop a managed care system. I understand that the first project is essentially completed, and changes are being implemented. As for the managed care project, we have the support of top management to implement a system, but we all realize that implementation will take several years. Several members of our workgroup, including Dr. Batliner and Dr. Hurlburt (Chief Medical

Dr. Joe Cash

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Officer, Alaska Area) will serve on the Managed Care Advisory Committee once the QM workgroup is finished. This advisory committee will carry on the work over the next several years.

QM: *Would you have done anything differently from what was done with your particular workgroup or with the QM effort as a whole?*

Dr. Cash: No. It has all worked out very well. I'm not a manager, so I didn't really know what to expect. But I was pleasantly surprised that it was an opportunity to really get some things done.

QM: *How has your experience on the workgroup affected you personally?*

Dr. Cash: It certainly has given me a great deal of knowledge about medical management, which will be quite valuable to me in my career. It has given me a greater understanding of how headquarters works and of how the contract health system works. I've been able to use a lot of the information I've gained from the workgroup at my own service unit. Our contract with the local hospital was coming up for review at about the same time that this workgroup started, so I've been able to use some of the knowledge gained to help with the negotiations.

QM: *And the knowledge that you gained will be spread throughout the agency through your workgroup's implementation plan, right?*

Dr. Cash: Exactly.

QM: *The QM effort is expected to have an impact on IHS's managerial culture. What does that mean to you?*

Dr. Cash: First of all, one of the constant criticisms of government in general is that large bureaucracies are resistant to change and slow to respond to new needs. The QM approach gives us a way of shaking up the bureaucracy and implementing change much faster than otherwise.

I think that the QM process should become a general mode of operation in IHS. Every year or two, IHS should identify the highest priority problems and assign Quality Management workgroups to address them. I think that will allow more efficient changes to occur within IHS.

QM: *What about the promotion of accountability, professionalism, and initiative, and not just through such special efforts as your workgroup's project, but on a day-to-day basis? Is QM the right mechanism for doing this?*

Dr. Cash: After working in a QM workgroup, one can't help but be affected by the positive experience and go back to one's service unit or area office and use what has been learned. QM is certainly a step in the right direction.

QM FACE-TO-FACE

Ms. Karen O'Steen, External Authorities Workgroup. *Ms. O'Steen is one of a small number of non-IHS QM workgroup members. She is the Director of the Executive Secretariat at the National Institutes of Health. The External Authorities Workgroup, which is chaired by Michel Lincoln, Director of the Navajo Area, was charged with improving the systems and mechanisms through which IHS relates to Departmental, Congressional, and other authorities. The charge included improving IHS's responsiveness with respect to controlled correspondence, which is coordinated by the IHS Executive Secretariat.*

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QM: *Ms. O'Steen, why do you think you were chosen to serve on a QM workgroup, and why, specifically, the External Authorities Workgroup?*

Ms. O'Steen: About two years ago, I met Mary Lou Andersen, who was the acting director of IHS's Executive Secretariat (Exec. Sec.) at the time. We were turning things around here in NIH's Exec. Sec., and Ms. Andersen wanted to learn more about what we were doing. When IHS was forming the External Authorities Workgroup, Ms. Andersen (now a member of the QM staff) asked me to participate. She thought we had done a good job here in upgrading significantly the kind of work that we do and how we do it. And I think that the perception of the outside world is that NIH now has a strong, properly functioning Exec. Sec.

QM: *Why did you accept the invitation to serve on the Workgroup?*

Ms. O'Steen: I like to solve problems. I also have a great deal of respect for people who recognize that they have a problem and want to make things better. I like the kind of work that we do, and I think it can be very important if done properly.

QM: *What is the role of a properly functioning Exec. Sec. and communication system, and why is it important to an agency like IHS?*

The role of a properly functioning Exec. Sec. is information management. Its mission is to make sure that the right people both inside the agency and outside have information that is timely and accurate, and to make sure that everyone in the agency is speaking with one voice. Exec. Sec. manages the generation, coordination, and storage of information used by managers within the agency and by policymaking and oversight organizations outside the agency.

No matter how well you do your work, if you don't communicate it properly — i.e., if you don't get the right information to the right people — then you haven't really done your job. It doesn't matter how well you've done if the key people who need to know don't.

It's clear to me that IHS has some really dedicated people who care deeply about improving the health of Native Americans. But the outside world has not perceived them as being truly professional or responsive. My workgroup has taken on that problem.

QM: *How do people and offices in the field contribute to effective information management?*

Ms. O'Steen: Information management is not just a one-way street. It is very important not only that headquarters keeps the field informed but also that it receives from the field the information it needs to develop policy, to respond to questions from Congress and others, and so on. For example, if an area office has learned through a telephone call that a senator or representative or tribal official is concerned about a

Ms. Karen O'Steen

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particular issue, it is important that that information be relayed to headquarters. And it is also very important that the answers that the area office gives are consistent with the answers that headquarters may later give in response to a formal letter or question at a hearing. The agency is in a very dangerous position when different offices are saying different things to external authorities.

QM: *What kinds of problems did the workgroup set out to solve?*

Ms. O'Steen: Essentially, we looked at three key problems with the way IHS currently manages information in response to external authorities: timeliness, accuracy, and coordination. Timeliness has been a major problem for a long time. For example, responses to letters from Congressional offices are frequently late, and many reports to Congress have sometimes been months, even years late. And when they do receive the letters or reports, it's often not the information they want or in a form useful to them. As for coordination, there are too many cases in which one office in IHS is saying one thing while another is saying something different. These are all serious problems, not just with Congressional authorities, but with those in PHS, the Department, and the tribes — all key customers of IHS information.

QM: *Are there any special issues or problems that have captured your interest while serving on the workgroup?*

Ms. O'Steen: One issue that I have been particularly interested in is the automation of IHS's system for tracking the production of documents and for storing information in one central place. We at NIH have just made a big difference through automating our own tracking and retrieval system, but technology is changing so rapidly that I can see our system will be out of date in five years. So, I was really interested in participating in a process that would look ahead for IHS because it would apply to NIH as well. I'm interested in the state-of-the-art in communicating and moving and tracking documents electronically.

QM: *What specific impacts do you think your workgroup can have on the way IHS does business and on how well it serves American Indians and Alaska Natives?*

Ms. O'Steen: There are a lot of things we can do . . . like enhancing the Exec. Sec. function and operation. That's a basic thing, but it makes a world of difference if everybody has the information that they need. There are information gaps all over the place right now in IHS: the area directors don't get the same information as the headquarters people are getting from the Congressional delegations; the headquarters people don't know what the area office people are doing because that information is simply not captured and shared in an orderly fashion. IHS can change this, and it should be fairly easy.

Some of the other things are a little harder, such as relationships with Congress, the press, the public, even IHS *employees*. They all need to

Ms. Karen O'Steen

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know what a great job the agency is doing. I think our group can have some meaningful impact on how to do that.

In some ways, IHS and NIH have a very analogous situation. While NIH is not geographically dispersed, we do have twenty-one institutes, centers, and divisions, all of which are fairly autonomous and have their own kind of mission. And the Director of NIH sits on top of all this and tries to make sure that information is shared among the institutes, with him and his immediate staff, and so on. Information management is not easy, but it is very important. You need to speak with one voice. The Director of NIH cannot be saying something to the Congress that conflicts with what the Director of the Cancer Institute just said yesterday. By the same token, the Director of the Cancer Institute needs to know that the NIH policy decision made yesterday is such-and-such so that he doesn't tell his constituents something different. If managers are not given the information they need to manage properly, it gives you a very bad reputation with the outside world — you look like you don't know what you are doing.

QM: *Does the External Authorities Workgroup differ from other task forces or committees you have served on in the past?*

Ms. O'Steen: I'm not sure I've been a part of very many groups of people who are willing to take a look at the way they do business at such a basic level and say, "Let's decide what we're doing wrong and go about changing it." I think IHS deserves a great deal of credit for taking that kind of a frank approach.

And these are broad problems. It's a lot easier to tackle some discrete piece that somebody thinks needs fixing. There's a real receptivity at IHS to figuring out what it is that's broken and how to go about fixing it on a very broad scale. That's different.

And certainly the members of the Workgroup are all very committed to this, and I think that's unusual, too. I have not often been part of such a cohesive group, with everyone committed to getting on with it and looking at the sacred cows, the long established practices, and saying, "Just because this is the way we've done it is not good enough." Typically, there's a part of a group that is resistant and must be dragged along to the idea of any change. Not so with this workgroup.

QM: *To what would you attribute the success of your workgroup?*

Ms. O'Steen: It's a bit premature to say that we have been successful, but I do think that we will be. The key to success is top management's commitment to our implementation plans. And everything I've seen so far says that they are willing to do this. And it's tough for top managers to admit that there are problems and that they're going to bite the bullet to do what needs to be done to fix them. I'm convinced that IHS management really does want to do all of that.

Ms. Karen O'Steen

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The other reason I expect we'll be successful is the dedication and professionalism of the other members of the workgroup, all of whom are IHS employees.

QM: *Is there anything you would have done differently with this workgroup, or with the QM effort as a whole?*

Ms. O'Steen: One of the strengths of this workgroup is the caliber of the people involved. Clearly, very top-notch people were selected. The problem is that many of these people are called upon to be part of lots of groups, not just QM workgroups — they are extremely busy people. It's difficult to coordinate the efforts of such people when they are being pulled in different directions at once. So, I would try to find a way to free these people up more while they are serving on the workgroup.

I also think there should be more publicity regarding QM, among both IHS employees and the world outside IHS. Particularly among IHS employees, because these are the people who are going to have to implement and live with the changes. Every IHS employee needs to be well informed about what's going on and really feel ownership of the process.

QM: *QM is expected to have an impact on the managerial "culture" at IHS. From your experience with QM, what does that mean to you?*

Ms. O'Steen: One of the things our group has focused on is managerial accountability, and appropriately so. I'm not sure if IHS has managerial accountability now or not, but clearly the *perception* is that it does not. That is something that needs to change. Individual line managers, at all levels, have to be accountable for the quality and timeliness of their work, and they have to recognize the importance of communicating with the outside world about what they are doing. Again, the perception is almost as important as the work that you do. You can sabotage yourself if you are doing a good job but do not let others know in a timely and appropriate way.

QM: *How has participation on the workgroup affected you personally?*

Ms. O'Steen: It's been intellectually stimulating. It's made me think more about the bigger picture at NIH — about how NIH, or any organization, communicates with external authorities. And, there are great people on this workgroup, top-notch professionals with whom I have enjoyed working.

My experience has also taught me more about IHS. Until now, I had had very little to do with IHS, and the agency's reputation within the department has not always been the best. I now feel, however, that I am a salesperson for IHS. When I talk to people about what I'm doing in QM, I get really excited about the people I'm working with, and about the honest attempt by IHS to change its managerial culture, to deal with broad-based problems. That's very unusual among organizations.

