IHS Circular Exhibit 24-10-A

TEMPORARY CLOSURE DECISION MEMORANDUM TEMPLATE

TO: [IHS Director or Designee]

FROM: [Area Director,]

SUBJECT: Temporary Closure of [Facility Name, Area] located in [City, State] – DECISION

ISSUE

The purpose of this memorandum is to request or your review and approval of the temporary closure of [Facility Name, Area] located in [City, State]. [Include a brief description of the reason for the temporary closure.]

DISCUSSION

The following report supports the decision to temporarily close an Indian Health Service (IHS) facility or a portion thereof.

1. Facility Information:
   a. IHS Area:
   b. IHS Service Unit:
   c. IHS Facility:
   d. Portion of the facility (if applicable):

2. Basis for the Temporary Closure:
   a. Category (check all applicable)
      ☐ Environmental
      ☐ Medical
      ☐ Safety

   b. Risk assessment (documentation of risks and benefits of temporary closure). [Include support for whichever environmental, medical, or safety reasons were cited in question 3(a). The recommendation should include, at a minimum:
      - The basis for the recommended closure (i.e., environmental, medical, or safety factors, or some combination of reasons) and the explanation of the underlying facts;

- A Risk Assessment analysis weighing the risks of not closing the facility against the benefits of temporary closure;
- An analysis of the anticipated impact of the temporary closure on the community;
- Anticipated dates of closure;
- A list and description of internal and external notifications; and
- When applicable, recommendations for correction and timelines for correction, including an explanation of the underlying facts.

Attach additional documentation on risk assessment, preparations to notify external facilities, EMS matters, and any other applicable information as needed.

4. Applicable Dates:
   a. Date of the decision:
   b. Anticipated start date of the temporary closure:
   c. Anticipated end date of the temporary closure:

5. Notifications Provided to all Internal Partners (check all that apply):
   ☐ The facility's staff/employees
   ☐ The facility's clinical or medical director
   ☐ The facility's Governing Body
   ☐ The Area Director
   ☐ The Deputy Director for Quality Health Care
   ☐ The IHS Director or designee

6. Notifications Provided to External Parties (check all that apply):
   ☐ Tribal Leadership
   ☐ Tribal Health Board.
   ☐ Patients (Please provide a brief description of how patients have been notified or your plan for doing so.)
   ☐ Local Facilities (Please provide a list of nearby facilities that will likely be impacted (if applicable, based on anticipated time of closure) and, if possible, provide them adequate notice to prepare for any potential complexity and surge in volume to maintain patient safety. Attach full notification plan for an anticipated long-term temporary closure.)
   ☐ EMS Notification (Please provide a list of nearby EMS services that will likely be impacted (if applicable, based on anticipated time of closure) and, if possible, provide them adequate notice to prepare for any potential complexity and surge in volume to maintain patient safety. Attach full notification plan for an anticipated long-term temporary closure.)
   ☐ Accreditation organizations
   ☐ CMS
   ☐ Other (Please briefly describe the other parties who will be notified.)

RECOMMENDATION

To ensure the safety and quality of healthcare to our beneficiaries, I recommend the temporary closure of [Facility Name, Area] located in [City, State].

DECISION

Approved: _____ Disapproved: _____

[Signors Name]