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INDIAN HEALTH SERVICE

Improvements Needed in Credentialing Temporary Physicians

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The Honorable Edolphus Towns
Ranking Minority Member
Human Resources and Intergovernmental
Relations Subcommittee
Committee on Government Reform
and Oversight
House of Representatives

Dear Mr. Towns:

The Indian Health Service (IHS) provides medical care to over 1 million American Indians and Alaskan Natives. Over 60 percent of this population relies solely on IHS services. You expressed concern about access to health care and the quality of the services that this population receives. This report discusses our review of IHS' process to examine the qualifications of temporary physicians who provided services in two IHS facilities. In addition, the report discusses the types of medical services that IHS purchases from private hospitals and providers through the contract health services program and the extent to which care is deferred under this program.

As arranged with your office, unless you publicly announce its contents earlier, we will make no further distribution of this report until 30 days after the date of this letter. At that time, we will send copies to the Assistant Secretary for Health, U.S. Public Health Service, and the Director of IHS.

Please contact me at (202) 512-7101 if you or your staff have any questions. Major contributors to this report are listed in appendix VII.

Sincerely yours,

David P. Baine

David P. Baine
Director, Federal Health Care
Delivery Issues

Executive Summary

Purpose

Over 1 million American Indians and Alaskan Natives are eligible for federally funded health care. The Indian Health Service (IHS) is responsible for providing this care, but most of its facilities are small and historically have not been able to fully meet the demand for services. Furthermore, IHS facilities have had difficulty hiring and retaining medical staff. To cope with these problems, IHS fills physician staffing vacancies with short-term, temporary physicians called locum tenens who provide services in IHS facilities. When IHS facilities cannot provide certain medical care, IHS refers patients to non-IHS providers. Nevertheless, IHS has not had sufficient funds to pay for all the health care services that must be acquired from non-IHS providers and has delayed providing some care that is not considered urgent. As a result, concern has arisen about American Indians' and Alaskan Natives' access to health care and the quality of the medical services they receive.

The Ranking Minority Member of the Human Resources and Intergovernmental Relations Subcommittee, House Committee on Government Reform and Oversight,[1] asked GAO to determine (1) IHS' efforts to ensure that temporary physicians working in IHS facilities are qualified and competent to perform assigned duties and (2) what happens when requested medical services are delayed.

Background

IHS, an agency of the U.S. Public Health Service, Department of Health and Human Services (HHS), delivers medical services at no cost to American Indians and Alaskan Natives in 49 IHS and tribally operated hospitals and 465 outpatient facilities. In fiscal year 1994, IHS' budget was approximately $1.9 billion. IHS is headquartered in Rockville, Maryland, and has 12 area offices that are responsible for overseeing the delivery of health care by IHS service units (see app. I). IHS' goal is to raise the health status of American Indians and Alaskan Natives to the highest possible level. In fiscal year 1993, IHS facilities had over 69,000 inpatient admissions and over 5.5 million outpatient visits.

IHS has a history of being unable to recruit and retain physicians to staff its facilities. To supplement physician staff, IHS purchases the services of temporary physicians to provide medical care in its facilities. For 9 months of fiscal year 1993, IHS estimated that it spent $16.4 million for these services. GAO estimated that individual service units and area offices contracted for over 300 such physicians in fiscal year 1993.

[1]GAO received the request when the requester was the Chairman of the Subcommittee.

Most IHS hospitals cannot provide a full range of services, such as high-risk obstetrics, or specialized medical services, such as ophthalmology. Furthermore, IHS medical facilities are not equally available and accessible to all eligible individuals in all parts of the country. When no IHS facility is accessible or when specific services are not available from IHS facilities, American Indian and Alaskan Native patients may be referred to non-IHS providers under the contract health services program. In fiscal year 1993, the Congress appropriated $328 million for this program.[2] Some areas, such as California and Portland (which covers Oregon, Washington, and Idaho) have no IHS hospitals and refer all American Indians and Alaskan Natives to non-IHS hospitals for all inpatient services.

Results in Brief

IHS has unknowingly allowed temporary physicians with disciplinary actions taken against their licenses for offenses, such as gross and repeated malpractice and unprofessional conduct, to treat patients. As a result, these patients may have been placed at risk of receiving substandard care. IHS' credentials and privileges policy does not explicitly require verifying all active and inactive state medical licenses that a temporary physician may have.[3] Rather, the policy requires that a physician have a current medical license with no restrictions against it to practice medicine. Furthermore, most IHS facilities that have contracts with locum tenens companies do not require the companies to inform IHS of the status of all medical licenses a physician may hold. In addition, IHS facilities do not have a formal network to share information on the performance of temporary physicians who have worked within the IHS medical system. Therefore, IHS facilities are not always aware of temporary physicians who have had performance or disciplinary problems.

Because all types of health care services are not available in IHS facilities, IHS purchases specialized and other medical services from non-IHS providers through the contract health services program. Emergent and urgent care that IHS cannot directly provide is given first priority for funding under this program and requests for this care are generally funded. Other care is not always funded. For example, in fiscal year 1993, IHS deferred 70,540 requests for preventive, acute, and chronic care such as mammogram screening, specialty consultations in pediatrics, and care in skilled nursing facilities. Two IHS areas—Oklahoma and Navajo—accounted for 69 percent of these deferrals and IHS officials cited the lack of sufficient funding as the primary cause. Some of these patients

[2]The fiscal year 1994 appropriation was $350 million.

[3]A physician may have a medical license from more than one state to practice medicine.

may have received care from IHS or others after their initial deferral, but IHS does not have data readily available on the extent to which this occurred.

IHS is implementing staff reductions as required by the Federal Workforce Restructuring Act of 1994. An official in IHS' Office of Administration and Management believes that scheduled reductions in fiscal years 1995 and 1996 will not significantly affect either the delivery of medical services or the planned expansion programs if IHS' fiscal year 1996 appropriation is not reduced. However, he is concerned about how scheduled staff reductions in fiscal year 1997 and beyond may affect the delivery of medical services and IHS' plans to staff new facilities scheduled to open after fiscal year 1996.

Principal Findings

More Complete Information on Past Performance Is Needed Before Temporary Physicians Treat Patients

IHS relies on temporary physicians to fill vacancies at its various facilities. It also relies on the companies that provide IHS with these physicians under contract to inform IHS of those who had performance or disciplinary problems. However, neither IHS' policy nor most of its contracts with locum tenens companies explicitly requires that an examination be done of all medical licenses a temporary physician may have before the physician is allowed to treat IHS patients. Furthermore, the contracts do not require that locum tenens companies provide IHS with all the information they may have on all licenses a physician may hold. Rather, IHS requires only that a physician have a medical license without restrictions to practice medicine. Because of this, IHS has unknowingly allowed temporary physicians with past performance and disciplinary problems to treat patients. In fiscal year 1993, 5 companies supplied 50 temporary physicians to the 2 facilities we visited. We reviewed the credentials files of 21 of these physicians and found that 7 had prior histories of performance or disciplinary problems.

Funding and Staffing Limitations Reduce Availability of Medical Care

Generally, IHS health care facilities cannot meet all of the medical needs of the population they serve. To compensate, IHS purchases specialized and other medical services from non-IHS providers through its contract health services program. In fiscal year 1993, the Congress appropriated $328 million for this purpose and in fiscal year 1994, $350 million.

However, IHS officials said that these funds are about 75 percent of what is needed to provide the full spectrum of care requested by IHS patients. Thus, IHS developed a medical priority system to determine what care will be funded by contract health services. Emergent care, such as life-threatening injuries, is given the highest priority for funding. Other care, such as preventive and treatment for chronic conditions, is given a lower priority and is not always funded.

IHS funds most requests for emergent and urgent care, but other care is not always funded. In fiscal year 1993, IHS deferred 70,540 requests for preventive, acute, and chronic care such as screening mammograms, pediatric consultations, and care in skilled nursing facilities. Some of these patients may have received care from IHS or others after their initial deferral, but IHS does not have data readily available on the extent to which this occurred. Most of the deferred requests came from American Indians in the Oklahoma and Navajo areas, and the results of the deferrals took many forms. For example, over 16,000 Navajo area people did not receive eye examinations or eyeglasses because of insufficient contract health services funds. Furthermore, we found situations in which care was deferred until patients' conditions demanded immediate attention.

The Federal Workforce Restructuring Act of 1994 requires an overall reduction in executive agencies' full-time equivalent employee positions. HHS requested a waiver for IHS from the Office of Management and Budget (OMB) to defer or cancel the proposed staff reductions. OMB denied the waiver but agreed to give IHS time to implement staff reductions in such a way as to minimize the impact on IHS' delivery of medical services and its planned expansion program. Accordingly, IHS anticipates that it must reduce its workforce by over 1,300 positions by September 30, 1999. An official in IHS' Office of Administration and Management believes that scheduled reductions in fiscal years 1995 and 1996 will not affect either the delivery of medical services or planned expansion programs if IHS' fiscal year 1996 appropriation is not reduced. However, if IHS' appropriation is reduced, the demand for contract health services funds may increase because IHS facilities will have less capability to provide direct services. Moreover, this official is concerned that scheduled staff reductions in fiscal year 1997 and beyond could adversely affect the delivery of medical services and IHS' plans to staff its facilities. In fiscal year 1997, IHS plans to open and staff a large hospital in Anchorage, Alaska, to replace the old

hospital. Additionally, IHS must staff new or expanded services in eight other facilities.[4]

Recommendations

GAO recommends that the Assistant Secretary for Health, Public Health Service, ensure that the Director of IHS take the following actions:

- Revise IHS' credentials and privileges policy to explicitly state that the status of all state medical licenses, both active and inactive, be verified.
- Develop standard provisions to include in contracts with locum tenens companies that require a company to verify and inform IHS of the status of all state medical licenses, both active and inactive.
- Establish a system that will facilitate the dissemination of information among IHS facilities on the performance of temporary physicians who provide services to IHS.

Agency Comments

The U.S. Public Health Service, HHS, provided written comments on a draft of this report. It concurred with the report's findings and recommendations, and detailed the actions it will take to implement the recommendations. The agency's comments are evaluated in chapter 2 and included as appendix VI. The agency also provided technical comments that GAO incorporated, where appropriate, in the report.

[4]Shiprock Hospital, New Mexico; Kotzebue Hospital, Alaska; Harlem Health Center, Montana; White Earth Health Center, Minnesota; Pinon Health Center, Arizona; Second Mesa Health Center, Arizona; Winnebago Hospital, Nebraska; and Chief Gaul Youth Alcohol Treatment Center, South Dakota.

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Abbreviations

ENT	ear, nose, and throat
FSMB	Federation of State Medical Boards
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
IHS	Indian Health Service
JCAHO	Joint Commission on the Accreditation of Healthcare Organizations
OMB	Office of Management and Budget

Introduction

Over 1 million American Indians and Alaskan Natives are eligible for federally funded health care. The Indian Health Service (IHS), an agency of the U.S. Public Health Service, Department of Health and Human Services (HHS), serves as the principal federal agency for providing health care services to this population. IHS' goal is to raise the health status of American Indians and Alaskan Natives to the highest possible level. This is to be accomplished primarily through direct delivery of health care services and assisting tribes in developing and operating their own health care programs.

In fiscal year 1994, IHS operated with a budget of about $1.9 billion and was authorized 15,441 full-time equivalent employee positions. Of the total number of positions, about 60 percent or 9,400 are directly involved in the delivery of health care. This includes about 5,500 health care professionals, such as physicians,[5] nurses, and physical therapists. The remaining 40 percent is composed of administrative, technical, and management employees, some of whom administer the contract health services program.

Administratively, IHS is organized into 12 area offices with headquarters in Rockville, Maryland (see app. I). The area offices are responsible for overseeing the delivery of health care services to American Indians and Alaskan Natives by the 144 service units.[6] The service units are responsible for providing health care.

IHS provides direct health care services at no cost to eligible American Indians and Alaskan Natives in 41 hospitals and 114 outpatient facilities. Tribes and tribal groups operate another 8 hospitals and 351 outpatient facilities funded by IHS. IHS and tribally operated hospitals are generally small, with 80 percent of them having 50 or fewer beds. IHS' three largest hospitals are in Phoenix, Arizona; Gallup, New Mexico; and Anchorage, Alaska. The type and scope of direct health care services vary by facility and depend on the availability of staff, equipment, and financial resources. Most IHS and tribal hospitals do not provide nonprimary care services, such as cardiology, ophthalmology, and orthopedics. In fiscal year 1993, IHS facilities had a workload of over 69,000 inpatient admissions and 5.5 million outpatient visits.

[5]In fiscal year 1993, IHS identified 1,057 physician positions for funding.

[6]A service unit is the basic health care unit that delivers care; about 10 to 20 service units compose an IHS area.

Health care services that IHS cannot provide in its hospitals and outpatient facilities are purchased from the private sector through the contract health services program. In fiscal year 1993, the Congress appropriated $328 million for this program and in fiscal year 1994, $350 million. These funds are used to obtain care from non-IHS hospitals and providers for (1) patients needing medical services beyond the scope and capability of IHS hospitals and clinics or in emergency situations and (2) American Indians and Alaskan Natives living in IHS areas that do not have direct care medical services. To receive such funding, an individual must (1) be eligible for direct care from the IHS, (2) reside within a designated contract health services delivery area, and (3) be either a member of, or have close social and economic ties with, the tribe located on the reservation. However, some IHS areas, such as California and Portland (which covers Oregon, Washington, and Idaho), do not have any IHS hospitals and refer all American Indians and Alaskan Natives for all inpatient services to non-IHS facilities.

Contract health services funds are used to purchase medical services based on a priority system and specific authorization guidelines established by headquarters. The Congress annually appropriates funds for these services as a separate category within the IHS clinical services budget. IHS distributes these funds to area offices primarily based on past funding history. The area offices then distribute the funds to the service units.

IHS has historically had difficulty recruiting and retaining physicians to staff its hospitals and outpatient facilities. To compensate for physician shortages, IHS often contracts with companies that supply locum tenens physicians, who are temporary physicians hired to fill vacancies for a specific period of time. In addition, these physicians temporarily replace staff who are in training, sick, or on vacation. For 9 months of fiscal year 1993, IHS estimated that this service cost $16.4 million.

As U.S. citizens, American Indians and Alaskan Natives are eligible to participate in Medicare and Medicaid on the same basis as any other citizen.[7] In fiscal year 1993, third-party sources reimbursed IHS service units for more than $145 million for direct care services provided to this population. IHS policy requires that third-party payers be used before it will assume responsibility for payment of services rendered by non-IHS providers. Thus, American Indians and Alaskan Natives who receive health

[7]Of the 1.2 million American Indians and Alaskan Natives who used IHS within the last 3 years, about 3 percent had Medicare part A, 19 percent had Medicaid, and 18 percent had private insurance. Approximately 60 percent had no insurance and relied on IHS as their sole source of health care.

care under the contract health services program and who are eligible for Medicaid, Medicare, or have private insurance must first use these resources to pay for their medical care. IHS will assume responsibility, as funding permits, for any remaining balance for the care received.

Health care services provided by IHS to American Indians and Alaskan Natives are not a federal health care entitlement. Rather, the Health Care Improvement Act (25 U.S.C. 1602), which authorizes IHS to provide health care services to American Indians and Alaskan Natives, depends on appropriations from the Congress. Thus, IHS provides health care services only to the extent that funds and resources are made available.

American Indian and Alaskan Native leaders have consistently maintained that health care is part of the trust obligation the United States has with the Indian people and that IHS is responsible for providing for all of the health care needs of this population. Tribal leaders do not believe that IHS is providing this level of service and in 1994, during hearings on health care reform, brought this issue before the Congress. In those hearings, tribal leaders stated that they want assurance that their members will receive basic and adequate health care coverage. These leaders also said that if the health care problems of American Indians and Alaskan Natives are not addressed in their early stages of development, the result will be an increase in serious illnesses.

The health status of this population is worse than that of the general population. For example, the death rate from tuberculosis for American Indians and Alaskan Natives is six times higher than for other Americans and three times higher for diabetes. Furthermore, diabetes is now so prevalent that in many tribes 20 percent of the members have the disease. Diabetes can cause other medical problems, such as (1) eye complications that can lead to blindness, (2) kidney problems that may require dialysis or a kidney transplant to sustain life, and (3) vascular problems that can lead to amputation of a leg. However, these complications can be delayed or prevented with early diagnosis and appropriate treatment, usually by a specialist.

Objectives, Scope, and Methodology

Concerned about American Indians' and Alaskan Natives' access to health care and the quality of the medical services they receive, the Ranking Minority Member of the Human Resources and Intergovernmental Relations Subcommittee, House Committee on Government Reform and

Oversight,[8] asked us in April 1993 to review the quality of medical care received. In subsequent discussions with subcommittee staff, we agreed to focus our review on two areas:

- IHS' efforts to ensure that temporary physicians working in IHS facilities are qualified and competent to perform assigned duties, and
- what happens when requested medical services are delayed.

We performed work at IHS headquarters, the Oklahoma area office, and at Ada and Claremore, Oklahoma, IHS hospitals. We selected these sites because both hospitals indicated they had problems with temporary physicians. We selected the following companies for our review because they had contracts with the hospitals we visited: Harris, Kovacs, Alderman Locum Tenens, Inc., Atlanta, Georgia; Medical Doctor Associates, Norcross, Georgia; Jackson and Coker Locum Tenens, Inc., Atlanta, Georgia; and EmCare, Dallas, Texas.

To identify IHS facilities that used temporary physicians and determine the cost of their services, we surveyed IHS facilities (see app. II). To address the issue of how IHS ensures that temporary physicians working in IHS facilities are qualified and competent to perform the work assigned to them, we (1) reviewed IHS' policies and procedures for credentialing and privileging temporary physicians, (2) obtained and analyzed fiscal year 1993 contracts that IHS facilities had with locum tenens companies, (3) reviewed the credentials files of temporary physicians at two IHS hospitals, and (4) interviewed officials at four locum tenens companies that IHS had contracts with and discussed each company's policies and procedures for credentialing physicians. At the hospitals we visited, we reviewed minutes of 1993 meetings of quality assurance committees to determine whether the quality of care being provided by temporary physicians was ever questioned. When we identified problems, we reviewed the medical records of the patients involved and discussed the care with IHS staff physicians. We also interviewed an official of the Federation of State Medical Boards (FSMB) to discuss dissemination of physician performance and disciplinary information obtained from FSMB's data bank.

To determine what happened to patients who did not receive health care services at the time they were requested, we reviewed a list prepared by the hospitals of all denials and deferrals for fiscal year 1993 at the two hospitals we visited. From this list, we selected 20 files and tracked

[8]We received the request when the requester was the Chairman of the Subcommittee.

whether these patients eventually received care from either IHS or elsewhere and interviewed the IHS and non-IHS clinicians who provided this care. We also interviewed tribal leaders and health advocates from the Chickasaw and Choctaw Nations and the Sisseton-Wahpeton Sioux and Oglala Sioux Tribes; and interviewed Oklahoma, Navajo, and Aberdeen area office staff and non-IHS health care providers. We reviewed and analyzed documents related to their contract health services budgets, eligibility requirements for receipt of care, medical priorities for funding, and program operations. At IHS headquarters, we analyzed contract health services management reviews of selected area and service unit programs and interviewed IHS officials who were knowledgeable about the program.

We performed our work between April 1993 and October 1994 in accordance with generally accepted government auditing standards.

Chapter 2

More Complete Information on Past Performance Is Needed Before Temporary Physicians Treat Patients

IHS has a difficult time retaining enough qualified physicians. To help meet the constant need for physicians to fill vacancies at various facilities and to supplement current medical staff, IHS service units enter into contracts with private companies that supply temporary physicians, known as locum tenens physicians, who provide services in IHS facilities. However, neither IHS' policy nor most of its service units' contracts with locum tenens companies explicitly requires that an examination be done of all medical licenses that a temporary physician may have before deciding whether the physician is allowed to treat IHS patients. Furthermore, the contracts do not require that locum tenens companies provide IHS with all information they may have on all licenses a physician may hold.[9] Instead, IHS requires only that a physician have a medical license without restrictions to practice medicine. Furthermore, IHS' own credentialing review process for temporary physicians is often not done in a timely manner.[10] As a result, IHS has unknowingly allowed physicians with performance problems or disciplinary actions taken or pending against their licenses for offenses such as gross and repeated malpractice and unprofessional misconduct to work in IHS hospitals and treat patients. At the two IHS hospitals we visited, we found that 7 of the 50 temporary physicians referred to IHS had prior histories of performance or disciplinary problems. In some cases, IHS officials did not know of these problems when the hospital accepted the physician for work because of incomplete credentials information.

IHS does not have a formal system to help its facilities share information on the performance of temporary physicians. At one hospital, IHS officials concluded that a temporary physician misdiagnosed and inappropriately treated a patient, which may have contributed to the patient's death. The IHS facility notified the locum tenens company of the incident and told them that it did not want further services from this physician. However, the IHS facility took no action to alert other IHS facilities.

IHS Relies on Temporary Physicians to Fill Staffing Needs

IHS estimated that for 9 months of fiscal year 1993, it spent about $16.4 million on contracts with locum tenens companies.[11] We estimated that during fiscal year 1993 IHS obtained the services of more than 300 temporary physicians working in such areas as family practice, internal medicine, emergency room care, pediatrics, and obstetrics and

[9]A physician may have a medical license from more than one state to practice medicine.

[10]Credentialing involves the systematic review and primary source verification of the licenses, education, and training of all physicians seeking appointment in a medical facility.

[11]We obtained the $16.4 million cost figure for temporary physicians services from a 1993 IHS special study on the recruitment and retention of health care professionals.

gynecology.[12] These physicians were needed because of vacancies and short-term absences of physicians who were on vacation, in training, or sick. While facilities in each of IHS' 12 area offices use temporary physicians, 5 areas—Oklahoma, Aberdeen, Navajo, Phoenix, and Alaska—accounted for most of the funds expended for temporary physicians' services. Collectively, the 5 areas serve about 67 percent of IHS' user population and, as table 2.1 shows, accounted for 84 percent of the $16.4 million spent during fiscal year 1993 on temporary physicians' services as of July 1993.

Table 2.1: Expenditures for Temporary Physicians in Five Service Areas, 9 Months of Fiscal Year 1993

Area	Cost (millions)
Oklahoma	$5.0
Aberdeen	3.8
Navajo	2.0
Phoenix	1.6
Alaska	1.4
Total	**$13.8**

Source: IHS' Division of Health Professions Recruitment and Training.

IHS Contracts Do Not Always Require That Information Be Shared

IHS facilities generally do not include a requirement in their contracts with locum tenens companies to (1) verify all licenses that a physician may hold, (2) inform IHS of the status of all licenses, and (3) provide all performance and disciplinary data that they may have on a temporary physician.[13] Furthermore, IHS' credentials and privileges policy requires only that a physician have an active state medical license with no restrictions to practice medicine. As a result, IHS does not always obtain complete credentials information and is not always aware of temporary physicians with performance or disciplinary problems.

At the two locations we visited, 5 locum tenens companies provided 50 temporary physicians in fiscal year 1993. We reviewed the credential files of 21 of these physicians and found that 7 had prior performance or

[12]IHS has a nationwide contract with Project USA of the American Medical Association to obtain temporary physicians. Between January and November 1993, Project USA provided over 500 temporary physicians to IHS facilities. We did not include this contract in our study because we focused on contracts awarded by individual service units and area offices.

[13]States issue licenses to physicians authorizing them to practice medicine. If it is proven that a physician's performance was deficient or inappropriate, a state can impose sanctions, such as revoking or restricting a physician's license or placing the physician on probation.

disciplinary problems. This information had not been provided to the IHS facility that had contracted for each physician's services. IHS officials at these locations told us that they did not specifically request the companies to provide all available data because they were under the impression that the contracts with locum tenens companies require disclosure of performance and disciplinary information.

IHS contracts with locum tenens companies generally specify the length of time physician services are required; the type of specialty needed, such as emergency room physician; the diagnostic and procedural skills needed; and the minimum professional qualifications that a physician must meet. To determine whether a physician meets the minimum qualifications, contract terms also require that the locum tenens companies submit the following credentialing information to an IHS facility: (1) evidence that the physician has a medical degree, (2) a copy of the physician's current medical license, (3) evidence of liability insurance, (4) a signed IHS application for appointment to the medical staff, (5) a request for clinical privileges, and (6) a statement of health. Other minimum qualifications vary by IHS facility and by the type of specialty requested.

Locum tenens company officials told us that they will perform whatever physician verification of professional qualifications and requirements are necessary to meet the terms of the contract. But most IHS contracts do not (1) contain explicit requirements that locum tenens companies obtain and disclose information on actions taken against any medical licenses held by a physician or (2) require that locum tenens companies obtain and provide IHS with any information on ongoing or pending investigations involving temporary physicians.

Three of the four locum tenens companies we visited routinely use FSMB's disciplinary data bank to determine if any information has been reported on a physician's performance. The FSMB data bank provides historical information from all state medical licensing boards about whether a physician's medical license has action taken against it and the nature and date of the action. However, the FSMB data bank does not contain information on ongoing or pending investigations against a medical license. This information must be obtained from the individual state medical licensing boards, which all the locum tenens companies we visited contact to verify medical licenses.

Locum tenens companies query the FSMB data bank electronically and often receive results in a day. Thus, they quickly become aware of any

performance problems that a temporary physician had in the past. However, the FSMB contract with locum tenens companies precludes the companies from providing detailed information on a physician's performance to a third party, such as IHS. A company can, however, inform a third party that a physician had a performance or disciplinary action taken against a medical license. Thus, IHS can obtain an indication that a performance problem may exist if it asks for such information from a contractor. One of the IHS facilities that we visited does obtain this information. Because of prior problems that this facility encountered with temporary physicians and locum tenens companies, it contractually requires locum tenens companies to query FSMB and inform it as to whether a physician had performance or disciplinary action taken against a license.[14] Because temporary physicians do not always disclose complete information on their past performance, IHS officials at this facility believe that it is especially critical that they check the status of each medical license.

The following example shows the importance of checking all medical licenses that a physician may have.

At one IHS facility, a temporary physician worked as an internist from June 21 to July 15, 1993. The locum tenens company provided the hospital with a curriculum vitae on June 17, 1993. The physician's application for appointment to the medical staff at the IHS facility indicated that the physician was licensed to practice medicine in three states and that the physician was never censured or reprimanded by a licensing board. The locum tenens company provided copies of two state medical licenses. On June 21, 1993, the IHS credentialing official called the licensing board in one of these two states and learned that the physician's license was in good standing. Upon further review of the physician's curriculum vitae, the credentialing official noticed that the physician had practiced for 15 years in one of the three states where he was licensed. However, neither the company nor the physician had provided IHS with a copy of this license. The credentialing official contacted that state's medical licensing board on July 14, 1993, and learned that the physician had two actions taken against this license in April 1992. According to the state licensing board's report, the physician was fined $3,000 and ordered to attend 50 hours of continuing medical education for failure to keep written medical records justifying the course of treatment of a patient, altering medical

[14]The U.S. Public Health Service used to centrally query FSMB every 2 weeks to obtain information about full-time physicians for IHS. It took about 2 to 4 weeks to receive results because the Public Health Service did not query electronically. As of March 1, 1995, the Public Health Service no longer performs this function. IHS is considering options to institute a new process.

records, and failing to practice medicine with an acceptable level of care, skill, and treatment in properly diagnosing a patient's heart condition. The physician left the IHS facility after his contractual obligation ended on July 15, 1993.

IHS Does Not Always Verify Temporary Physicians' Credentials in a Timely Manner

The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) requires all entities that seek accreditation to perform a credentialing review on each physician it employs. This requirement is designed to protect a patient from being treated by an unqualified or incompetent physician. IHS follows JCAHO's accrediting requirements and requires each of its facilities to conduct a credentials review that consists of (1) verifying with a state medical licensing board that a physician has an active, unrestricted medical license; (2) verifying training with the medical school, internship, or residency program, and professional affiliations, such as board certification; (3) obtaining information to evaluate the physician's suitability for appointment to the medical staff, such as explanations of past performance problems, disciplinary actions taken against a physician's license, or malpractice suits that involved the physician; (4) checking with references to verify clinical competence, judgment, character, and ability to get along with people; and (5) obtaining information on physical and mental health status.

IHS procedures also require that a physician's credentials be verified before the physician is allowed to provide medical services to a patient. However, if time does not permit a full credentialing review before a physician reports for duty, an IHS facility director can grant temporary privileges to practice medicine. The decision to grant temporary privileges to a physician is based on the clinical director's review and approval of the physician's application for appointment to the medical staff and his or her request for clinical privileges. But the credentialing official is still expected to perform a full review of a physician's credentials.

IHS credentialing officials told us that sometimes they cannot conduct a full credentials review before a temporary physician treats patients because of the short period between the time when an IHS facility contracts for physician services and the time when a physician reports to the facility. As a result, a temporary physician can treat patients and leave a facility before a complete credentials review has been performed. An incomplete credentialing process can result in a health care facility unknowingly allowing an incompetent physician to provide medical care to patients, thereby placing the facility and patients at risk.

The short time frames were evident in the 43 contracts we reviewed; 37 were awarded less than 2 weeks before the facility acquired physician services,[15] not enough time for a facility to confirm credentials information before a temporary physician begins work. Furthermore, temporary physicians often perform work and are gone before the credentials check is completed. The credentials check can take 30 days to complete. The average time from when a contract was awarded to the date services began was 7 days. The length of time IHS facilities needed the services of temporary physicians varied, with many periods of service ranging from 21 to 32 days. In addition, locum tenens companies often use more than one physician to fulfill a contract. For example, a company sent 10 different temporary physicians to staff 1 position for 1 month. When multiple physicians are used to fulfill a contract, credentialing becomes an even more time-consuming and complicated process.

IHS Service Units Do Not Share Information on Performance of Temporary Physicians

An official from one locum tenens company told us that temporary physicians tend to be transient and fall into one of three categories: (1) new physicians who do not know where they want to practice medicine and want to explore different settings before starting a practice, (2) physicians over 40 years old who no longer want to maintain a private practice and want to travel to different locations, and (3) physicians with performance or disciplinary problems who move from place to place to escape detection. Physicians in the latter category are identified primarily through state medical licensing boards although not all performance problems are reported to the boards.

At present, IHS facilities do not have a formal mechanism to share information on the performance of temporary physicians who have worked in the IHS system. As a result, a poorly performing physician can move from one IHS location to another with little chance of being detected. The importance of sharing information among IHS facilities is highlighted by the following example.

A temporary physician examined a patient in the emergency room. The patient was complaining of chest and abdominal pain that the physician diagnosed as constipation. He prescribed a laxative for the patient and sent him home. The patient returned to the emergency room about an hour later saying his pain had worsened. The temporary physician reexamined him, reaffirmed the diagnosis of constipation, and told him to go home

[15]We reviewed 71 contracts but only 43 contained information on the length of time physician services were requested and the date the contract was approved.

again. However, the emergency room nursing supervisor noticed from the patient's medical chart that he had a history of heart disease and that his condition had deteriorated since his first visit. Therefore, she ordered an electrocardiogram[16] be performed on the patient and notified the full-time IHS internal medicine physician of the patient's condition. The IHS staff physician ordered that the patient be admitted to the intensive care unit to determine whether the patient was having a heart attack. The nurse admitted the patient immediately, but he died of a cardiac arrest 15 minutes after being admitted.

The IHS facility's chief of the emergency department deemed that the care this physician provided was unacceptable and informed the locum tenens company of his performance problems. The company removed the physician from its active list of applicants. However, the IHS facility did not inform other facilities of this individual's performance. As a result, the physician could find work at another IHS facility under contract with a different locum tenens company.

Conclusions

American Indian and Alaskan Native patients should have reasonable assurance that every physician who treats them in an IHS facility is qualified to do so. Thus, except for emergencies, we do not believe that IHS should allow physicians to work within the IHS system until a complete examination of all medical licenses has been performed and IHS service unit officials are informed of the results. Furthermore, locum tenens companies under contract with IHS need to be required to provide all information they have available to them on a temporary physician that could potentially adversely affect the care provided to patients. Current IHS policy does not explicitly require that all medical licenses be verified. However, a review of all medical licenses can reduce the risk of patients receiving substandard care from temporary physicians who may have had prior performance problems.

IHS facilities can benefit from sharing information about the performance of temporary physicians. Better communication among facilities is needed to identify and track temporary physicians' performance, both good and bad, while working with IHS. Such an information sharing network would be of substantial benefit to IHS personnel responsible for conducting credentialing checks and could reduce duplicative credentialing checks.

[16]An electrocardiogram is a graphic record of the electrical impulses generated by the heart.

Recommendations

We recommend that the Assistant Secretary for Health, Public Health Service, ensure that the Director of IHS take the following actions:

- Revise IHS' credentials and privileges policy to explicitly state that the status of all state medical licenses, both active and inactive, be verified.
- Develop standard provisions to include in contracts with locum tenens companies that require a company to verify and inform IHS of the status of all state medical licenses, both active and inactive.
- Establish a system that will facilitate the dissemination of information among IHS facilities on the performance of temporary physicians who provide services in IHS.

Agency Comments and Our Evaluation

In commenting on a draft of this report, the U.S. Public Health Service agreed with our findings and recommendations. Its response is reprinted in appendix VI. The Public Health Service stated that IHS plans to revise its policy on personal services contracts to make it consistent with its policy guidance on the credentials and privileges review process of medical staff. This revision will require the verification of all medical licenses, both active and inactive, for all physicians—including temporary physicians whether hired directly by IHS or through locum tenens companies. The policy guidance on personal services contracts will also be revised to require locum tenens companies to verify and inform IHS of adverse actions taken on all medical licenses. In addition, IHS is developing an electronic bulletin board to share personnel information among area offices and services units. The bulletin board will include a component on credentialing activities, such as performance information on temporary physicians.

The Public Health Service also pointed out that in verifying state medical licenses, many states will not release information on matters under investigation. While this may be true in general, many state medical licensing boards will disclose whether an investigation is being conducted on a particular physician. If state boards are queried, the clinical director of the IHS facility can be alerted that a problem may exist and that follow-up with the physician in question may be warranted.

Funding and Staffing Limitations Reduce Availability of Medical Care

IHS facilities cannot meet all of the health care needs of American Indians and Alaskan Natives. Recognizing this, the Congress annually appropriates funds for care to be administered by non-IHS providers under contract with IHS. But the funds cover only 75 percent of the need for these services. Because of the limited funds, IHS prioritizes the care that it will pay for. The result is reduced access to contract medical services for American Indians and Alaskan Natives. In fiscal year 1993, IHS denied or deferred 82,675 requests for contract medical services.

IHS is now implementing staff reductions as required by the Federal Workforce Restructuring Act of 1994. An official in IHS' Office of Administration and Management does not believe that these reductions will significantly affect either the delivery of medical services or planned expansion programs in fiscal years 1995 and 1996 if IHS' appropriation for fiscal year 1996 is not reduced and medical services can be purchased through contracts with health care providers. However, he is concerned about how scheduled staff reductions after fiscal year 1996 may affect IHS' delivery of medical services and its expansion program.

IHS Facilities Cannot Provide All Needed Medical Services

Few IHS service units are able to provide a full range of medical services to American Indians and Alaskan Natives. Thus, IHS utilizes non-IHS providers to deliver services that cannot be provided in-house. This is done with contract health services funds. For example, only 4 of IHS' 144 service units have hospitals that are equipped and staffed to provide comprehensive medical services such as intensive care, inpatient surgery, high-risk obstetrics, and specialty medical services such as ophthalmology (see apps. III and IV for sizes of hospitals). Forty-five service units have inpatient hospitals that do not provide a full range of medical services, such as inpatient surgical services and obstetrical deliveries. Eighty-four service units have no inpatient IHS hospital and provide services at outpatient facilities. And 11 service units have no IHS medical facilities at all.

Contract Health Services Funds Used to Purchase Care From Non-IHS Providers

IHS distributes contract health services funds among its 12 area offices based primarily on the level of funding that the area received in previous years. This system of allocating funds does not take into account current data on the number of American Indians and Alaskan Natives in each area who rely on IHS for health care services, the health care needs of the population, or the health care services available within each area.[17]

In fiscal years 1991 and 1992, appropriations for contract health services increased about 6 percent each year. However, an IHS official told us that the cost for contract health services rose over 11 percent from 1991 to 1992. Furthermore, according to IHS, the total funds available for contract health services covered only 75 percent of the need for this type of service. Table 3.1 shows the amount of contract health services funds available to area offices and the eligible population of each area for fiscal year 1993.

Table 3.1: Contract Health Services Allocations and Eligible Population by Area for Fiscal Year 1993

Area office	Contract health services allocation	Eligible population
Aberdeen	$39,361,501	90,614
Alaska	36,094,377	65,235
Albuquerque	17,339,950	75,525
Bemidji	17,164,300	79,926
Billings	29,118,470	53,084
California	6,582,644	49,633
Nashville	13,737,538	41,812
Navajo	39,564,507	124,550
Oklahoma	42,005,083	349,587
Phoenix	29,489,800	127,048
Portland	34,045,882	82,939
Tucson	7,643,200	15,479
Total	**$312,147,252[a]**	**1,155,432**

[a]The total of $312,147,252 does not include an allocation of $5,952,718 for IHS headquarters.

Source: IHS Contract Health Services Office.

[17]In a February 1991 report, we addressed requiring IHS to distribute its funds based on different methods, such as those methods that give greater weight to the measures of need. However, IHS has encountered strong opposition to a new method and consequently has had limited success in redistributing funds. See Indian Health Service: Funding Based on Historical Patterns, Not Need (GAO/HRD-91-5, Feb. 21, 1991).

Needed Outside Medical Services Are Not Always Provided in a Timely Manner

IHS has developed medical priorities guidelines that are used by all facilities to determine what care will receive the highest priority for available contract health services funds (see app. V). Emergent and urgent care—such as emergency room care, life-threatening injuries, obstetrical deliveries, and neonatal care—is given the highest priority for funding and is generally funded. However, other care is given a lesser priority and is not always funded. Preventive care, such as screening mammograms, is next on the priority list. Third on the priority list are primary and secondary care services, such as specialty consultations in pediatrics and orthopedics. The lowest priority is for chronic tertiary and extended care services, such as skilled nursing facility and rehabilitation care.

Using medical priority guidelines, IHS service units denied or deferred 82,675 requests for contract health services in fiscal year 1993.[18] This represents a 76 percent increase over denials and deferrals reported in fiscal year 1990. A request for funding is denied when the patient's care does not fall within the medical priorities for which funds are available and the patient informs the contract health services staff that he or she intends to obtain medical care regardless of whether IHS will pay for it. If the medical care does not fall within medical priorities and a patient is willing to wait until funding may become available, the care is deferred. Of the 70,540 requests that were deferred, 43 percent were for preventive care, such as eye examinations. The remaining deferrals were for acute and chronic primary, secondary, and tertiary care, such as coronary bypass surgery and hip replacement surgery. Some of the patients whose initial requests were deferred may have ultimately received care from IHS or others, but IHS does not have data readily available on the extent to which this has occurred.

The following is an example of a case where the patient requested funding for medical care from the contract health services program, but had her request deferred because her condition was not of a sufficiently high priority to receive immediate funding. As a result, care was delayed for 6 months until the patient's condition deteriorated to the point where the problem was critical and immediate care was required.

The 73-year-old woman was diagnosed with severe circulatory problems in her left leg in January 1993 at an IHS hospital. The physician assistant who saw the patient thought she should be referred to a vascular surgeon in the community for surgical treatment. The physician assistant did not believe that the patient was in immediate danger, that is, was not in danger of

[18]As of December 1994, no data were available for fiscal year 1994.

losing her leg within 48 hours. However, he did believe that care was needed to prevent further deterioration. This case was presented to the hospital's contract health services committee on January 25, 1993, to determine whether her care was a high enough priority to be funded. Contract health services staff deferred her care because the funds available only allowed the service unit to treat the more seriously ill patients with more urgent medical conditions than hers. Although the woman was covered by Medicare, she could not afford to pay the $338 that Medicare would not cover. Had she been able to pay the $338, she could have received immediate care from a non-IHS provider.

Once a month for the next 6 months, the patient returned to the IHS hospital clinic for care. After each visit, her case was referred to the contract health services committee and her care was deferred each time because it did not fall within medical priorities. In July 1993, the patient's referral was approved by contract health services because her condition had deteriorated to such an extent that she was in immediate danger of losing her left leg. IHS contract health services funds then paid the costs not covered by Medicare that the patient could not afford to pay.

Table 3.2 shows the number of cases that were denied and deferred in fiscal year 1993 by area office. IHS officials stated that the number of deferrals and denials only document part of the unmet need. Deferrals and denials only track those who have requested services. There is no way to track the number of American Indians and Alaskan Natives who do not use the IHS system because they know that their care will be deferred.

Table 3.2: Denials/Deferrals by Area for Care Not Within Medical Priority, Fiscal Year 1993

	Denials	Deferrals			
IHS area office	Care not within medical priority	Preventive	Acute and chronic primary and secondary care	Acute and chronic tertiary care	Total
Aberdeen	846	2,155	5,821	29	8,005
Alaska	359	2,138	1,984	115	4,237
Albuquerque	301	168	493	25	686
Bemidji	197	385	1,976	18	2,379
Billings	50	37	285	7	329
California	331	162	389	6	557
Nashville	313	835	635	13	1,483
Navajo	2,695	19,037	10,142	2	29,181
Oklahoma	6,261	2,818	15,491	189	18,498
Phoenix	377	431	371	2	804
Portland	404	1,970	2,084	56	4,110
Tucson	1	3	267	1	271
Total	**12,135**	**30,139**	**39,938**	**463**	**70,540**

Note: IHS does not track denied care by type of care, such as preventive or primary care.

Source: IHS Contract Health Services Office.

The Navajo and Oklahoma areas accounted for 69 percent of the total denials and deferrals in fiscal year 1993. These areas have 13 IHS hospitals ranging in size from 11 to 107 beds and 49 outpatient facilities that provide medical services to approximately 488,395 American Indians. This represents about 41 percent of all American Indians and Alaskan Natives who have used IHS services within the last 3 years. The hospitals and outpatient facilities in these areas do not have the staff or equipment to provide all of the health care services needed. As a result, contract health services funds are being relied upon to provide care that IHS does not have the capacity to provide. But if the care needed is not a high priority, it does not get funded. For example, in fiscal year 1993 in the Navajo area, 16,503 requests for eye examinations or eyeglasses were not funded because of insufficient contract health services funds.

Officials in both area offices told the Public Health Service that they need more funds to meet the needs of their populations. IHS has requested increased funding for the contract health services program, but HHS has not approved the level of increases that IHS has requested. Furthermore,

the dollars available for health services to all areas are limited and any increase in funds to one IHS area would likely result in a decrease in funds to another IHS area.

Staff Reductions Could Increase Demands on Contract Health Services Program

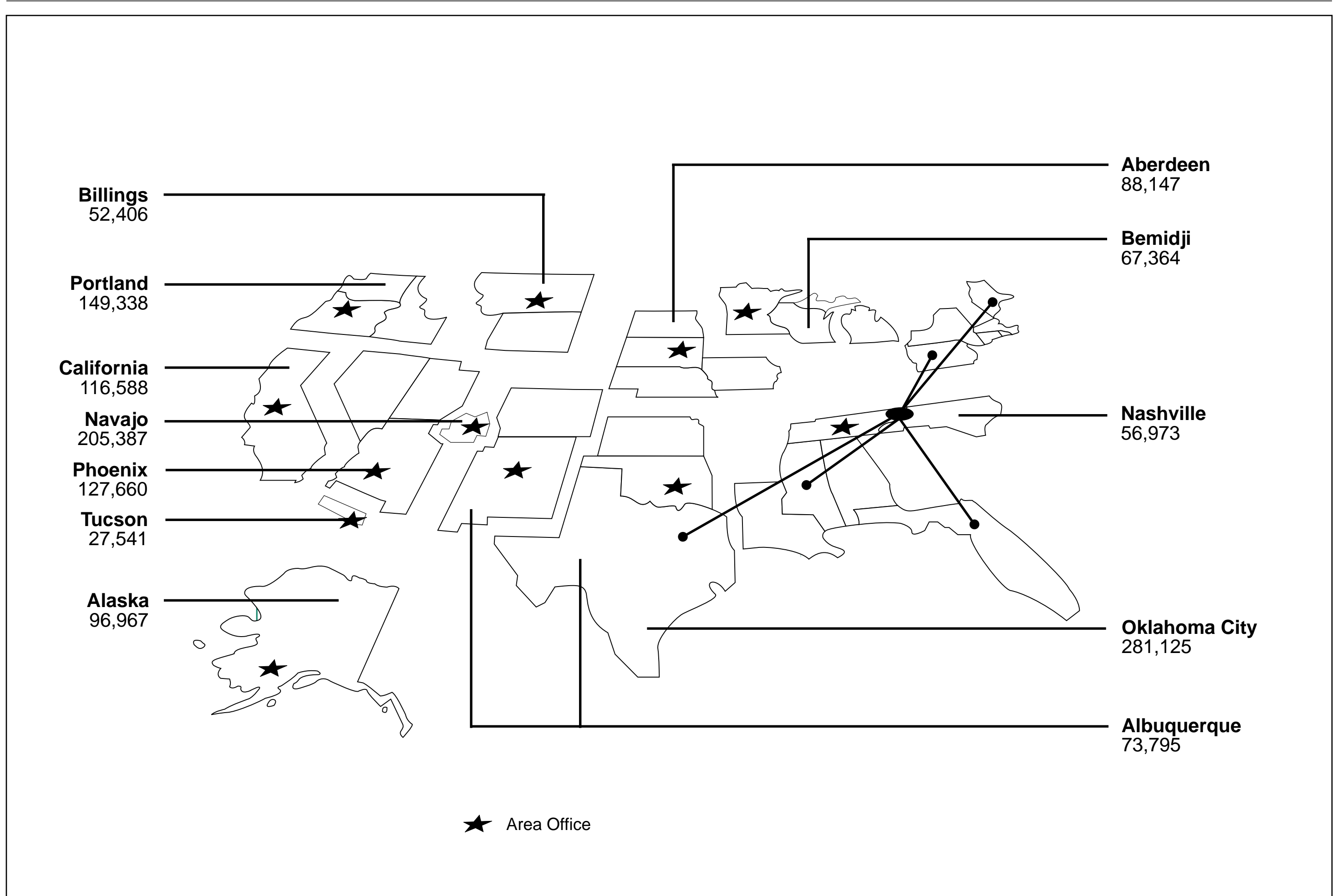
The Federal Workforce Restructuring Act of 1994 requires executive agencies to reduce staff. In a September 1994 meeting with the Office of Management and Budget (OMB), the Secretary of HHS requested a waiver of this requirement for IHS. The Secretary stated that IHS needed time to plan and implement a restructuring program that would consolidate some of IHS' area offices to reduce IHS' workforce without drastically affecting delivery of health services. OMB did not approve the waiver but did agree to give IHS time to implement staff reductions in a way to minimize the impact on IHS' delivery of medical services and its planned expansion program.

IHS has 15,425 staff for fiscal year 1995.[19] Beginning in fiscal year 1996, this number will decrease annually until a staffing level of 14,083 is reached in fiscal year 1999. An official in IHS' Office of Administration and Management told us that when supplemented by contract physicians, IHS' staffing levels in fiscal years 1995 and 1996 will be adequate to meet the staffing requirements of both its current health facilities and those that are scheduled to open in these years. However, in his opinion, if IHS' fiscal year 1996 appropriation is reduced, the agency will not be able to adequately staff its present facilities and the new facilities scheduled to open in fiscal years 1995 and 1996. If the agency is not able to adequately staff its new facilities, it will be unable to provide services such as physical therapy, respiratory therapy, radiology, optometry, and community health services, according to IHS officials. These services will have to be sought from non-IHS providers in the community with contract health services funds. As a result, more medical services could be denied and deferred.

This official also told us that he is concerned that the staffing reductions in fiscal year 1997 and beyond could affect IHS' delivery of medical services and its planned expansion program. In fiscal year 1997, IHS plans to open and staff a large medical center in Anchorage, Alaska, to replace its old hospital. Additionally, IHS must staff new or expanded services in eight other facilities.

[19]An IHS official told us that for the agency to meet the requirements of the Federal Workforce Restructuring Act, IHS' staffing target for fiscal year 1995 was 14,327. However, OMB and HHS approved 1,098 additional staff for IHS. Therefore, IHS' authorized full-time equivalent employee level is now 15,425.

IHS Area Offices and Service Populations



Note: Texas is administrated by Nashville, Oklahoma City, and Albuquerque.

GAO Methodology on Use and Cost of Temporary Physicians

IHS does not routinely collect data on the extent or cost of temporary physicians in its facilities. To obtain this information, we developed a questionnaire to collect 1993 information on (1) the number of IHS hospitals that use temporary physicians, (2) the number of temporary physicians used and their specialties, (3) the cost of using temporary physicians, (4) whether the facility experienced problems in obtaining credentials information, and (5) whether the facility had problems with the medical care provided by temporary physicians. IHS headquarters sent our questionnaire to its 12 area offices. The area offices sent the questionnaire to all facilities in their areas, about 500 facilities. We concentrated on the responses received from IHS hospitals because our primary focus was on inpatient care.

Of the 49 IHS hospitals, 22 hospitals responded to our survey. Of those responses, 12 hospitals indicated that they either experienced a problem in obtaining credentials information from a locum tenens company or had problems with a temporary physician. Collectively, the 22 hospitals had 71 contracts with locum tenens companies. At 12 hospitals that identified problems, the problems occurred across 16 contracts and involved issues such as questionable competency of a temporary physician. We visited two of these hospitals.

One IHS hospital we visited had contracts with 10 locum tenens companies and had identified problems with temporary physicians supplied by 2 companies. Together, the 2 companies provided 37 temporary physicians to this hospital. On our survey, the hospital noted that it had problems obtaining credentials information from these companies and also had problems with some of the temporary physicians provided. However, the hospital did not specifically identify the physicians involved. Therefore, we randomly selected for review the credentials files of 17 temporary physicians at this hospital. The credentials files contained limited information and no information on physician performance. We also reviewed the minutes of the hospital's quality assurance meetings from 1993. During our review of these minutes, we found references to problems with patient care, such as misdiagnosis and inappropriate treatment, given by 5 of the 17 temporary physicians. We do not know whether the other 12 temporary physicians had problems with patient care, but we did not identify any problems through the quality assurance minutes.

The second IHS hospital we visited had contracts with three locum tenens companies and had identified problems with physicians from two of these

companies. The hospital's survey indicated that the 2 companies provided 13 physicians and noted problems in obtaining credentials information on 4 physicians. We reviewed the credentials files of nine physicians including the four physicians noted to have problems. In the files of the four physicians noted to have problems was information that indicated three physicians had histories of performance and disciplinary problems. We reviewed the hospital's 1993 quality assurance committee minutes and did not find any references to the care provided by temporary physicians.

Size of IHS Hospitals, Fiscal Year 1993

Hospitals by area	Beds available
Aberdeen area	
Belcourt, ND	42
Eagle Butte, SD	27
Fort Yates, ND	16
Pine Ridge, SD	46
Rapid City, SD	32
Rosebud, SD	35
Sisseton, SD	18
Wagner, SD[a]	•
Winnebago, NB	30
Alaska area	
Anchorage, AK	143
Barrow, AK	15
Albuquerque area	
Acoma-Laguna, NM	25
Albuquerque, NM	28
Mescalero, NM	13
Santa Fe, NM	39
Zuni, NM	37
Bemidji area	
Cass Lake, MN	13
Red Lake, MN	23
Billings area	
Browning, MT	27
Crow Agency, MT	34
Harlem, MT	16
Nashville area	
Cherokee, NC	29
Navajo area	
Chinle, AZ	60
Crownpoint, NM	39
Fort Defiance, AZ	49
Gallup, NM	107
Shiprock, NM	50
Tuba City, AZ	85

(continued)

Hospitals by area	Beds available
Oklahoma area	
Carl Albert, OK	53
Claremore, OK	50
Clinton, OK	11
Lawton, OK	42
W.W. Hastings, OK	60
Phoenix area	
Ft. Yuma, CA	17
Hu-Hu-Kam, AZ	10
Keams Canyon, AZ	18
Owyhee, NV	15
Parker, AZ	20
Phoenix, AZ	142
San Carlos, AZ	8
Whiteriver, AZ	45
Tucson area	
Sells, AZ	34

[a]Wagner discontinued inpatient services November 16, 1992.

Size of Tribally Operated Hospitals, Fiscal Year 1993

Hospitals by area	Beds available
Alaska area	
Kanakanak, AK	16
Maniilaq, AK	25
Mount Edgecumbe, AK	78
Norton Sound, AK	14
Y-K-D, Bethel, AK	50
Nashville area	
Choctaw, MS	37
Oklahoma area	
Creek Nation, OK	34
Choctaw Nation, OK	52

IHS Medical Priorities Guidelines for the Authorization of Payment for Contract Health Services Medical Care

The following was excerpted from a July 16, 1993, IHS memo from Michel E. Lincoln, Acting Director, Indian Health Service.

I. Emergent/Acutely Urgent Care Services

Definition: Diagnostic or therapeutic services which are necessary to prevent the immediate death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible health care available and capable of furnishing such services. Diagnosis and treatment of injuries or medical conditions that, if left untreated, would result in uncertain but potentially grave outcomes. Categories of services include (random order):

- emergency room care for emergent/urgent medical conditions, surgical conditions or acute trauma
- emergency inpatient care for emergent/urgent medical conditions, surgical conditions or acute injury
- renal dialysis, acute and chronic
- emergency psychiatric care involving suicidal persons or those who are a serious threat to themselves or others
- services and procedures necessary for the evaluation of potentially life-threatening illnesses or conditions
- obstetrical deliveries and acute perinatal care
- neonatal care.

II. Preventive Care Services

Definition: Primary health care that is aimed at the prevention of disease or disability. This includes services proven effective in avoiding the occurrence of a disease (primary prevention) and services proven effective in mitigating the consequences of an illness or condition (secondary prevention). Level II services are available at most Indian Health Service facilities. Categories of services include (random order):

- routine prenatal care
- non-urgent preventive ambulatory care (primary prevention)
- screening for known disease entities (secondary prevention)
- screening mammograms
- public health intervention.

III. Primary and Secondary Care Services

Definition: Inpatient and outpatient care services that involve the treatment of prevalent illnesses or conditions that have a significant impact on morbidity and mortality. This involves treatment for conditions that may be delayed without progressive loss of function or risk of life, limb or senses. It includes services that may not be available at many Indian Health Service facilities and/or may require specialty consultation. Categories of services include (random order):

- scheduled ambulatory services for non-emergent conditions
- specialty consultations in surgery, medicine, obstetrics, gynecology, pediatrics, ophthalmology, ENT [ear, nose, and throat] orthopedics, dermatology
- elective, routine surgeries that have a significant impact on morbidity and mortality
- diagnostic evaluations for non-acute conditions
- specialized medications not available at Indian Health Service facilities, when no suitable alternative exists.

IV. Chronic Tertiary and Extended Care Services

Definition: Inpatient and outpatient care services that (1) are not essential for initial/emergent diagnosis or therapy, (2) have less impact on mortality than morbidity, or (3) are high cost, are elective, and often require tertiary care facilities. These services are not readily available from direct care Indian Health Service facilities. Careful case management by the service unit contract health services' committee is a requirement, as is monitoring by the Area Chief Medical Officer, or his/her designee. Depending on cost, the referral may require concurrence by the Chief Medical Officer. Categories of services include (random order):

- rehabilitation care
- skilled nursing home care
- highly specialized medical services/procedures
- restorative orthopedic and plastic surgery
- other specialized elective surgery such as obesity surgery, elective open cardiac surgery
- organ transplantation (HCFA [Health Care Financing Administration] approved organs only)
- care provided under the direction of an advance directive.

V. Excluded Services

Definition: Services and procedures that are considered purely cosmetic in nature, experimental or investigational, or have no proven medical benefit.

Cosmetic procedures: Payment for certain cosmetic procedures may be authorized if these services are necessary for proper mechanical function or psychological reasons. Approval from the Chief Medical Officer is required.

Experimental and other excluded services: Payment is not authorized, unless a formal exception is granted by the Office of Health Programs.

The list of therapies and procedures classified as potentially cosmetic in nature, experimental, or excluded will be reviewed and updated on an annual basis. Categories of excluded services:

- all purely cosmetic (not reconstructive) plastic surgery
- procedures listed as experimental by HCFA
- procedures for which there is no proven medical benefit—procedures listed as “Not Covered” in the Medicare Coverage Issuance Manual, Section 27,200
- extended care nursing homes (intermediate or custodial care)
- alternate medical care (e.g., homeopathy, acupuncture, chemical endarterectomy, natureopathy).

Comments From the U.S. Public Health Service

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

MAR - 6 1995

Mr. David P. Baine
Director, Federal Health Care
Delivery Issues
U.S. General Accounting Office
441 G. Street, N.W.
Washington, D.C. 20548

Dear Mr. Baine:

Enclosed are the Public Health Service's comments on your draft report, "Indian Health Service: Improvements Needed in Credentialing Temporary Physicians." The comments represent the tentative position of the Public Health Service and are subject to reevaluation when the final version of this report is received.

The Public Health Service appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

Philip R. Lee, M.D.
Assistant Secretary for Health

Enclosure

COMMENTS OF THE PUBLIC HEALTH SERVICE ON THE GENERAL ACCOUNTING OFFICE DRAFT REPORT "INDIAN HEALTH SERVICE: IMPROVEMENTS NEEDED IN CREDENTIALING TEMPORARY PHYSICIANS," FEBRUARY 1995

General Comments

The Public Health Service (PHS) has reviewed the General Accounting Office (GAO) draft report and is in agreement with the draft report's findings and recommendations.

Primary verification of physicians' credentials is a lengthy process, requiring from 4 to 6 weeks, and it is often difficult to complete full verification in advance of a temporary (locum tenens) physician providing medical care, especially when his or her services are needed urgently. It may be even more difficult and take longer to verify the status of multiple State licenses and/or inactive licenses. In addition, many (if not most) States will not release information on pending adverse actions that are still under investigation.

Although verification of licensure is a required part of the Indian Health Service (IHS) credentials review process, IHS policy does not explicitly state that all licenses held by the applicant must be verified as current and unrestricted. This is because the U.S. Office of Personnel Management and the PHS require only that a physician have a valid and unrestricted license as a condition for employment.

The PHS is concerned that report readers might not understand that most direct IHS physician services are provided by regular employees of the IHS and not by locum tenens. As of September 30, 1994, the IHS had 914 fundable physician positions, of which 102 were vacant. It is these current vacant positions, as well as "fill ins" for physicians on leave or in training, for which the locum tenens physicians are used.

GAO RECOMMENDATION

We recommend that the Assistant Secretary for Health, Public Health Service, ensure that the Director of IHS:

(1) Revise IHS' credentials and privileges policy to explicitly state that the status of all State medical licenses, both active and inactive, be verified.

PHS COMMENT

We concur. The IHS thoroughly checks all licenses held by physicians applying for temporary and permanent direct hire positions for past performance and disciplinary actions. However, this has not always been possible for contracted locum tenens physicians when insufficient time precludes carrying out a full credential review before the locum tenens physician begins to provide patient care services. Although verification of licensure is a required part of the IHS credentials review process, IHS policy does not explicitly require all licenses held by the applicant to be verified as current and unrestricted. The IHS policy permits temporary medical staff to provide services prior to a complete credentials review as long as an application form has been completed, privileges have been requested, and both have been reviewed by the IHS service unit clinical director; and the IHS service unit director has granted temporary privileges until the governing board takes action.

In order to eliminate this disparity, the IHS will revise IHS Circular 95-2, "Personal Services Contracts," to be consistent with the IHS Circular 93-2, "Credentials and Privileges Review Process for the Medical Staff," to require the verification of the status of all State medical licenses, both active and inactive, for all physicians including locum tenens whether hired directly by IHS or through locum tenens companies. The IHS expects to have this policy change in place by the summer of 1995.

GAO RECOMMENDATION

(2) Develop standard provisions to include in contracts with locum tenens companies that require a company to verify and inform IHS of the status of all State medical licenses, both active and inactive.

PHS COMMENT

We concur. The IHS will revise IHS Circular No. 95-02, "Personal Services Contracts," to direct all contracting officers and other appropriate personnel, to require the inclusion of model language in contracts with locum tenens companies that instructs these locum tenens companies to verify and inform the IHS of adverse actions taken on all medical licenses. The IHS expects to have this policy change in place by the summer of 1995.

GAO RECOMMENDATION

(3) Establish a system that will facilitate the dissemination of information among IHS facilities on the performance of temporary physicians who provide services in IHS.

PHS COMMENT

We concur. The Office of Human Resources, IHS, is currently working on establishing an electronic bulletin board to share personnel information, with plans to grant access at both the IHS Area Office level and the Service Unit level. The IHS plans to include in the bulletin board a sub-menu for credentialing activities, such as information on the performance of locum tenens. The IHS expects to have this action accomplished within 6 months.

The IHS will also consider adding a question on the standard IHS medical staff application form asking applicants to list all IHS facilities where he/she has been previously stationed. The credentialing official would then be able to call the listed IHS facility(ies) for additional information on the applicant.

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