



December 2020

INDIAN HEALTH SERVICE

Actions Needed to Improve Oversight of Provider Misconduct and Substandard Performance

Accessible Version

GAO Highlights

Highlights of [GAO-21-97](#), a report to congressional requesters

Why GAO Did This Study

IHS provides care to American Indians and Alaska Natives (AI/AN) through a system of federally and tribally operated facilities. Recent cases of alleged and confirmed misconduct and substandard performance by IHS employees have raised questions about protecting the AI/AN population from abuse and harm. For example, in February 2020, a former IHS pediatrician was sentenced to five consecutive lifetime terms for multiple sex offenses against children. Several studies have been initiated or completed in response, and IHS has reported efforts to enhance safe and quality care for its patients.

GAO was asked to review IHS oversight of misconduct and substandard performance. This report (1) describes IHS policies related to provider misconduct and substandard performance and (2) assesses IHS oversight of provider misconduct and substandard performance. GAO reviewed policies and documents, including minutes from 80 governing board meetings from January 2018 to December 2019. GAO also interviewed IHS officials from headquarters, all nine area offices with two or more federally operated facilities, and two federally operated facilities.

What GAO Recommends

GAO is making three recommendations, including that IHS should establish a process to review area office trainings as well as establish a standard approach for documenting governing board review of information. HHS concurred with these recommendations.

View [GAO-21-97](#). For more information, contact Jessica Farb at (202) 512-7114 or farbj@gao.gov.

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INDIAN HEALTH SERVICE

Actions Needed to Improve Oversight of Provider Misconduct and Substandard Performance

What GAO Found

The Indian Health Service's (IHS) policies related to provider misconduct and substandard performance outline several key aspects of oversight, such as protecting children against sexual abuse by providers, ethical and professional conduct, and processes for managing an alleged case of misconduct. Although the Department of Health and Human Services (HHS) or IHS headquarters have established most of these policies, area offices that are responsible for overseeing facility operations and facilities, such as hospitals, may develop and issue their own policies as long as they are consistent with headquarters' policies, according to officials.

Although some oversight activities are performed at IHS headquarters, IHS has delegated primary responsibility for oversight of provider misconduct and substandard performance to the area offices. However, GAO found some inconsistencies in oversight activities across IHS areas and facilities. For example,

- Although all nine area offices require that new supervisors attend mandatory supervisory training, most area offices provided additional trainings related to provider misconduct and substandard performance. The content of these additional trainings varied across area offices. For example, three area offices offered training on conducting investigations of alleged misconduct, while other area offices did not. Officials from IHS headquarters told GAO they do not systematically review trainings developed by the areas to ensure they are consistent with policy or IHS-wide training.
- Facility governing boards—made up of IHS area office officials, including the Area Director, and facility officials, such as the Chief Executive Officer—are responsible for overseeing each facility's quality of and access to care. They generally review information related to provider misconduct and substandard performance. However, there is no standard format used by governing boards to document their review, making it difficult to determine the extent this oversight is consistently conducted. In some cases, there was no documentation by governing boards of a discussion about provider misconduct or substandard performance. For example, none of the seven governing board meeting minutes provided from one area office documented their discussion of patient complaints. In other cases, there was detailed documentation of the governing board's review. Additionally, governing boards did not always clearly document how or why an oversight decision, such as whether to grant privileges to a provider, had been made based on their review of available information.

These inconsistencies in IHS's oversight activities could limit the agency's efforts to oversee provider misconduct and substandard performance. For example, by not reviewing trainings developed by area offices, IHS headquarters may also be unable to identify gaps in staff knowledge or best practices that could be applied across area offices. Addressing these inconsistencies would better position the agency to effectively protect patients from abuse and harm resulting from provider misconduct or substandard performance.

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Abbreviations

AI/AN	American Indian and Alaska Native
DCPS	Division of Commissioned Personnel Support
FPPE	focused professional practice evaluation
HHS	Department of Health and Human Services
IHS	Indian Health Service
OHR	Office of Human Resources
OPPE	ongoing professional practice evaluation
QARMC	Quality Assurance Risk Management Committee

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December 10, 2020

Congressional Requesters

The Indian Health Service (IHS) provides health care for over 2 million American Indians and Alaska Natives (AI/AN) who are members or descendants of federally recognized tribes. According to IHS, its mission is to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level. IHS provides health care services to AI/ANs either directly through a system of federally operated IHS facilities or indirectly through facilities that are operated by tribes or others. As of July 2020, IHS, tribes, and tribal organizations operated 46 hospitals and 330 health centers—of which 24 hospitals and 51 health centers were federally operated IHS facilities.¹ With nearly 5 million outpatient visits in fiscal year 2018, federally operated IHS facilities provide mostly primary and emergency care services and are located in 10 of IHS’s 12 areas.² As of December 31, 2019, IHS reported that more than 5,500 providers served across these areas—of which more than 4,300 were federal civilian providers and more than 800 were Commissioned Corps providers.³

Recent cases of alleged and confirmed misconduct and substandard performance by IHS providers have raised questions about IHS’s ability to protect the AI/AN population from sexual abuse and harm.⁴ For example,

¹IHS federally operated facilities also include health stations and school health centers or youth regional treatment centers. IHS also provides funding to nonprofit, urban Indian organizations through the Urban Indian Health program to provide health care services to AI/AN people living in urban areas. See 25 U.S.C. § 1653.

²The 12 IHS areas are: Alaska, Albuquerque, Bemidji, Billings, California, Great Plains, Nashville, Navajo, Oklahoma City, Phoenix, Portland, and Tucson.

³The U.S. Public Health Service Commissioned Corps is one of the nation’s uniformed services—a branch committed to the service of health. Officers advance the nation’s public health, serving in agencies across the government, including IHS, as physicians, nurses, dentists, and other professionals. IHS also employs contract providers. As we previously reported, IHS does not maintain an agency-wide estimate of the number of contract providers. See GAO, *Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies*, [GAO-18-580](#) (Washington, D.C.: Aug. 15, 2018).

⁴In 2017, we added federal management of programs that serve Indian tribes and their members to our High Risk List, because inadequate oversight hindered IHS’s ability to ensure that Indian communities have timely access to quality health care, among other reasons.

the convictions of a former IHS pediatrician who sexually abused American Indian youth for decades highlights the vulnerability of some IHS patients.⁵ In addition, instances of alleged provider misconduct that have occurred since 2018 at federally operated facilities have included travel fraud, bringing a weapon onsite, and physical and sexual assaults on other employees and patients. Further, Congress has questioned the extent to which IHS uses transfers, duty reassignments, and administrative leave in lieu of addressing employee misconduct and performance issues.⁶

During Congressional hearings in spring 2019, the IHS Principal Deputy Director noted that the agency had begun efforts to enhance safe and quality care for its patients, noting, for example, that the agency had implemented stronger requirements for reporting suspected sexual abuse of children. According to the Principal Deputy Director, IHS was also working to implement newly developed and enhanced systems to support patient abuse reporting and identification of problem providers.⁷ Additionally, the Department of Health and Human Services (HHS) Office of Inspector General, a Presidential Task Force, and IHS—through an independent contractor—have also initiated or completed work in

⁵In February 2020, the convicted former pediatrician was sentenced to five consecutive lifetime terms for multiple sex offenses against children. See, Department of Justice, News Release: Convicted Former Pine Ridge Indian Health Service Pediatrician Sentenced to Five Consecutive Life Sentences for Multiple Sex Offenses Against Children (Feb. 10, 2020), accessed September 17, 2020, <https://www.justice.gov/usao-sd/pr/convicted-former-pine-ridge-indian-health-service-pediatrician-sentenced-five-consecutive>.

⁶Chairman Byron L. Dorgan of the S. Comm. on Indian Affairs, 111th Cong., In Critical Condition: The Urgent Need to Reform the Indian Health Service's Aberdeen Area (Comm. Print Dec. 28, 2010).

⁷Indian Health Service Budget Request for FY2020: Hearing Before the Subcomm. on Interior, Environment, and Related Agencies of the H. Comm. on Appropriations, 116th Cong. 3 (2019) (statement of Rear Admiral Michael Weahkee, Principal Deputy Director for IHS); Review of the FY2020 Budget Request for the Indian Health Service: Hearing Before the Subcomm. on Interior, Environment, and Related Agencies of the S. Comm. on Appropriations, 116th Cong. 4 (2019) (statement of Rear Admiral Michael Weahkee, Principal Deputy Director for IHS).

response to allegations and incidents of significant provider misconduct.⁸ Among other things, these studies examined IHS policies for preventing, reporting, and addressing patient abuse, and they made recommendations to address these issues.

You asked us to review IHS's oversight of provider misconduct and substandard performance that may affect American Indians treated at its federally operated facilities. In this report, we

1. describe IHS's policies for oversight of provider misconduct and substandard performance, and
2. assess IHS's oversight of provider misconduct and substandard performance.

To address the first objective, we reviewed IHS policies related to misconduct and substandard performance for federal civilian and Commissioned Corps providers, including those established by HHS, IHS headquarters, nine area offices with two or more federally operated facilities, and 13 selected facilities within these areas.⁹ For example, we reviewed *HHS's Supervisory Guide to Addressing Unacceptable Performance*, IHS's *Indian Health Manual* that included a section on

⁸Department of Health and Human Services Office of Inspector General, *Indian Health Service Has Strengthened Patient Protection Policies but Must Fully Integrate Them Into Practice and Organizational Culture*, OEI-06-19-0330 (Washington, D.C.: Dec. 18, 2019). See <https://oig.hhs.gov/oei/reports/oei-06-19-00330.asp>, accessed January 3, 2020. Presidential Task Force on Protecting Native American Children in the Indian Health Service System Report (Washington, D.C.: July 23, 2020). See <https://www.whitehouse.gov/wp-content/uploads/2020/07/Task-Force-Report-Protecting-Native-American-Children-in-the-Indian-Health-Service-System-April-2020.pdf>, accessed July 27, 2020. Indian Health Service, *Statement from Rear Adm. Michael Weahkee on the release of the Presidential Task Force on Protecting Native American Children in the Indian Health Service System report* (Rockville, Md.: July 23, 2020). See <https://www.ihs.gov/newsroom/pressreleases/2020-press-releases/statement-from-rear-adm-michael-weahkee-on-the-release-of-the-presidential-task-force-on-protecting-native-american-children-in-the-indian-health-service-system-report/>, accessed Sept. 24, 2020. More information on each study can be found in appendix I.

⁹According to IHS officials, contracted providers are overseen through the facility's medical staff bylaws and subject to the same oversight as civilian and Commissioned Corps providers. However, according to officials, additional punitive actions related to substandard performance or misconduct are managed by a provider's contractor, not IHS. As such, for the purpose of this report, we do not include contract providers in our analysis. We selected a nongeneralizable sample of 13 federally operated facilities across all nine area offices to include in our analysis. These facilities were selected to account for variation in health centers and hospitals, size of facilities, and evidence of misconduct or substandard performance issues.

ethical and professional conduct of providers, among other things, and facility medical staff bylaws. We reviewed the policies to identify any variation across area offices and facilities. Lastly, we interviewed officials at IHS headquarters, the nine area offices, and two facilities to identify relevant policies and to determine how these have changed over time.¹⁰ We planned to conduct additional site visits and planned interviews to other federal facilities, but we were unable to do so because of the effect of Coronavirus Disease 2019 on IHS operations and the agency's response and recovery efforts.

To address the second objective, we reviewed documentation and information that IHS uses as part of its efforts to oversee provider misconduct and substandard performance at federally operated IHS facilities. For example, we reviewed training materials used to educate providers and supervisors on their roles and responsibilities; written communications between staff, such as emails that shared updated policies or guidance; personnel information, such as documented approval of paid leave; governing board meeting minutes; and documents used to track alleged cases of misconduct.¹¹ In addition, we interviewed officials from IHS headquarters, nine area offices with two or more federally operated facilities, and the two facilities we visited to identify oversight efforts across the agency and to determine officials' understanding of their roles and responsibilities when overseeing misconduct and substandard performance. We also interviewed representatives from accrediting organizations—the Joint Commission and the Accreditation Association for Ambulatory Health Care—about the role they play in ensuring IHS has appropriate oversight of misconduct or substandard performance. We used information identified in documentation and interviews to identify any variation in oversight efforts across the agency. We compared IHS's oversight to IHS policy and IHS's Strategic Plan to determine if there were any limitations in oversight

¹⁰Specifically, we interviewed area office officials from Albuquerque, Bemidji, Billings, Great Plains, Nashville, Navajo, Oklahoma City, Phoenix, and Portland. We interviewed officials as part of a site visit to Cass Lake Hospital and Red Lake Hospital in the Bemidji area.

¹¹We reviewed minutes from all 80 governing board minutes that IHS provided for 13 facilities that occurred from January 2018 through December 2019.

efforts.¹² We also compared IHS's oversight to federal internal control standards.¹³ We determined that the control environment, control activities, and information and communication components of internal control were significant to this objective, along with the related principles that management should establish an organizational structure that develops and maintains documentation of its control system, implement control activities through policies, and use quality information to achieve the entities' goal.¹⁴

We conducted this performance audit from July 2019 to December 2020 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Indian Health Service

IHS, a component of HHS, was established within the Public Health Service in 1955 to provide health services to members of federally

¹²The Strategic Plan outlines three strategic goals: (1) ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/ANs; (2) promote excellence and quality through innovation of the Indian health system into an optimally performing organization; and (3) strengthen management and operations. Indian Health Service, *Indian Health Service Strategic Plan FY 2019-2023* (Rockville, Md.: July 9, 2019).

¹³GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 10, 2014). Internal control is a process effected by an entity's management, oversight body, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

¹⁴For example, we assessed oversight efforts to determine if information maintained on misconduct or substandard performance was current, complete, accurate, and used by management to make informed decisions.

recognized AI/AN tribes primarily in rural areas on or near reservations.¹⁵ IHS provides these services directly through a network of hospitals, clinics, and health stations operated by IHS, and it also funds services provided at tribally operated IHS facilities.¹⁶

IHS's headquarters office is responsible for setting agency-wide policies, including those related to provider misconduct and substandard performance; setting agency-wide strategic goals; and ensuring the delivery of quality comprehensive health services, among other things. Its area offices are responsible for disseminating and implementing agency-wide policy, monitoring federally operated IHS facilities' operations and finances, and providing guidance and technical assistance. In addition, five human resources regional offices assist the area offices with hiring providers, among other things. IHS facilities implement agency-wide and area office policy.

Each federally operated IHS facility has a governing board that includes leadership from the area office and facility, such as the Area Director, Chief Executive Officer, Chief Medical Officer, and others. Each Area Director chairs the facility governing boards within the area. The governing board is responsible for each facility's compliance with all federal and state laws and accreditation standards. IHS policy requires each IHS operated facility to meet the standards of a nationally recognized accrediting or certifying body. Two such nationally recognized accrediting or certifying bodies are The Joint Commission and the Accreditation Association for Ambulatory Health Care. Each of these

¹⁵Federally recognized tribes have a government-to-government relationship with the United States and are eligible to receive certain protections, services, and benefits by virtue of their status as Indian tribes. The Secretary of the Interior publishes annually in the Federal Register a list of all tribal entities that the Secretary recognizes as Indian tribes. As of January 30, 2020, there were 574 federally recognized tribes. See 85 Fed. Reg. 5462 (Jan. 30, 2020).

¹⁶IHS also provides funding to nonprofit, urban Indian organizations through the Urban Indian Health program to provide health care services to AI/AN people living in urban areas. See 25 U.S.C. § 1653.

Based on the needs of their communities, tribes and tribal organizations can choose to receive health care administered and operated by IHS, or assume responsibility for providing all or some health care services formerly administered and operated by IHS. Under the Indian Self-Determination and Education Assistance Act, as amended, federally recognized Indian tribes can enter into self-determination contracts or self-governance compacts with the Secretary of Health and Human Services to take over administration of IHS programs for Indians previously administered by IHS on their behalf. Pub. L. No. 93-638, 88 Stat. 2203 (1975) (codified, as amended, at 25 U.S.C. §§ 5301-5423).

accrediting bodies require facilities to define and verify medical staff qualifications and to have a process requiring the monitoring and evaluation of a provider’s professional performance.¹⁷ The governing board also is to oversee each facility’s quality of care and access to care, as well as its management and operations. In addition, the governing board is to approve each facility’s medical staff by-laws, which include provisions to address provider misconduct and substandard performance. (See fig. 1.)

Figure 1: Health Care Responsibilities of Indian Health Service (IHS) Headquarters, Area Offices, and Federally Operated Facilities



Source: GAO analysis of IHS documentation. | GAO-21-97

¹⁷As of the first quarter of fiscal year 2020, 83 percent of IHS hospitals and 97 percent of ambulatory health centers have earned accreditation from The Joint Commission or the Accreditation Association for Ambulatory Health Care. In addition, 96 percent of IHS hospitals are certified by the Centers for Medicare & Medicaid Services. See Indian Health Service, *National Accountability Dashboard for Quality*, accessed September 21, 2020, <https://www.ihs.gov/quality/national-accountability-dashboard-for-quality/fiscal-year-2020-quarter-1/>.

IHS federally operated facilities employ both federal civil service personnel (civilians) and Commissioned Corps officers as providers. IHS defines providers as any employee who provides physical or behavioral health treatment to patients at an IHS facility, such as physicians, nurses, dentists, podiatrists, optometrists, physician assistants, pharmacists, psychologists, and counselors. According to IHS officials, the Commissioned Corps officers follow the same process for applying for positions at IHS as federal civil service employees. IHS also supplements its workforce capacity with temporary and long-term contracts with individual physicians and medical staffing companies.¹⁸

Employee Misconduct in the Federal Government

Employee misconduct in IHS and in other agencies in the federal government is regulated by a well-developed body of law, including statutes and regulations, although “employee misconduct” does not have a general definition in a statute or government-wide regulation.¹⁹ Government agencies may elaborate on types of misconduct in handbooks and other internal guidance. Examples of activities that may be considered misconduct include absence without leave, insubordinate behavior, fighting, sexual harassment or abuse, and engaging in criminal activity (e.g., bribery or embezzlement), according to HHS/IHS policy.²⁰

While misconduct can be described as violations of stated policies or norms, substandard performance can generally be described as an employee’s inability to carry out work responsibilities, whether the employee does so willfully or otherwise. However, in certain cases, substandard employee performance and misconduct can overlap. For example, sleeping on the job is both a failure to abide by norms of

¹⁸According to IHS officials, contracted providers are overseen through the facility’s medical staff bylaws and subject to the same oversight as civilian and Commissioned Corps providers. However, according to officials, additional punitive actions related to substandard performance or misconduct are managed by a provider’s contractor, not IHS. As such, for the purpose of this report, we do not include contract providers in our analysis.

¹⁹GAO, *Federal Employee Misconduct: Actions Needed to Ensure Agencies have Tools to Effectively Address Misconduct*, [GAO-18-48](#) (Washington, D.C.: July 16, 2018).

²⁰See, for example, Department of Health and Human Services, *General Administration Manual, Chapter 5-10* (Washington, D.C.: Dec. 26, 2006).

conduct an agency would expect of an employee on duty and a failure to perform.

In general, federal employees' supervisors are responsible for taking corrective action to address instances of misconduct or substandard performance. For misconduct, supervisors gather facts about an alleged offense and, in consultation with the assigned human resources contact, determine the action or penalty required to deter the recurrence of the unacceptable behavior. For example, according to HHS policy, a supervisor may first try informal disciplinary actions, such as counseling, a verbal warning, or a letter of warning or admonishment if such actions will likely preclude a recurrence of the misconduct.²¹ Should the employee's misconduct continue, the supervisor can initiate formal actions, including a letter of reprimand or a suspension for 14 calendar days or less, among others.²² For substandard performance, each employee is under an annual performance plan that includes performance elements and standards that an employee must meet throughout the year, according to HHS policy. Employees not meeting required performance elements, such as consistently failing to meet assigned deadlines or failing to adhere to required procedures or instructions in completing work assignments, may be given the opportunity to demonstrate acceptable performance under a performance improvement plan. After a reasonable amount of time, if the employee's performance has not improved, then the employee could be reassigned or removed.

Recent Studies and Investigations of Patient Harm and Sexual Abuse within IHS

In response to allegations and incidents of significant provider misconduct, including the sexual abuse of minor children, the federal government recently initiated studies that have been completed or are ongoing. For example, the HHS Office of Inspector General issued a report in December 2019 examining IHS nation-wide policies and procedures for preventing, reporting, and addressing patient abuse and

²¹Department of Health and Human Services, *Human Resources Manual*, Instruction 752 Discipline and Adverse Action (Washington, D.C.: Mar. 20, 2009).

²²HHS policy urges the use of progressive discipline when possible. The Office of Personal Management defines progressive discipline as the imposition of the least serious disciplinary or adverse action applicable to correct the issue or misconduct with penalties imposed at an escalating level for subsequent offenses.

identified progress and potential challenges to their effective implementation.²³ According to the Office of Inspector General, it will continue its work by examining the sufficiency and implementation of these policies at the facility level and plans to include a survey of leadership at all IHS-operated health care facilities. In addition, in July 2020, the *Presidential Task Force on Protecting Native American Children in the Indian Health Service System*, which was broadly charged with investigating the institutional and systemic breakdown that failed to prevent and stop sexual abuse of AI/AN children by a former pediatrician, issued its findings and recommendations. The Task Force concluded that employees did not understand child abuse reporting obligations, and employees found policies, procedures, and jurisdictional issues confusing when reporting suspected child abuse, among other things.²⁴ See appendix I for more details on these reports.

IHS Has Several Policies that Inform Its Oversight of Provider Misconduct and Substandard Performance

Our review of agency documentation shows that IHS has several policies that inform its oversight of provider misconduct and substandard performance. HHS, IHS headquarters, area offices, or facilities established these policies. Many of these policies apply to all employees; however, IHS has established some that are specific to providers. These policies address several key areas, including (1) credentialing providers; (2) ethical standards and professional conduct of providers; (3) protections for children against sexual abuse by providers; (4) the process for managing an alleged case of misconduct, including discipline and adverse actions; (5) requirements for the use of paid leave for managing instances of misconduct; and (6) annual performance management. (See fig. 2.)

²³See Department of Health and Human Services, Office of Inspector General, *Indian Health Service Has Strengthened Patient Protection Policies but Must Fully Integrate Them Into Practice and Organizational Culture*, OEI-06-19-0330.

²⁴*Presidential Task Force on Protecting Native American Children in the Indian Health Service System Report*.

Figure 2: Indian Health Service (IHS) Policies Related to Overseeing Provider Misconduct and Substandard Performance



Source: GAO analysis of agency policy. | GAO-21-97

Addressing an allegation of misconduct

Management should conduct a thorough inquiry into any alleged misconduct to ensure all relevant facts and aspects of the case are reviewed, according to the Department of Health and Human Services' policy. Generally, the immediate supervisor will conduct this inquiry with guidance from human resources. In some cases, particularly those involving criminal activity, a case warrants investigation by the Office of Inspector General or other law enforcement agency. Minor misconduct should be corrected through informal action, such as through (1) supervisory counseling or (2) notices of warning that document misconduct and advise on more serious corrective action should unacceptable behavior not be corrected. Formal disciplinary action—known as adverse action—such as a letter of reprimand, suspension, or removal, should be taken in more severe cases of misconduct.

Source: Department of Health and Human Services' policy. | GAO-21-97

- **Credentialing providers.** IHS policy requires that facilities determine whether providers have the appropriate professional qualifications and clinical abilities to care for their patients, also known as credentialing.²⁵ Credentialing is an ongoing process that begins when providers apply to join a facility’s medical staff. At that time, the facility’s medical staff and governing board uses information on the providers’ professional credentials to evaluate their competency and, as appropriate, grant medical staff membership or clinical privileges.²⁶ According to IHS policy, the credentialing process must be completed before providers deliver care to any patient at an IHS facility. In addition to this initial review, IHS policy requires the facility’s medical staff and governing board to reassess providers’ credentials and privileges at least once every 2 years. For more information on the credentialing process, see appendix II.
- **Ethical standards and professional conduct of providers.** Policy developed by IHS headquarters details the ethical standards and professional conduct required of all providers at IHS, including physicians and nurses.²⁷ Among other things, the policy outlines requirements for interactions between providers and patients, relationships between providers and their coworkers, and the use of appropriate clinical treatment. The policy also describes responsibilities of key IHS staff to ensure providers meet these ethical standards. For example, facility medical staff, clinical supervisors and managers, and facility Chief Executive Officers are required to report all allegations of misconduct to the appropriate official—either in writing or verbally—depending on

²⁵Indian Health Service, “Part 3, Chapter 1: Medical Credentials and Privileges Review Process,” in *Indian Health Manual* (Rockville, Md.: Nov. 19, 2008).

²⁶Privileges are the specific services and procedures a provider is permitted to perform at a facility, e.g., diagnostic services, procedures, prescribing medication. The granting of privileges is based on the review of a provider’s professional training, licensure, experience, and expertise.

²⁷Indian Health Service, “Part 3, Chapter 23: Ethical and Professional Conduct of Health Care Providers,” in *Indian Health Manual* (Rockville, Md.: Aug. 5, 2004). See <https://www.ihs.gov/ihm/pc/part-3/p3c23/>, accessed July 30, 2019.

their position.²⁸ Area Directors are responsible for ensuring that any violations of ethical standards are reported to the appropriate professional organization, state licensing boards, and the IHS Office of Human Resources (OHR), Division of Personnel Security and Ethics or the HHS Office of Inspector General, among other things.²⁹ In addition, the policy describes the consequences of improper conduct. For example, substantiated allegations of unethical behavior or misconduct may lead to disciplinary action.

- **Protections for children against sexual abuse by providers.** IHS policy provides professional standards and guidance to protect against sexual abuse or exploitation of children by providers.³⁰ IHS issued this policy in February 2019 in response to multiple allegations of sexual abuse of American Indian youth by a pediatrician. The policy reinforces a March 2018 communication to all IHS staff that the agency has a zero tolerance for all forms of sexual abuse of patients. It also outlines the roles and responsibilities of all staff, including supervisors, the service unit's Chief Executive Officer, Area Director, IHS Deputy Director for Field Operations, and Director of OHR. For example, all staff are responsible for reporting any incident or reasonable suspicion of sexual abuse of a child by a provider to the proper authorities, including the Office of Inspector General and the service unit's supervisor and Chief Executive Officer.³¹
- **Process for managing an alleged case of misconduct.** IHS policies related to the process of managing an alleged case of misconduct apply to civilian providers, while other directives apply to Commissioned Corps providers. They were established in

²⁸Medical staff must report to their supervisor or other appropriate official. Clinical supervisors and managers must report to the appropriate senior leadership of the facility, or the area office. The Chief Executive Officer at a facility must report to the area office, the Office of Inspector General, or the Program Integrity and Ethics Staff.

²⁹The Program Integrity and Ethics Staff manages and directs IHS's Ethics Program, directs fact-finding and resolution of allegations of impropriety, such as violations of the Standards of Ethical Conduct, and advises the IHS Director and IHS management of appropriate corrective and remedial actions, among other things.

³⁰Indian Health Service, "Part 3, Chapter 20: Protecting Children from Sexual Abuse by Health Care Providers," in *Indian Health Manual* (Rockville, Md.: Feb. 6, 2019). See <https://www.ihs.gov/ihtm/pc/part-3/p3c20/#3-20.4C>, accessed July 2, 2019.

³¹Proper authorities also include the IHS Hotline and appropriate law enforcement or child protective services.

federal regulation and by HHS.³² The policies are generally similar, although the processes differ for civilian versus Commissioned Corps providers in certain cases such as determining disciplinary action. For example, for both of these providers, these policies define misconduct, and they describe who is responsible for reporting an alleged case of misconduct, roles and responsibilities of supervisors, how to conduct an investigation, an employee's rights during and after an investigation, and how to determine appropriate disciplinary action, among other things. For civilian providers, disciplinary action is managed by the area office, including human resources staff. For Commissioned Corps providers, the Division of Commissioned Personnel Support manages all disciplinary action with assistance from the area office and Commissioned Corps headquarters.

- **Requirements for the use of paid leave to manage instances of misconduct.** In response to proposed regulations by the Office of Personnel Management implementing the Administrative Leave Act of 2016, IHS issued an interim policy in June 2018 to ensure that administrative leave is no longer used indefinitely to address instances of employee misconduct.³³ The new policy allows the agency to use administrative leave for misconduct for no more than 10 workdays during any calendar year.³⁴ Any additional paid leave associated with misconduct is defined as either investigative

³²For example, see Department of Health and Human Services, *Personnel Delegation HHS Instruction 572-I*, accessed July 24, 2019, <https://www.ihs.gov/IHM/doa/pers/pers-01hhs/#60>.

³³Pub. L. No. 114-328, § 1138, 130 Stat. 2000, 2460 (2016) (codified at 5 U.S.C. §§ 6329a-6329c). The Act created new categories of authorized paid leave and established parameters for their use by federal agencies. The Office of Personnel Management issued a proposed rule to implement the Act in 2017. 82 Fed. Reg. 32263 (proposed July 13, 2017). As of May 2020, the IHS policy is interim as agencies await issuance of a final rule by the Office of Personnel Management. See Indian Health Service, *Managing Administrative, Investigative and Notice Leave in the Indian Health Service*, Special General Memorandum 18-02 (Rockville, Md.: June 1, 2018). The interim policy applies to all IHS employees.

³⁴According to agency officials, administrative leave may also be used for office closures due to weather, among other things.

or notice leave.³⁵ In addition to defining each type of leave, the policy outlines requirements for their use, including how long an employee can be placed on leave, who can serve as an approving official, how to document approval of leave, and where to maintain that documentation.³⁶ For example, administrative leave can be approved at the local level, while investigative and notice leave must be requested and approved by IHS headquarters using a standard form. Officials noted that this policy was implemented to ensure paid leave is only approved in accordance with law and is used sparingly to manage instances of misconduct.³⁷

- **Annual performance management.** Policies governing annual performance management for providers cover the Performance Management Appraisal Program for civilian providers and the Commissioned Officer Effectiveness Report for Commissioned Corps providers. These annual performance management programs serve as overarching policy for evaluating performance for civilian and Commissioned Corps providers, respectively.³⁸ Both policies include procedures to plan, monitor, develop,

³⁵Investigative leave accounts for time spent conducting an investigation of an employee, such as an inquiry of alleged misconduct, and notice leave accounts for the periods attached to adverse actions made against an employee. Both investigative and notice leave are only to be used after determining that all other available options—such as assigning an employee to duties in which the employee no longer poses a threat—are unacceptable.

³⁶During any calendar year, an agency can place an employee on paid administrative leave for no more than a total of 10 work days. Upon the expiration of the 10 day work period, and if an agency determines an extended investigation of an employee is necessary, an employee can be placed on investigative leave for an initial period of no more than 30 work days, with the option to extend up to 90 work days. Notice leave can be no longer than the duration of the period of adverse action.

³⁷Between June 2018 and January 2020, 10 providers have been placed on either investigative or notice leave for reasons related to misconduct or substandard performance. IHS officials noted that the data on administrative leave do not provide information on the reason for leave. As a result, they are not able to determine how many additional providers were approved for up to 10 work days of administrative leave for issues related to misconduct or substandard performance as opposed to weather.

³⁸For more information about the Performance Management Appraisal Program process, see Indian Health Service, “Part 7, Chapter 7: Performance Management Appraisal Program,” in *Indian Health Manual* (Rockville, Md.: Feb. 13, 2017). See <https://www.ihs.gov/ihtm/pc/part-7/p7c7/>, accessed July 30, 2019. For more information about the Commissioned Officer Effectiveness Report process, see Department of Health and Human Services, *Commissioned Corps Instruction 351.01, Commissioned Officers’ Effectiveness Report* (Washington, D.C.: Nov. 9, 2010). See https://dcp.psc.gov/ccmis/ccis/documents/CCPM25_1_1.pdf, accessed May 29, 2020.

appraise, recognize employee performance, and address substandard performance. Additionally, both policies outline roles and responsibilities of those involved in the performance assessment, including the provider, the performance rater, and the reviewing official. Should a civilian or Commissioned Corps provider not meet performance expectations, then the supervisor is expected to take appropriate actions to improve performance, including seeking advice from Employee Relations specialists.³⁹ Providers must be given a reasonable period of time to demonstrate improvements in performance. If providers do not improve during this time, then they could face disciplinary action.

Most policies used by IHS related to overseeing provider misconduct and substandard performance have been established by HHS or IHS headquarters. For example, some policies are included in HHS-wide policy documents while others are included in IHS' *Indian Health Manual*, which contains national policies and procedures specific to IHS.⁴⁰ These policies are then disseminated to area offices and facility staff. According to officials, these policies serve as standardized, national directives that are implemented at the local level.

According to IHS officials, area offices are required to implement national policies within their own areas. Area offices may develop and issue their own policies to supplement or clarify national policy to help ensure appropriate implementation. According to IHS officials, any area office policy must be consistent with national policy. Based on review of documentation, we identified three area offices that established policies that were either specific to or included information about addressing misconduct or substandard performance. For example, our review of

³⁹Employee Relations/Labor Relations specialists provide advice and assistance to employees and managers in matters related to conduct, performance, attendance, and dispute resolution. They establish and maintain effective relations with labor organizations that represent federal employees, including providing guidance and consultation to management on a variety of labor relations matters.

⁴⁰See, for example, *HHS's General Administration Manual, Chapter 5-10*, which defines improper conduct, criminal, and administrative offenses that apply to civilian providers, and *HHS's Commissioned Corps Directive 111.02*, which describes the types of disciplinary actions that may be taken against a Commissioned Corps officer, among other things. Department of Health and Human Services, *General Administration Manual, Chapter 5-10* (Washington, D.C.: Dec. 26, 2006); and Department of Health and Human Services, *Commissioned Corps Directive 111.02: Disciplinary Action* (Washington, D.C.: June 18, 2018). For more information on the *Indian Health Manual*, see <https://www.ihs.gov/ihm/>, accessed on September 25, 2020.

documentation shows that one area office developed a policy on managing allegations of improper or criminal conduct to supplement and reinforce existing HHS and IHS policy. Specifically, this policy reinforces roles and responsibilities of IHS staff, when to involve the Office of Inspector General, and Whistleblower protections, among other things.⁴¹ In addition to these policies, officials from two area offices we interviewed told us they created supplemental guidance to help their facilities address issues related to misconduct, including how to document disciplinary action.

Facilities also establish medical staff bylaws that outline performance requirements for providers, including those related to issues of misconduct or substandard performance. For example, medical staff bylaws may describe what corrective actions may be taken to address instances of misconduct or substandard performance, such as issuing a warning, reprimand, requirement for remedial or additional training, or imposition of enhanced monitoring procedures. In another example, medical staff bylaws may outline the process and approval requirements for credentialing and privileging providers. Medical staff bylaws are to be approved by the service unit's governing board. According to officials from IHS headquarters, processes outlined in medical staff bylaws may differ across facilities.

IHS's Oversight Activities Related to Provider Misconduct and Substandard Performance Have Been Inconsistent and In Some Cases Limited across Areas and Facilities

Although some oversight activities are performed at the headquarters level, the agency has delegated primary responsibility for oversight of provider misconduct and substandard performance to the area offices. Officials from the nine area offices in our review told us that their oversight generally includes the following activities: (1) reviewing and, in some cases, establishing policies, (2) communicating with and holding trainings for facility staff, (3) reviewing available information related to provider misconduct and substandard performance, and (4) collecting and

⁴¹Indian Health Service Portland Area, *Management of Allegations of Improper Conduct and/or Criminal Offenses*, Special General Memorandum 19-03 (Portland, Ore.: May 29, 2019).

reporting information to headquarters on provider misconduct and substandard performance.

Reviewing and establishing policies. Officials from all nine area offices in our review told us that they review facility policies related to provider misconduct or substandard performance.⁴² According to officials we interviewed, the governing boards—which include area office officials—conduct periodic reviews of medical staff bylaws and other facility policies. In particular, officials from two area offices told us that the governing board reviews these policies to ensure that they align with national accreditation standards, which include standards related to the oversight of misconduct and substandard performance. An example of accreditation standards that relate to the oversight of provider misconduct and substandard performance is an organization applying for accreditation must maintain an active and organized process for peer review, including to have each health care provider be reviewed at least once by a peer, monitor important aspects of care provided by health care providers on an ongoing basis, and use the results of peer review as a part of the process for granting clinical privileges, according to the Accreditation Association for Ambulatory Health Care. According to IHS officials, these standards are essential to providing quality care to their patients and ensuring that provider misconduct and performance are monitored.⁴³

Additionally, officials from two area offices told us they have reviewed policies to address issues specific to provider misconduct. For example, officials from one area office told us that, having identified issues with breaches of ethical and professional boundaries in one facility, the governing board reviewed the facility's policies to determine if changes needed to be made. Having identified gaps in the existing policies, the

⁴²Each federally operated IHS facility has a governing board that includes leadership from the area office and facility. For example, Area Directors chair the facility governing boards within their area.

⁴³According to HHS, IHS has reported that all IHS federally operated facilities that provide direct patient care have achieved and maintain standards set forth by Centers for Medicare & Medicaid Services, The Joint Commission, or the Accreditation Association for Ambulatory Health Care. Officials told us that, while the standards of these organizations may vary, the premise of these accreditation organizations is to ensure quality care and services in a safe environment.

governing board asked the facility to revise them, according to area office officials.

In addition to reviewing facility policies, area offices may also establish area-level policies. Officials from six area offices told us they have not established their own policies related to provider misconduct because, for example, they said they rely on headquarters' policies. Officials from three area offices told us they have established their own policies to clarify national policies on provider misconduct or to address perceived gaps in national policy.⁴⁴ For example, one area office enacted a policy on managing investigations of alleged improper and criminal conduct, which included guidance on roles and responsibilities of IHS staff, when to involve the Office of Inspector General in an investigation, and Whistleblower protections. Area officials told us they developed this policy to reinforce existing national policy and increase awareness of how to handle misconduct in their area. In another example, one area office enacted a policy that broadens IHS headquarters' policy on protecting children from sexual abuse by providers. Specifically, this policy expands IHS headquarters' policy to apply to any type of abuse (e.g., sexual or physical abuse); any employee, including providers and other staff (e.g., administrative staff); and any patient, including children, adults, and elders.⁴⁵ Area office officials told us they developed this policy following a visit from the Centers for Medicare & Medicaid Services, during which agency officials told the area office to focus on any possible abuse or neglect of patients.⁴⁶

Although area offices may establish their own policies, officials from IHS headquarters told us any area policies must be consistent with IHS headquarters' policy. However, IHS headquarters officials told us they do

⁴⁴None of the officials from the nine area offices in our review told us that they had established area-level policies related to substandard performance.

⁴⁵IHS officials told us that they are working on expanding the policy "Protecting Children From Sexual Abuse by Health Care Providers" to meet the recommendations made in HHS Office of Inspector General report, which asked IHS to extend the policy to address more types of perpetrators, victims, and abuse, among other things. See Department of Health and Human Services, Office of Inspector General, *Indian Health Service Has Strengthened Patient Protection Policies*. According to IHS officials, they intend to finalize this expanded policy by the end of calendar year 2020.

⁴⁶The Centers for Medicare & Medicaid Services provides for surveys of health care facilities participating in Medicare and Medicaid programs to assess compliance with health and safety standards.

not systematically review policies established by the area offices because they have delegated development of area office policies down to the local level. Federal internal control standards state that management should implement control activities through policies, including periodically reviewing policies for continued relevance and effectiveness in achieving the entity's objectives or addressing related risk.⁴⁷ By not conducting such a review, IHS headquarters lacks reasonable assurance that area office policies are consistent with IHS headquarters' policy, which could result in area offices handling instances of misconduct or substandard performance inconsistently. Additionally, IHS headquarters may be unable to identify potential best practices in policies related to overseeing provider misconduct or substandard performance that could be applied across area offices.

Communicating with and holding trainings for facility staff. Officials from all nine of the area offices in our review told us that they ensure facilities understand IHS policy related to provider misconduct and substandard performance by communicating with and holding trainings for facility staff. According to area officials, they communicate with facility staff through emails and meetings, both over teleconference and in person. Officials told us that they generally use email to disseminate policies and guidance from IHS headquarters and in some cases to provide information on any recent changes to policy, such as the policy on protecting children from sexual abuse by health care providers that was established in February 2019. Additionally, area officials told us they hold regular meetings with their counterparts at the facilities, the frequency of which ranges from weekly to quarterly. For example, officials from four of the area offices said that the area office Chief Medical Officer meets at least monthly with facility Clinical Directors. According to officials, these meetings are used to discuss a range of management issues, which can include provider misconduct or substandard performance.

In addition to regular communication, all nine area offices provide training for facility staff related to provider misconduct and substandard

⁴⁷[GAO-14-704G](#).

performance.⁴⁸ Specifically, according to officials, all areas require new supervisors to attend training that includes information on how to address provider misconduct and substandard performance.⁴⁹ Our review of documentation and interviews with agency officials shows that trainings are generally the same across areas and include information on documenting provider misconduct, investigating provider misconduct, and conducting and writing annual performance assessments, among other things. While these trainings are required for both civilian and Commissioned Corps officers, officials from one area office said that they also provide a separate supervisory training for new or newly transferred Commissioned Corps officers on a quarterly basis.

In addition to these mandatory supervisory trainings, officials from all nine area offices told us that they provide other trainings to facility staff related to misconduct or substandard performance. Specifically, five of these nine area offices provide additional mandatory trainings for staff in their areas, and five of these nine area offices provide additional voluntary trainings. The availability and content of these additional trainings vary across area offices. For example, according to officials from one area office, the area office requires all managers to take an annual training that covers standards of conduct, how to conduct an investigation, and how to determine disciplinary action, among other things. Officials from the area office told us that they created this training when the Area Director realized that supervisors and managers were not as knowledgeable as they could be on actions to address misconduct. In another example, three other area offices offer voluntary training on how to conduct administrative investigations of alleged misconduct. See table 1 below for more information on area-specific trainings beyond new supervisor training.

⁴⁸All IHS employees are also required to complete several annual trainings related to provider misconduct and substandard performance that are provided online. For example, in June 2019, IHS required all employees to complete a training on the agency's new policy of protecting children from sexual abuse by health care providers by September 30, 2019. According to agency documents and interviews with officials, all employees completed that training except for those on extended leave, such as medical leave, among other things. The trainings also cover ethics and the performance management appraisal program for civilians.

⁴⁹All HHS supervisors are also required to complete supervisory trainings provided online, both when they initially become a supervisor and every 3 years after that. These supervisory trainings includes sections on hiring, performance management, leave administration, quality of work life, and labor and employee relations.

Table 1: Area Office Specific Mandatory and Voluntary Trainings on Misconduct and Substandard Performance, as of September 2020

Training	Description	Number of area offices that provide the training
Mandatory: Annual trainings on misconduct	Explains staff roles and responsibilities, such as who needs to make the first call about a suspected misconduct issue and how to work with the Office of Inspector General. Required of all employees.	One
Mandatory: Annual employee relations/labor relations trainings	Covers information related to managing misconduct and substandard performance, including standards of conduct, reporting criminal activity, and determining disciplinary action, among other things. Required of all managers.	One
Mandatory: Training on area-specific policy on abuse	Covers area office policy on preventing any type of abuse, by any person, against all patients, regardless of age. Required of all employees.	One
Mandatory: Supervisory training “refresher”	Covers same information provided in the new supervisor training. ^a Required of all supervisors and managers every 3 years for one area office and annually for the other area office.	Two
Mandatory: Biannual “in week sessions”	While not specific to provider misconduct or substandard performance, includes information related to those issues, such as how to write performance assessments. Required of all facility Chief Executive Officers.	One
Voluntary: Quarterly supervisor trainings	Includes information on issues related to performance and misconduct, such as employee responsibilities, progressive discipline, and mistakes to avoid when addressing these issues.	Two
Voluntary: Training on conducting investigations	Includes information on how to investigate an allegation of misconduct, such as how to obtain evidence and conduct a root cause analysis.	Three
Voluntary: Training on credentialing and privileging	Includes information on the purpose of credentialing, the role of the area office credentialing specialist, and how to run reports in the electronic credentialing system MD Staff.	One

Source: GAO review of trainings and interviews with agency officials. | GAO-21-97

Notes: Our review of trainings is of nine of the 12 Indian Health Service area offices. This table provides information on area specific training that is separate from the mandatory new supervisor training provided by all of the nine area offices in our review. The number of area offices does not sum to total (9) because some area offices provided multiple trainings.

^aNew supervisor training includes information on how to document provider misconduct, how to investigate provider misconduct, and how to conduct and write annual performance assessments, among other things.

IHS headquarters officials told us that they do not systematically review trainings developed by the area offices because they delegate authority to each regional human resources director to enable each to develop the necessary training within the areas they serve. According to officials, regional human resources offices do not systematically review trainings

but area offices can request that they provide feedback on the trainings they develop. However, because there is no formal, systematic review of these trainings, IHS headquarters officials lacks reasonable assurance that area-specific trainings are consistent with policy or IHS-wide trainings. This is inconsistent with the IHS Strategic Plan for 2019-2023, which states that, as appropriate, IHS must evaluate training efforts that are provided to ensure quality improvement and accountability.⁵⁰ Further, federal internal control standards state that management should implement control activities through policies, including periodically reviewing control activities, such as training, for continued relevance and effectiveness in achieving the entity's objectives or addressing related risks.⁵¹ By not conducting these reviews, IHS headquarters runs the risk that area office trainings include inconsistent requirements or practices that may result in a different understanding of how to address misconduct and substandard performance among facility staff across areas. Additionally, by not conducting a systematic review, IHS headquarters may be unable to identify best practices that could be applied to trainings offered across areas.

Reviewing information related to provider misconduct and substandard performance. Officials from all nine area offices told us that they review information related to provider misconduct or substandard performance, and that these reviews generally occur during facility governing board meetings. According to area office officials, the

⁵⁰IHS, *Indian Health Service Strategic Plan FY 2019-2023*.

⁵¹[GAO-14-704G](#).

Incident reports

Facility employees generally report incidents that occur at Indian Health Service (IHS) facilities, such as medication errors or patient falls, through the IHS incident reporting system. As of August 2020, incidents are reported through the IHS Safety Tracking & Response (I-STAR) System, according to IHS officials. Incidents were previously reported through WebCident. Although not all incidents reported through the IHS incident reporting system involve provider misconduct or substandard performance, incident reports can contain information on these issues. For example, as of February 2019, IHS requires staff to document all incidents or reasonable suspicion of sexual abuse of a child in the IHS incident reporting system. According to IHS policy, an incident is any event, or chain of events, that results in property damage, injury, or illness to any person(s) or interrupts, interferes or has the potential to interfere with the orderly progress of work or for which a tort claim may be possible.

Source: Indian Health Service documentation and interviews with agency officials. | GAO-21-97

information that governing boards generally review includes incident reports, patient complaints, and professional evaluations. Officials told us that governing boards may review this information for an individual provider, such as during the credentialing process, or in aggregate, such as the number of patient complaints that have been received and resolved by the service unit.

However, it is unclear the extent to which governing boards consistently conducted this oversight activity because at the time of our review the way governing boards documented their review of this information varied. We found variation in what information appeared to be discussed and what was documented in minutes from 80 governing board meetings that occurred from January 2018 through December 2019 for 13 selected facilities across the nine area offices in our review. For example, none of the seven governing board meeting minutes provided from one area office documented a discussion of patient complaints or professional evaluations. In contrast, all three of the governing board minutes from one area office included extensive documentation of their review of incident reports and patient complaints, including (1) the total number of incidents by type, (2) how the area office was going to address a newly identified trend in incidents, and (3) the percentage of cases closed in WebCident each month.

Patient complaints

Patient complaints can range from a dissatisfied patient to concerns of inappropriate behavior by a provider. For example, documentation from one governing board noted a trend in complaints made against staff for being rude or unprofessional. In another example, documentation from another governing board noted a complaint regarding a provider failing to diagnose a condition that required possible surgery because the provider did not conduct a full examination of a patient.

Source: Indian Health Service documentation. | GAO-21-97

Our review of meeting minutes at the 13 facilities also found that the level of detail provided in documentation regarding these reviews varied across areas. Specifically, some governing boards documented details about their discussions of the information reviewed, while others only noted that a topic was discussed. For example, in one area, documentation from governing boards included a summary of patient complaints reviewed, while documentation from governing boards in other areas merely noted they reviewed patient complaints, providing no further detail.

Additionally, the meeting minutes did not always clearly document how or why the governing board reached certain decisions. For example, meeting minutes from one governing board showed that the board unanimously voted to grant a physician assistant's privileges. The meeting minutes also documented that this provider had a few outstanding malpractice cases. However, the minutes did not memorialize the board's discussion about this information or how it factored into its decision in granting the provider privileges.

The variation in documentation reflects the fact that IHS headquarters has not established a standard approach or tools for governing boards to use in reviewing information related to provider misconduct and substandard performance because, according to IHS officials, they have delegated oversight decisions to the service unit governing boards. Such a standardized approach or tool could help ensure consistent review of information and consistent documentation of discussions and decisions. Federal internal control standards calls for management to establish an organizational structure, assign responsibility, and delegate authority to

Professional evaluations

According to officials, facility governing boards generally review results of professional evaluations, including as part of the medical credentials and privileges process. There are two types of evaluations that are primarily included in these reviews: the ongoing professional practice evaluation (OPPE) and the focused professional practice evaluation (FPPE). The OPPE uses qualitative and quantitative data, such as patient complaints and post-procedure infection rates, to identify general professional practice trends that may affect quality of care, while the FPPE is a time-limited evaluation of providers' competence in performing a specific privilege.

Source: Indian Health Service and the Joint Commission documentation and interviews with agency officials. | GAO-21-97

achieve the entity's objectives, including developing and maintaining documentation that provides a means to retain organizational knowledge and mitigate the risk of having that knowledge limited to a few personnel.⁵² Additionally, IHS's strategic plan states that in order to recruit, develop, and retain a dedicated, competent, and caring workforce, IHS must improve knowledge sharing of critical employee, administrative, and operational functions through written communication and documentation within IHS.⁵³ Without a standard approach or tool for documenting their review of information related to misconduct and substandard performance, IHS headquarters lacks the information to determine whether or not governing boards are providing consistent oversight at federally operated facilities. This in turn limits their ability to identify trends related to provider misconduct and substandard performance.

Collecting and reporting information related to provider misconduct.

Officials from all nine area offices in our review told us they collect and report to IHS headquarters information related to provider misconduct. IHS officials told us that area offices have been required to collect and report information on potential or actual disciplinary actions to IHS's OHR on a monthly basis since 2016.⁵⁴ OHR required the area offices to submit

⁵²[GAO-14-704G](#).

⁵³Indian Health Service, *Indian Health Service Strategic Plan FY 2019-2023*.

⁵⁴Formal disciplinary actions include letters of reprimand, suspensions, and removal.

information in a standard format using an Excel spreadsheet, according to officials. The template included data fields for the date the disciplinary case was opened, the reason for disciplinary action, and what formal disciplinary action was or will be taken against them, among other things. OHR officials told us that they used this information to compile reports for IHS leadership, in particular the Quality Assurance Risk Management Committee (QARMC).⁵⁵ According to IHS officials, the director of OHR—who is a member of QARMC—brings information reported by the area offices on high risk cases to the attention of the committee. The QARMC intends to use this and other information to identify systemic changes needed to improve the quality of health care services and operation of federally operated hospitals and clinics.

However, our review of IHS documentation shows that the information area offices report to IHS headquarters was inconsistent and sometimes limited because it was not always complete or submitted in a timely manner, making it difficult to aggregate the information or track a case from start to finish, among other things. OHR officials told us that they review the information submitted by the area offices and require the area office to update them if information was missing. However, our review of information reported between 2016 and 2019 found that most area offices in our review had submitted spreadsheets with one or more entries that contained missing information. Examples of missing information include the date the disciplinary case was open, the date the case was closed, the position of the employee being disciplined, and the facility where the employee worked. This missing information would make it difficult to determine how long it took a disciplinary case to be closed, among other things.

We also found inconsistencies in how area offices documented information on formal disciplinary actions in the spreadsheets that may make it difficult to aggregate information or determine whether disciplinary

According to officials, while area offices are not required to submit information to the Division of Commissioned Personnel Support (DCPS) on a monthly basis, DCPS also maintains information on all formal disciplinary actions taken against Commissioned Corps officers in an Excel spreadsheet.

⁵⁵IHS established QARMC in November 2019 to provide senior level oversight and management of complex adverse patient safety events and administrative matters involving fraud, waste, and employee misconduct at IHS facilities. QARMC is supported by IHS's Office of Quality, which the agency established in 2019 in order to strengthen its efforts to ensure the delivery of high quality care at IHS facilities.

Officials told us that DCPS, like OHR, reports information on high risk cases to QARMC.

policy is being implemented consistently. For example, in some instances one area office would specify the length of a suspension (e.g., 14-day suspension) when entering the disciplinary action being taken against an employee, while other times they would not. This inconsistency in documentation could make it difficult to determine whether employees who have committed equivalent offenses are being suspended for an equivalent period of time across areas. Moreover, our review of the spreadsheets submitted by area offices shows that between 2016 and 2019, all nine area offices in our review did not submit information on formal disciplinary actions every month as required. Officials from headquarters confirmed that this information was not always submitted on a monthly basis, due in part to staffing challenges.

IHS is taking steps to improve reporting from area offices. IHS officials told us that in July 2020 IHS headquarters implemented a new electronic case management system throughout the agency to improve the tracking of disciplinary actions. According to officials, this new system is an online application where human resources staff can document and manage formal or informal disciplinary actions in a centralized system. IHS officials told us that this new system will allow OHR to run reports on disciplinary actions at both the national and local level. According to officials, it will also allow them to analyze disciplinary data to identify and address trends on a variety of issues, including those involving employee performance and conduct. However, it is too early in the implementation of the new case management system to determine whether it will address the limitations we identified during our review of prior tracking documents. In September 2020, IHS headquarters issued a memo stating that all employee relations specialists are required to manage their cases in this new system and that OHR will conduct a monthly review of cases from each area office. The memo also notes that OHR will evaluate the effectiveness of the system on a bi-annual basis to identify and effect system improvements. These evaluations will be important to ensure they have the ability to analyze agency-wide provider misconduct and substandard performance information to identify trends and make management decisions regarding misconduct and substandard performance.

Conclusions

While IHS has taken some steps to address recent cases of misconduct and substandard performance by IHS providers against the AI/AN population, such as implementing an agency-wide policy for reporting

suspected sexual abuse of children, we found that inconsistencies in IHS's oversight activities could limit IHS's efforts to oversee provider misconduct and substandard performance. For example, the agency has not developed a systematic process for IHS headquarters to review policies and trainings developed by area offices to ensure that they are consistent with agency-wide policy. By not conducting these reviews, IHS headquarters may also be unable to identify gaps in knowledge among staff or best practices that could be applied across area offices. In addition, while facility governing boards generally review information related to provider misconduct and substandard performance, it is unclear the extent to which they consistently conduct this oversight as there is no standard format used by governing boards to document their review. Addressing these inconsistencies would better position the agency to effectively protect patients from abuse and harm resulting from provider misconduct or substandard performance.

Recommendations for Executive Action

We are making the following three recommendations to IHS:

1. The Director of IHS should establish a process at headquarters to review area office policies related to misconduct and substandard performance to ensure that area office policies are consistent with headquarters' policies. (Recommendation 1)
2. The Director of IHS should establish a process at headquarters to review area office trainings related to misconduct and substandard performance to ensure that staff receive consistent information about how to address misconduct or substandard performance. (Recommendation 2)
3. The Director of IHS headquarters should establish a standard approach or tool to ensure that governing boards consistently document their review of information related to provider misconduct and substandard performance. (Recommendation 3)

Agency Comments and Our Evaluation

We provided a draft of this report to HHS for review and comment. HHS provided written comments, which are reprinted in appendix III. HHS concurred with our three recommendations.

In its comments, HHS stated that, in February 2020, IHS headquarters established a framework and compliance review protocol for IHS headquarters' oversight reviews of each area office. These reviews will be conducted annually for each IHS area office, and topics are chosen to respond to the agency's highest risk areas.

Regarding our first recommendation, HHS stated that IHS plans to review area office misconduct policies as part of IHS headquarters' 2021 oversight review plan. Reviewers will include senior officials from IHS's Office of Human Resources and the Office of Management Services.

Regarding our second recommendation, HHS stated that IHS will also include a review of training material related to addressing misconduct and performance management issues for each area office as part of its 2021 headquarters' oversight review plan. HHS stated that reviewers for this portion of the oversight review will include senior officials from IHS's Office of Human Resources.

Regarding our third recommendation, HHS stated that one of the six topics chosen for IHS's oversight review in 2020 was governance. As part of this review, officials from IHS's Office of Quality examined how area governing bodies address complaints as well as concerns related to credentialing and privileging of providers stemming from allegations of misconduct and substandard performance. However, HHS did not elaborate on how IHS plans to use the results of the review to ensure that oversight of provider misconduct and substandard performance by facility governing boards is documented and conducted consistently.

HHS also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the Secretary of Health and Human Services and other interested parties. In addition, the report will be available at no charge on GAO's website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at farbj@gao.gov. Contact points for our Office of Congressional Relations and Office of Public Affairs can be found on the last page of this report. Other major contributors to this report are listed in appendix IV.

Letter

A handwritten signature in black ink that reads "Jessica Farb". The signature is written in a cursive style with a large, looped "J" and "F".

Jessica Farb
Director, Health Care

List of Requesters

The Honorable John Hoeven
Chairman
The Honorable Tom Udall
Vice Chairman
Committee on Indian Affairs
United States Senate

The Honorable John Barrasso, M.D.
United States Senate

The Honorable Steve Daines
United States Senate

The Honorable James Lankford
United States Senate

The Honorable Catherine Cortez Masto
United States Senate

The Honorable Lisa Murkowski
United States Senate

The Honorable Tina Smith
United States Senate

The Honorable Jon Tester
United States Senate

Appendix I: Recent Studies and Investigations of Patient Harm and Sexual Abuse within the Indian Health Service

In response to allegations and incidents of significant provider misconduct, including the sexual abuse of minor children, the federal government initiated three studies that have been completed or are ongoing.¹ Specifically:

- The Department of Health and Human Services Office of Inspector General has embarked on a two-phase approach to this work. Phase 1 inventoried and examined Indian Health Service (IHS) agency-wide policies and procedures for preventing, reporting, and addressing patient abuse. This phase also identified progress and potential challenges to their effective implementation. A report was released in December 2019.² Phase 2 will evaluate the sufficiency and implementation of these policies at the facility level and will include a survey of leadership at all IHS-operated health care facilities.
- In March 2019, a *Presidential Task Force on Protecting Native American Children in the Indian Health Service System* was broadly charged with investigating the institutional and systemic breakdown that failed to prevent and stop a predatory pediatrician committing sexual abuse of American Indian/Alaska Native children. It was also charged with identifying ways to better protect

¹Although we reviewed these studies as part of our research, we did not focus our review on the specific provider incident that was the impetus for these studies.

²Department of Health and Human Services, Office of Inspector General, *Indian Health Service Has Strengthened Patient Protection Policies but Must Fully Integrate Them Into Practice and Organizational Culture*, OEI-06-19-0330 (Washington, D.C.: Dec. 18, 2019). See <https://oig.hhs.gov/oei/reports/oei-06-19-00330.asp>, accessed January 3, 2020.

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children and improve the care provided by IHS. The Task Force issued its findings and recommendations in July 2020.³ The Task Force concluded that employees did not understand child abuse reporting obligations, and that employees found policies, procedures, and jurisdictional issues confusing when reporting suspected child abuse, among other things.

These reports made several recommendations to IHS. See table 2 below for a summary of the recommendations and IHS' responses.

³*Presidential Task Force on Protecting Native American Children in the Indian Health Service System Report* (Washington, D.C.: July 23, 2020). See <https://www.whitehouse.gov/wp-content/uploads/2020/07/Task-Force-Report-Protecting-Native-American-Children-in-the-Indian-Health-Service-System-April-2020.pdf>, accessed July 27, 2020.

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Table 2: Recent Reports, Recommendations, and Indian Health Service (IHS) Response

Report	Recommendations	IHS Response
Office of Inspector General, <i>Indian Health Service Has Strengthened Patient Protection Policies but Must Fully Integrate Them Into Practice and Organizational Culture</i> (Phase 1)	<p>The Office of Inspector General made five recommendations:</p> <ol style="list-style-type: none"> 1. extend policies to address more types of perpetrators, victims, and abuse; 2. ensure that the new incident reporting system is effective and addresses the risks identified in the current system; 3. designate a central owner in IHS headquarters to ensure clear roles and responsibilities for shared ownership in implementing patient protection policies, and managing and responding to abuse reports; 4. continue to actively promote an organizational culture of transparency, and work to resolve barriers to staff reporting of abuse; and 5. conduct additional outreach to Tribal communities to inform them of patient rights, solicit community concerns, and address barriers to reporting of patient abuse. 	IHS agreed with these recommendations and is working to implement them.
Office of Inspector General, Phase 2, expected issuance in fiscal year 2021	Not applicable	Not applicable

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Report	Recommendations	IHS Response
<i>Presidential Task Force on Protecting Native American Children in the Indian Health Service System Report</i>	<p>The Presidential Task Force made 10 recommendations:</p> <ol style="list-style-type: none"> 1. IHS should require annual, in-person, standardized training of IHS employees conducted by instructors with law enforcement and/or child welfare experience. 2. IHS should make reporting of child abuse easier and more streamlined by creating and publicizing a centralized child abuse hotline. 3. The Director of IHS should establish policies and procedures pertaining to allegations of child sexual abuse. 4. IHS should withhold retiree pay and benefits for civil service employees and U.S. Public Health Service Commissioned Corps officers convicted of sexual exploitation crimes against children. 5. IHS should designate all federal employees, contractors, and volunteers at federal facilities, including IHS, as mandatory reporters for reasonable suspicion of child abuse. 6. IHS should explore the viability and benefits of expanded use of telemedicine. 7. IHS should bolster recruitment and retention of quality of healthcare professionals. 8. IHS should develop and implement a uniform credentialing and privileging policy. 9. The Secretary of HHS should commission an independent review of U.S. Public Health Service Commissioned Corps management practices within 180 days of this report. 10. IHS should recommend that the President task the Secretary of HHS with following up on the Task Force's recommendations, including legislative or other actions, every 90 days until implemented. 	<p>According to IHS, several of the recommendations in the Task Force's report would require Congressional action and the IHS has made legislative proposals in the agency's FY2021 budget justification that would address several recommendations.^a</p>

Source: GAO review of reports | GAO-21-97

Notes: Reports reviewed include Department of Health and Human Services, Office of Inspector General, *Indian Health Service Has Strengthened Patient Protection Policies but Must Fully Integrate Them Into Practice and Organizational Culture*, OEI-06-19-0330 (Washington, D.C.: Dec. 18, 2019); and *Presidential Task Force on Protecting Native American Children in the Indian Health Service System Report* (Washington, D.C.: July 2020). Although we reviewed these studies as part of our research, we did not focus our review on the specific provider incident that was the impetus for these studies.

^aIndian Health Service, *Statement from Rear Adm. Michael Weahkee on the release of the Presidential Task Force on Protecting Native American Children in the Indian Health Service System report* (Rockville, Md.: July 23, 2020). See <https://www.ihs.gov/newsroom/pressreleases/2020-press-releases/statement-from-rear-adm-michael-weahkee-on-the-release-of-the-presidential-task-force-on-protecting-native-american-children-in-the-indian-health-service-system-report/>, accessed Sept. 24, 2020.

In addition, IHS conducted its own internal evaluation. Specifically,

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- On May 10, 2019, IHS awarded a contract to Integritas Creative Solutions, LLC, to conduct a medical quality assurance review to examine whether laws, policies, and procedures have been followed with regard to protecting patients from sexual abuse. According to IHS, this medical quality assurance review is a retrospective review to evaluate actions taken from 1986, when former IHS pediatrician Stanley Patrick Weber began working at IHS, to the present. The contractor was asked to identify any further improvements that IHS can implement to better protect patients.⁴
- The report made a number of recommendations, and, according to IHS officials, the agency is working to implement them. According to officials, they are evaluating the feasibility and appropriateness of these recommendations. In addition, they are considering similar recommendations received from the Office of Inspector General and the White House Task Force when determining how to implement these recommendations. Since the Integritas report was issued, IHS has launched a new website to provide information to patients, employees, and tribal and urban Indian organization partners on IHS efforts and actions individuals can take to prevent sexual abuse in IHS.⁵

⁴Indian Health Service, *Principle Deputy Director Michael Weahkee statement on announcement of contract for medical quality assurance review* (Rockville, Md.: May 13, 2019). **See** <https://www.ihs.gov/newsroom/pressreleases/2019pressreleases/ihs-principal-deputy-director-michael-weahkee-statement-on-announcement-of-contract-for-medical-quality-assurance-review/>, accessed July 9, 2019.

⁵See Indian Health Service, *Sexual Abuse Prevention*, accessed Sept. 24, 2020, <https://www.IHS.gov/sexualabuseprevention>.

Appendix II: Indian Health Service Provider Credentialing Process

Indian Health Service (IHS) requires each federally operated facility to perform a credentialing process to determine whether providers have the appropriate professional qualifications and clinical abilities to care for patients.¹ This process helps ensure that quality care is provided. Per IHS policy, credentialing involves an ongoing process whereby a facility's medical staff obtains, verifies, and assesses a provider's professional credentials. The facility's medical staff and governing board utilize this information to evaluate provider competency and appropriately grant medical staff membership or clinical privileges.² All licensed independent providers and other providers who give direct patient care should be credentialed and privileged, according to IHS policy.³ Specifically, providers that undergo this process include physicians, dentists, and others as determined by facility medical staff and the governing board.

Initial credentialing. The credentialing process begins when providers first apply to join a facility's medical staff, before the providers are permitted to deliver care to patients at an IHS facility.

¹IHS policy requires each IHS operated facility to meet the standards of a nationally recognized accrediting or certifying body. Two such nationally recognized accrediting or certifying bodies are The Joint Commission and the Accreditation Association for Ambulatory Health Care. Each of these accrediting bodies require facilities to define and verify medical staff qualifications and to have a process requiring the monitoring and evaluation of a provider's professional performance.

²Indian Health Service, "Part 3, Chapter 1: Medical Credentials and Privileges Review Process," in *Indian Health Manual* (Rockville, Md.: Nov. 19, 2008). Throughout this appendix, we use the term credentialing and recredentialing to include assessing a providers privileges. All health care facilities credential their providers.

³IHS policy defines licensed independent providers as fully licensed individuals permitted by law to provide patient care services independently and without concurrent direction or supervision, within the scope of their license and in accordance with individually granted clinical privileges. Other providers may be included in the credentialing process, such as physician assistants and nurse practitioners, based on certifications or registrations that define these providers' scope of practice.

IHS policy indicates a facility's Clinical Director may designate individuals to assist in the credentials review process, such as credentialing specialists.⁴ Credentialing specialists must review and verify certain elements of the provider's qualifications per IHS policy. Specifically, credentialing specialists:

- Examine information derived from the provider's application such as relevant education and training; professional references; state licensure; and past, current, or pending professional liability claims, among other information listed in the IHS policy.
- Verify certain credentials with their primary sources, such as the original issuing entity for a provider's professional education, professional board certifications, and state medical licenses.
- Check the provider against the National Practitioner Data Bank—an electronic repository of providers who have either been disciplined by a state licensing board, professional society, or a health care entity; or named in a medical malpractice settlement or judgment.
- Identify potential issues that may warrant further consideration by the facility's medical staff and governing board. For example, reviewing past medical malpractice claims or adverse actions taken against a provider's state licenses may show a pattern of provider clinical issues that should be considered when reviewing the provider's application and the clinical privileges requested.
- Look for unaccounted gaps in a provider's work history to determine if past employment has been left off of the resume for some reason.
- Determine that the provider has a current, unrestricted medical license to practice in the provider's specialty. IHS policy states a provider with any restrictions on any state license will not be granted medical staff membership or clinical privileges, although exceptions can be granted on a case-by-case basis by an authorized individual.⁵

⁴Indian Health Service, "Part 3, Chapter 1: Medical Credentials and Privileges Review Process."

⁵Effective August 6, 2020, any provider with any restriction must be forwarded to the IHS Quality Assurance Risk Management Committee for endorsement, prior to final action by the facility's governing board.

IHS policy states that the Clinical Director ensures that initial credentialing is completed for every provider granted clinical privileges through the medical staff.⁶ In addition, IHS policy specifies that the governing board is the only authority that can grant full medical staff membership and clinical privileges. The Clinical Director may therefore designate individuals or committees to provide the governing board, such as the Medical Executive Committee, or its equivalent as defined in facility's medical staff bylaws, to make credentialing recommendations. The resulting credentialing recommendations may be routed through the facility's Clinical Director and the Chief Executive Officer (or designee) to the governing board.

Provisional status for first year after initial credentialing. According to IHS policy, each provider initially credentialed with approved clinical privileges should be placed on a provisional status for the first year, during which time the provider's qualifications and clinical skills are assessed.⁷ One mechanism that a facility's governing board may use for a provider's assessment is the focused professional practice evaluation (FPPE).⁸ According to IHS headquarters officials, one example of how a facility's governing board may place a provider under a FPPE is when a facility has a low volume of patients that require a certain type of surgery that a provider performs. The FPPE would require the provider to perform a certain number of those surgeries at another facility that has a higher volume of patients needing the surgery under appropriate peer supervision. Upon successful completion of the FPPE, providers would return to their facility and be able to perform the surgery when needed.

⁶Indian Health Service, "Part 3, Chapter 1: Medical Credentials and Privileges Review Process."

⁷Indian Health Service, "Part 3, Chapter 1: Medical Credentials and Privileges Review Process."

⁸According to the IHS Manual, *Part 3, Chapter 7, Pharmacy*, a FPPE is a process used to validate the privilege-specific competency of a provider in the following situations: required for all new clinical privilege requests, as needed for a currently privileged provider in circumstances where privileges or clinical processes change, and as needed for currently privileged provider to determine the validity of patient care issues or concerns of poor care trends revealed through reviews by a provider's peers. In addition, a provider may be under an ongoing professional practice evaluation (OPPE), defined as an ongoing monitoring process for oversight of the provider to confirm the quality of care delivered and ensure patient safety. The OPPE allows clinical leadership to identify professional practice trends that affect quality of care and patient safety, some of which may require intervention.

Re-credentialing. According to IHS policy, each provider is required to have their credentials and privileges reassessed near the end of their initial 1-year period and then at least once every 2 years, a process referred to as re-credentialing.⁹ IHS policy states that renewal is neither automatic nor guaranteed, and it should include information on the provider's performance since the last time the provider was credentialed. IHS policy does not specify explicitly how a provider's performance and clinical competence should be assessed during re-credentialing. Information that could be considered to assess a provider's clinical competence and performance can come from a variety of sources, including

- patient complaints about a provider's behavior or competence, such as complaints about a provider being disrespectful with a patient;
- adverse events—incidents that pose a risk of injury to a patient as the result of medical intervention or the lack of an appropriate intervention, such as a missed or delayed diagnoses—recorded for a provider;
- peer review results for a provider, whereby a provider with similar clinical privileges reviews another provider based on identified criteria, such as a provider's compliance in proper medical record documentation; and
- provider performance under FPPEs and ongoing professional practice evaluations to determine whether a provider requires additional training, for example.

As with initial credentialing, the governing board makes the final determination of whether or not to re-credential a provider, as specified in IHS policy.

Credentialing data. Service units document information gathered during the credentialing and re-credentialing process in an electronic system known as MD Staff. IHS began the transition from a paper-based credentialing process to MD Staff in May 2017, and it is being used in all IHS service units. MD Staff enables a single common database of credentialing data within IHS, which according to IHS officials, provides real-time situational awareness to governing boards on providers.

⁹Indian Health Service, "Part 3, Chapter 1: Medical Credentials and Privileges Review Process."

Appendix III: Comments from the Department of Health and Human Services

**Appendix III: Comments from the Department
of Health and Human Services**



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

November 17, 2020

Jessica Farb
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Farb:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*INDIAN HEALTH SERVICE: Actions Needed to Improve Oversight of Provider Misconduct and Substandard Performance*" (Job code 103641/GAO-21-97).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

**Sarah C.
Arbes -S**

Digitally signed by
Sarah C. Arbes -S
Date: 2020.11.17
13:00:51 -05'00'

Sarah C. Arbes
Assistant Secretary for Legislation

Attachment

**Appendix III: Comments from the Department
of Health and Human Services**

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: INDIAN HEALTH SERVICE: ACTIONS NEEDED TO IMPROVE OVERSIGHT OF PROVIDER MISCONDUCT AND SUBSTANDARD PERFORMANCE (GAO-21-97)

The U.S. Department of Health & Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report.

General Comment

The recommendations are not clear about whether GAO is referring to a central process at IHS Headquarters, or something else. For each of the recommendations, suggest clarifying GAO's recommendation. For example: "The Director of IHS headquarters should establish a process at [insert descriptor (e.g., Headquarters)] to review area office policies related to misconduct and substandard performance to ensure that area office policies are consistent with headquarters' policies. (Recommendation 1)."

Recommendation 1

The Director of IHS headquarters should establish a process to review area office policies related to misconduct and substandard performance to ensure that area office policies are consistent with headquarters' policies. (**Recommendation 1**)

HHS Response

HHS concurs with GAO's recommendation.

In February, 2020, IHS developed a robust framework and compliance review protocol for completion of IHS HQ oversight reviews of each IHS Area, beginning in March 2020. The HQ Oversight Reviews are coordinated by the IHS Chief Compliance Officer, with senior manager leadership in national functional areas serving as the HQ Review Team. Annual reviews are planned to be conducted each year for each IHS Area. Topics of the IHS HQ oversight reviews are revisited each year in January, and are chosen to respond to the agency's highest risk areas.

IHS plans to include a review of misconduct policies in Area Offices, as a component of the 2021 HQ oversight review plan. HQ Reviewers for this portion of the oversight review will include senior officials from the IHS Office of Human Resources and the IHS Office of Management Services.

Recommendation 2

The Director of IHS headquarters should establish a process to review area office training related to misconduct and substandard performance to ensure that staff receive consistent information about how to address misconduct or substandard performance. (**Recommendation 2**)

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HHS concurs with GAO's recommendation.

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The Director of IHS headquarters should establish a standard approach or tool to ensure that governing boards consistently document their review of information related to provider misconduct and substandard performance. (**Recommendation 3**)

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One of the six topics chosen for review in 2020 was *Governance*. Part of the review protocol for this topic is examining how Area governing bodies address complaints, and concerns related to credentialing and privileging of providers stemming from allegations of misconduct and substandard performance. The HQ reviewers for this portion of the 2020 HQ oversight review are officials from the IHS Office of Quality.

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

Jessica Farb, (202) 512-7114 or farbj@gao.gov

Staff Acknowledgments

In addition to the contact named above, Kristi Peterson, Assistant Director; Amy Leone, Analyst-in-Charge; Moira Lenox; Lisa Rogers; Ethiene Salgado-Rodriguez; Caitlin Scoville; and Jennifer Whitworth made key contributions to this report.

Appendix V: Accessible Data

Agency Comment Letter

Accessible Text for Appendix III Comments from the
Department of Health and Human Services

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