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Indian Health Service Facilities Made Progress Incorporating Patient Protection Policies, but Challenges Remain

Christi A. Grimm

Principal Deputy Inspector General

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Why OIG Did This Review

In recent years, the Indian Health Service (IHS) had cases of health care providers abusing patients under facility care. In February 2019, the Deputy Secretary of HHS and the Senate Committee on Indian Affairs both requested that OIG review IHS policies for preventing, reporting, and addressing patient abuse in IHS facilities.

An OIG report issued in December 2019 found that IHS had strengthened its policies to protect children from sexual abuse by providers. Yet, we found gaps in IHS policies, such as not covering different types of abuse and circumstances, and found that some IHS facilities had not implemented the new agencywide policies. This study expands on that report, assessing facility implementation of the policies, and identifying potential challenges to their effectiveness.

How OIG Did This Review

We based our findings on survey responses from 97 IHS-operated health care facilities, including hospitals, health centers, and health stations, and onsite interviews with leadership and staff at 16 of these facilities. We collected our data during February–March 2020. Topics for the survey and interviews included implementation of IHS patient protection policies and related challenges, training needs, communication and collaboration with IHS headquarters and Area Offices, and barriers to patient abuse reporting and improvement efforts.

Indian Health Service Facilities Made Progress Incorporating Patient Protection Policies, but Challenges Remain

Key Takeaway

IHS facilities made strides to incorporate the agency's updated policies to prevent and address child sexual abuse by health care providers. However, IHS should work to resolve the challenges that its facilities report in carrying out the policies and their concerns that staff and patients may not feel safe reporting abuse.

What OIG Found

Most IHS facilities (81 of 97) reported that they fully incorporated the agencywide patient protection policies, aimed at preventing and addressing child sexual abuse by health care providers, into their local policies and procedures, but some facilities are still early in implementation. All facilities reported that staff completed mandatory training on the new policies. Many facilities supplemented the training and expressed need for further training to support staff understanding of reporting requirements.

We found that nearly two-thirds of facilities (62 of 97) reported encountering challenges in carrying out the policies. The most common challenges were providing chaperones during medical exams, due to staffing shortages and delays in background investigations; ensuring anonymity of victims and reporters; coordinating with law enforcement; and understanding the policies.

All facilities said that they were generally confident that staff would report suspected patient abuse, but most (88 of 97) noted existing barriers that may deter staff and patients from reporting. We found that IHS has established avenues for reporting patient abuse and taken steps to promote an organizational culture of transparency, but the facilities reported remaining barriers, including fear of retaliation, stigma related to sexual abuse, and lack of awareness on what and how to report, among others. We identified some of the same barriers in our 2019 report.

What OIG Recommends

To address the issues identified in this report and further protect patients from abuse, we recommend that IHS: (1) provide additional guidance and training to facilities on patient protection policies; (2) improve the process and timeliness for conducting staff background investigations and notifying facilities when staff are approved; (3) examine and revise, as needed, the abuse reporting structure to ensure that staff and patients can report anonymously; and (4) establish and enforce a deadline by which all facilities must fully incorporate the new requirements, and actively monitor facility adherence. IHS concurred with our recommendations, and reported actions taken and planned to implement the recommendations.

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BACKGROUND

Objective

To assess implementation of Indian Health Service (IHS) policies and procedures for preventing, reporting, and addressing patient abuse at IHS-operated health care facilities, and identify potential challenges to their effectiveness.

Indian Health Service

IHS is responsible for providing Federal health services to American Indians and Alaska Natives (AI/ANs) and has an annual budget of \$6 billion.¹ In partnership with the 574 federally recognized Tribes, IHS provides primary and preventive health care services to approximately 2.6 million AI/ANs living in the United States.² IHS's mission is "to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level."³

Recent cases of patient abuse by IHS employees have raised concerns about protecting the AI/AN population. The convictions of a former IHS pediatrician in September 2018 and 2019 brought attention to the issue and shed light on areas requiring improvement within IHS.^{4, 5} At congressional hearings in April and May 2019, the then Principal Deputy Director (currently Director) of IHS noted that the agency does "not tolerate sexual assault and abuse in its facilities" and had added efforts to ensure safe and quality care for its patients, including implementing stronger requirements for IHS employees to report suspected sexual abuse of children.^{6, 7} IHS also issued new patient protection policies to be implemented across its health care facilities and began developing and enhancing systems that support identification of problem providers and patient abuse reporting.^{8, 9, 10}


Organizational Structure

IHS headquarters (HQ) provides general direction, policy development, and support to each of 12 Area Offices and their IHS-operated health care facilities, which may include hospitals, urgent-care clinics, and/or other types of facilities.¹¹ Area Offices oversee the delivery of health services and provide administrative and technical support to the facilities. IHS maintains its current policies, procedures, and operating standards in the Indian Health Manual (IHM). IHS policy directs that the IHM is the primary reference for IHS staff regarding agency-specific policy and procedural information.¹²

IHS-Operated Facilities

IHS provides health care services to AI/ANs directly through IHS-operated health care facilities or provides financial support for the Tribes to operate their own health care systems.^{13, 14, 15} The IHS-operated facilities include 24 hospitals, 50 health centers, 24 health stations, and 11 school health centers.¹⁶ (See Exhibit 1 for a description of the different facility types.)

Exhibit 1: IHS-operated health care facilities vary in size, scope of services, and hours of operation.

 Hospital A facility that contains inpatient beds and organized staff (including physician services and continuous nursing services), and provides comprehensive health care (including diagnosis and treatment) for patients.	 Health Center A facility physically separated from a hospital, where one or more clinical treatment services are available at least 40 hours a week for outpatient care.	 Health Station A facility physically separated from a hospital or health center, where one or more clinical treatment services are available on a regular scheduled basis but for less than 40 hours a week.	 School Health Center A facility that is a health center and primarily serves students.
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Source: IHS, IHM, Part 1, Chapter 4, Section 1-4.4, "Indian Health Service Locations."

Cases of Patient Abuse at IHS

Over the years, there have been a number of allegations of patient abuse committed by IHS employees, some of which involved minors. For example, Stanley Patrick Weber, a former IHS physician, was found guilty on September 6, 2018, and sentenced to 18 years in prison, for sexually abusing patients while he was a pediatrician at Blackfeet Community Hospital in Montana between 1992 and 1995.^{17, 18, 19} On September 27, 2019, Dr. Weber was also found guilty of sexually abusing minors at Pine Ridge Hospital in South Dakota, where he worked from 1995 until he resigned in 2016.²⁰ He was sentenced to five lifetime prison terms, plus an additional 45 years in prison, for those crimes.²¹ The crimes for which he was convicted and sentenced occurred both at the hospital and in his home. This case was particularly troubling given that hospital staff raised suspicions to hospital leadership, on multiple occasions, that Dr. Weber was abusing children, yet he continued to work as a pediatrician at IHS hospitals until his resignation, which allowed him to treat and victimize children for more than two decades.²²

In addition to Dr. Weber, other IHS health care providers were accused of patient abuse over the past two decades. In February 2020, an IHS physician was indicted on eight counts of sexual abuse against four adult female patients.²³ In 2013, IHS fired a physician after receiving complaints of sexual misconduct involving patients.²⁴ In 2005, an adult patient sued a physician working under a term contract with IHS, for sexual assault; the suit was later settled out of court.^{25, 26} In 1999, IHS settled a lawsuit involving a teenage patient and an IHS psychologist.^{27, 28}

Requests for OIG Evaluation

Dr. Weber's case has specifically raised concerns about IHS actions and efficacy of policies and procedures for addressing patient abuse in its facilities. In February 2019, the Office of Inspector General (OIG) received a request from the Deputy Secretary of the Department of Health and Human Services (HHS) to review IHS's newly issued series of systemwide policies and procedures designed to promote a zero-tolerance policy against patient abuse. In the same month, OIG also received a request from the Senate Committee on Indian Affairs asking OIG to evaluate applicable IHS policies, procedures, standards, and other requirements intended to prevent, address, and correct misconduct present in the Weber case.

Related OIG Report

OIG issued a report in December 2019 that examined the sufficiency of IHS policies for preventing, reporting, and addressing patient abuse.²⁹ Through document reviews and interviews with key officials at IHS HQ and Area Offices, we found that IHS strengthened its patient protection policies, and that those policies largely aligned with those of other professional health care organizations selected for comparison, including the American Academy of Pediatrics, the American Medical Association, and the National Council of State Boards of Nursing. However, we found gaps in IHS policy coverage and found that the agency was still early in implementation. Specifically, the IHS policies did not explicitly address different types of abuse (e.g., physical, emotional), adult victims, or perpetrators who are not health care providers. We also found significant shortcomings in IHS systems for storing and tracking patient abuse reports and confusion within the agency regarding roles and responsibilities related to such tasks. We made recommendations to IHS to address these findings to which the agency concurred and noted that it had begun addressing the recommendations.

Other External Evaluators of IHS Patient Protection Policies

In May 2019, IHS awarded a contract for an independent medical quality assurance review that assessed IHS adherence to laws, policies, and procedures aimed at protecting patients from sexual abuse.³⁰ The review was largely retrospective and included medical record reviews from 1986 to present. The independent contractor was tasked with identifying system failures that may have contributed to IHS's

inability to prevent or address Dr. Weber's patient abuse, and determining further improvements that IHS can implement to better protect patients.^{31, 32} The independent contractor submitted its final report to IHS leadership in January 2020.³³

The Government Accountability Office (GAO) has also conducted work in this area, in response to a request from the Senate Committee on Indian Affairs in May 2019 to review IHS policies and actions for addressing personnel performance and misconduct issues.^{34, 35} In December 2020, GAO issued a report that found that IHS had taken steps to address provider performance and misconduct issues but there were inconsistencies across Area Offices and facilities. GAO recommended that IHS establish a process to review Area Office policies and trainings on misconduct and substandard performance to ensure consistency, and establish a standard approach for documenting governing board reviews of information related to provider misconduct and performance issues.³⁶

Additionally, in March 2019, the White House formed the Presidential Task Force on Protecting Native American Children in the IHS System, composed of top-level officials from the White House, U.S. Attorney's Office for the Northern District of Oklahoma, Bureau of Indian Affairs, Federal Bureau of Investigation, IHS, and Office of Management and Budget. The President charged the task force with developing and recommending policies, protocols, and best practices for protecting AI/AN children from abuse while under the care of IHS.³⁷ In July 2020, the task force released a report detailing its investigation of institutional and systemic breakdowns that failed to prevent Dr. Weber from sexually abusing children under his care. From April through July 2019, the task force traveled to Montana, New Mexico, Oklahoma, and South Dakota and interviewed Tribal leaders and other community members, health care professionals, government (e.g., U.S. Attorney's Offices) and law enforcement officials, sexual-assault experts, and Tribal school administrators and teachers. The task force also met with senior officials at IHS, HHS, and the U.S. Public Health Service Commissioned Corps.

The task force found that many IHS employees did not understand their reporting obligations and were inadequately trained on how to report child sexual abuse. The task force also found that IHS policies and procedures were confusing and not implemented the same across IHS health care facilities. The task force made several recommendations to IHS, including that IHS should require annual, in-person, standardized training of IHS employees to be conducted by instructors with law enforcement and/or child welfare experience; make reporting of child abuse easier and more streamlined by creating and publicizing a centralized child abuse hotline; and establish and implement uniform policies and procedures pertaining to allegations of child sexual abuse.³⁸

IHS Actions to Address and Prevent Patient Abuse

As a result of the Weber and other patient abuse cases, IHS initiated several efforts in 2017 to further address and prevent patient abuse in its facilities.³⁹ In 2018, IHS

leadership notified all staff of the agency's "zero-tolerance" policy, which prohibits staff from engaging in intimate physical relationships with patients and requires staff to report, investigate, and follow up on any concerns of patient abuse.⁴⁰ IHS also revised policy documents and systems, including methods for screening providers and reporting allegations of abuse; launched new mandatory training for all of its employees and contractors; and created a website to provide resources and information for staff, patients, and others on the agency's efforts to prevent sexual abuse.^{41, 42, 43, 44, 45}

New IHM Policies on Preventing Child Sexual Abuse

In February 2019, IHS issued new policies in the IHM ("Protecting Children From Sexual Abuse by Health Care Providers") that include guidance specific to provider interactions with children.^{46, 47} The policies serve as an update to prior policies about patient abuse in the IHM and also provide greater specificity, outlining roles and reporting responsibilities for leadership and staff at all levels of the agency to protect children from sexual abuse and exploitation in IHS-operated health care facilities.⁴⁸ The policies also include provisions for the use of chaperones during medical exams and guidance regarding staff rights.⁴⁹ In December 2019, IHS began efforts to broaden its policies to include other types of abuse, victims, and perpetrators. However, IHS has since halted its efforts and shifted its focus to respond to the COVID-19 pandemic. IHS anticipates issuing the broader policies by December 2020.^{50, 51}

Ethical Standards

The IHS Division of Personnel Security and Ethics (DPSE), formerly known as the Program Integrity and Ethics Staff, administers and manages ethics programs at IHS, including training and directives for the agency's ethical conduct standards.⁵² Along with following IHS policies, most IHS staff working in IHS-operated health care facilities must also adhere to Federal requirements for reporting suspected child abuse and neglect.^{a, 53, 54}

The IHM has had guidelines for reporting and responding to violations of ethical standards in place since August 2004.^{55, 56} The policies ("Ethical and Professional Conduct of Health Care Providers") detail the reporting structure for allegations of unethical conduct and state that "it is unethical not to report known violations of misconduct or violations of ethical standards."⁵⁷ The policies dictate that facility staff immediately report allegations of misconduct or violations of ethical standards to their supervisor or other appropriate officials, and that the supervisors must then report the allegations to senior leadership in the facility and/or the Area Office. They also require that Chief Executive Officers (CEOs) of the IHS-operated facilities report all allegations to their respective Area Office, OIG, and/or DPSE. Once Area Offices

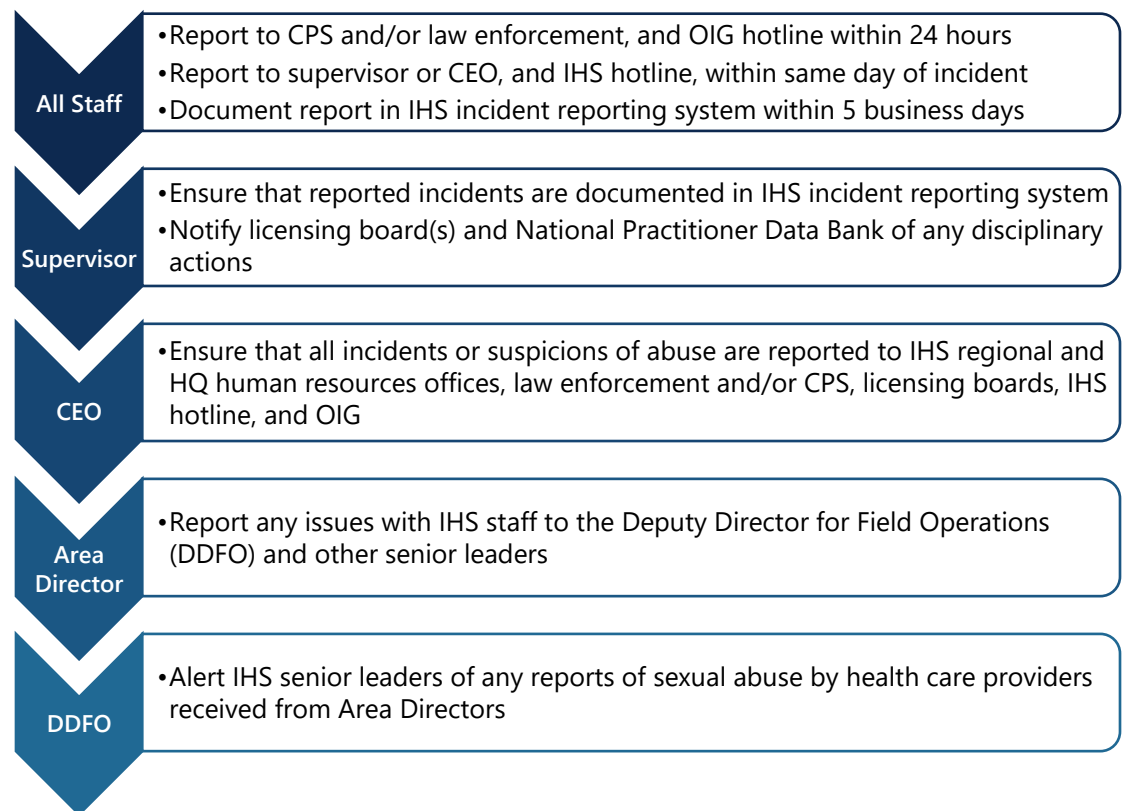
^a Federal law, including Section 226 of the Crime Control Act of 1990 and Section 404 of the Indian Child Protection and Family Violence Prevention Act, requires health care professionals and other covered individuals, while engaged in a professional capacity on Federal land, to report suspected child abuse.

are notified, the Area Directors must report the allegations to DPSE and/or OIG and to the appropriate professional organizations and State licensing and certification boards.⁵⁸

Reporting Allegations of Abuse

Under the most recent IHS policies for protecting children from sexual abuse, all staff, including health care providers, with reasonable cause to suspect that a provider has sexually abused a child must report the incident, within 24 hours, to child protective services (CPS) and/or law enforcement authorities, as well as OIG.⁵⁹ IHS defines a health care provider as anyone who provides physical or behavioral health treatment to patients (e.g., physicians, nurses, dentists, and psychologists).⁶⁰ Staff must also report to their supervisor or facility CEO and to the IHS hotline within the same day of the incident, and document the report in the IHS incident reporting system within 5 business days.⁶¹ (See Exhibit 2 for IHS reporting responsibilities from the 2019 IHS policies on protecting children from sexual abuse.)

Exhibit 2: IHS Reporting Responsibilities for Incidents or Suspicions of Sexual Abuse of Children by Health Care Providers.



Source: IHS, IHM, pt. 3; Ch. 20; section 3-20.2 (Responsibilities). IHS training, *Protecting Children from Sexual Abuse in Health Care Settings—Supporting a Culture of Community Safety*, June 28, 2019.

In December 2018, IHS awarded a contract for a new adverse events reporting and tracking system to replace WebCident, IHS's longstanding incident reporting

system.^{62, 63, 64} IHS officials reported to OIG that the new system, IHS Safety Tracking and Response (I-STAR), would have an improved interface and would capture data from IHS-operated facilities, including patient safety errors, adverse events, and abuse, which will enhance IHS management of incidents and improve data quality, reports, and dashboard tracking.^{65, 66} IHS reported to OIG that it completed the rollout of I-STAR to its facilities in August 2020 and is working to transfer data from WebCident into I-STAR.⁶⁷ The system resides in the Office of Quality, which IHS established in January 2019 to strengthen the agency's efforts to ensure the delivery of quality health care, patient safety, compliance, and consistency across IHS facilities.^{68, 69, 70}

IHS and OIG also provide telephone hotlines that IHS staff, contractors, patients, and others can use to file complaints and report allegations of patient abuse involving IHS staff.⁷¹ Callers can be anonymous and may use the hotlines to elevate concerns regarding fraud, waste, and mismanagement at IHS.⁷² Complaints and reports can also be submitted electronically on the IHS and OIG websites.^{73, 74} IHS is currently working with OIG to establish a hotline dedicated specifically to child abuse reports, as recommended by the Presidential Task Force on Protecting Native American Children in the IHS System. The new hotline will provide immediate connection to OIG and will handle all sexual abuse reports, including adult victims.

Whistleblower Protections

The new IHM policies for protecting children from sexual abuse prohibit administrative or adverse action against an employee who reports an allegation.⁷⁵ Federal law further provides whistleblower protections to most Federal employees, Commissioned Corps Officers, and employees of Federal contractors, subcontractors, grantees, and subgrantees. These protections bar retaliation for reporting protected disclosures, including violations of law.^{76, 77, 78} Officials who retaliate against whistleblowers may be subjected to corrective or disciplinary action.⁷⁹ OIG has a Whistleblower Protection Coordinator (formerly "Ombudsman"), who is responsible for educating HHS employees on their whistleblower protections.⁸⁰

Oversight of Patient Abuse Reports

In November 2019, IHS formally established the Quality Assurance Risk Management Committee to provide senior-level oversight and management of high-risk administrative matters and complex adverse patient safety events, including employee misconduct and patient abuse allegations. The committee, which is largely composed of agency officials in IHS HQ, meets regularly to review high-risk events. Other oversight activities of the committee include identifying needs for systemic change to improve quality of care and safety, monitoring policy implementation and quality assurance across IHS, and providing facilities with technical assistance and support, as needed.^{81, 82}

Mandatory Training on Protecting Children From Sexual Abuse

In June 2019, IHS launched a new mandatory web-based training on the contents for the new IHM policies ("Protecting Children from Sexual Abuse by Health Care Providers") and related reporting requirements. All IHS employees and contractors must complete this training as part of the agency's new employee orientation and annual training requirements. It covers information on indicators of abuse, warning signs and common perpetrator behaviors, organizational safeguards for ensuring patient safety, and reporting guidelines for suspected sexual abuse.

Other Related OIG Work

In addition to our 2019 report, OIG has a body of work related to IHS. Since 2016, OIG has focused largely on IHS management of hospitals. Our work has included issuing reports describing lack of quality oversight and a number of challenges that affect IHS hospitals' ability to provide quality care and maintain compliance with Federal requirements.^{83, 84} Recently published OIG reports include a medical record review examining adverse events (patient harm resulting from medical care) in IHS hospitals and a companion report focusing on labor and delivery care.^{85, 86} Other OIG reports include a case study of IHS management of a 7-month closure of the Rosebud Hospital emergency department and a management review of IHS HQ operations and organizational challenges.^{87, 88}

OIG has also conducted a number of audits of Tribal health programs that receive funding from IHS and has found vulnerabilities in those programs. In a recent early alert issued in August 2020, OIG found that Tribal health programs did not always perform required background checks for employees, contractors, and volunteers who have regular contact with children, which may compromise the safety and well-being of children who receive treatment at Tribal health care facilities.⁸⁹

Scope of Inspection

This study expands on the 2019 OIG report and examines implementation of IHS policies and procedures for preventing, reporting, and addressing patient abuse at IHS-operated health care facilities. We collected data through surveys and interviews with facility leadership and staff during February and March 2020. We examined facilities' progress in incorporating IHS patient protection policies and their perceived challenges in carrying out the policies in practice and organizational culture.

Methodology

Data Collection and Analysis

Survey. We administered an electronic survey, in February–March 2020, to facility leadership at all IHS-operated hospitals (24), health centers (50), and health stations (24), totaling 98 facilities. We removed one facility (a health center) from the survey that was experiencing transition in leadership at the time of our data collection, resulting in a total number of 97 facilities. We received survey responses from all 97 facilities. The survey included both closed- and open-ended questions regarding facility implementation of IHS patient protection policies and procedures and relevant trainings, reporting of patient abuse allegations and related barriers, and communication and collaboration with IHS HQ and Area Offices.

Onsite Interviews. We selected a purposive subset of 16 IHS-operated health care facilities (7 hospitals, 7 health centers, and 2 health stations) and conducted onsite interviews with their leadership and staff in February 2020. These facilities were located in five Areas: Albuquerque, Great Plains, Navajo, Oklahoma, and Phoenix. We selected these facilities based on facility type and size (i.e., hospital, health center, health station) and geographic location (i.e., urban, remote). We conducted 44 individual or group interviews with over 200 participants, including CEOs, Clinical Directors, Directors of Nursing, Quality Compliance Officers, and other medical and nonmedical supervisory and nonsupervisory staff.

During these interviews, we discussed implementation of the agencywide patient protection policies and other facility-level efforts aimed at preventing and protecting patients from abuse, barriers to policy implementation and strategies to address those challenges, communication with staff regarding policy and procedural changes, and outreach activities to inform Tribal community members about the reporting process and their rights. We used semistructured interview protocols that allowed us to follow up on additional issues as we learned new information and identified key issues.

Data Analysis

We conducted a quantitative analysis of the closed-ended survey responses to identify trends in the implementation of patient protection policies and related challenges, assess completion of training requirements, and determine the prominence of barriers to patient abuse reporting. For the open-ended survey responses and interview transcripts, we conducted a qualitative analysis to identify themes and select examples for illustration.

Limitations

We did not independently verify the information reported by facility leadership and staff or review individual facility policies or procedures. Further, we did not assess

potential breakdowns that contributed to the Weber case or review any earlier improvement efforts undertaken by IHS to address patient abuse before his indictment in 2017. Lastly, this study focused only on IHS-operated facilities and did not include any tribally operated health care facilities.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Most IHS facilities reported that they incorporated the new IHS patient protection requirements into their local policies, but many faced challenges in carrying out the policies in practice

To ensure agencywide adherence to the 2019 IHM policies for protecting children from sexual abuse by health care providers, IHS required all health care facilities to establish local policies and procedures that incorporate the new policy content. At the time of our review, 81 of the 97 IHS-operated health care facilities that we surveyed reported that they fully incorporated the new IHS requirements into their local policies, and the remaining 16 facilities stated that they were in the process of incorporating them.

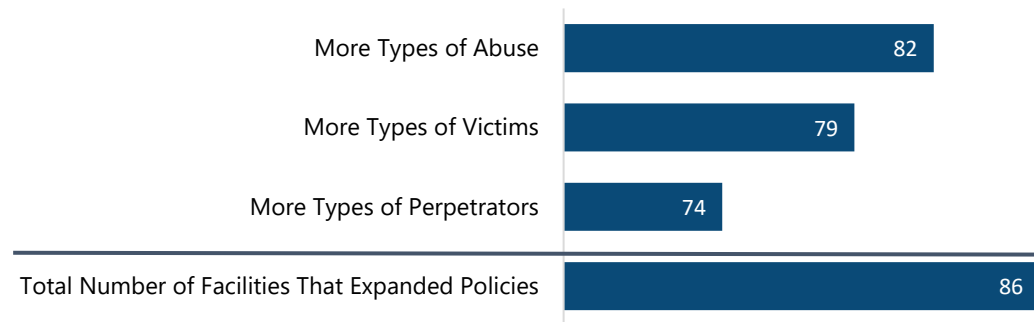
To implement the new policies, facilities reported receiving guidance and support from IHS HQ and Area Offices. Although facilities found this support helpful, facility administrators and staff reported challenges in carrying out the new policy provisions and expressed the need for additional assistance in addressing those challenges.

Many facilities revised their local policies to reflect the new IHS policies and extended coverage to include more types of abuse, victims, and perpetrators

Incorporating the new IHS policies at the local level was a substantial undertaking for some facilities, and we found that there was no uniform approach among facilities in how they aligned their individual policies to the new requirements. Some facilities reported revising their local policies to ensure that they both conformed with the IHS guidelines and were tailored to their community and facility, while other facilities reported making few changes because their existing local policies already covered the IHS provisions.

In updating their local policies, 86 of 97 facilities reported extending the agencywide guidelines to include more types of abuse, victims, and/or perpetrators—coverage that we identified, in our 2019 report, as lacking in IHS policies. Administrators in one facility described how their local policies included protections for the elderly and individuals with disabilities. Another facility detailed how it expanded its policies to protect all patients from any form of abuse, including physical, psychological, sexual, neglect, and harassment, perpetrated by staff, other patients, or visitors. The facility also developed policies to address suspected or confirmed abuse of children, elderly, and disabled adults that may occur outside of the facility but is identified by facility staff during a medical visit. (See Exhibit 3 for the number of facilities that expanded policy coverage.)

Exhibit 3: Most facilities expanded patient protection policies to include more types of abuse, victims, and perpetrators (n=97 facilities).



Source: OIG analysis of 97 facility survey responses, 2020.

Note: Chart is based on a multiple-choice survey question for which facilities could select more than one response.

Nearly two-thirds of facilities reported challenges in carrying out the new policies, and administrators and staff expressed the need for additional support from IHS HQ and Area Offices

Most facilities (74 of 97) reported receiving guidance and support from IHS HQ and Area Offices during the policy implementation process, largely through agency- or Area-wide communication. For some facilities, Area Offices also administered templates and specific instructions on how to incorporate the new policy guidelines and reviewed local policies to ensure that they aligned with the agencywide requirements.

Despite the support from IHS HQ and Area Offices, 62 of 97 facilities reported that they encountered, or anticipated encountering, challenges in carrying out the new policy provisions. The most commonly reported challenges related to providing chaperones during medical exams, ensuring anonymity of victims and reporters of patient abuse, coordinating with law enforcement regarding patient abuse allegations, and understanding policy content and coverage. Facility administrators and staff often expressed the need for additional support from IHS HQ and Area Offices to address these challenges, such as more staff training. (See Exhibit 4 for a list of challenges and the number of facilities that reported those challenges.)

Exhibit 4: Nearly two-thirds of all facilities reported challenges in carrying out IHS patient protection policies (n=97).



Source: OIG analysis of 97 facility survey responses, 2020.

Note: Chart is based on a multiple-choice survey question for which facilities could select more than one response.

Thirty-three facilities reported challenges with delayed background investigations and staffing shortages limiting providers who could perform or chaperone medical exams, and some called for expedited investigations. IHS policy dictates that providers must have favorable adjudications of background checks before they can perform medical exams without a chaperone or serve as a chaperone for other providers. IHS patient protection policies state that facilities must provide chaperones when requested by a patient, parent, or caregiver, and must be offered to minors during a medical exam. The policy provisions also state that any providers in “contact with or [that] have control over a child” who have a pending background investigation must be within sight and under the supervision of a chaperone with a favorably adjudicated background investigation on file. Facilities reported that it was sometimes difficult to meet the chaperone requirement because of delays in receiving favorable adjudications, which can take a year or longer. Adding to this, some facilities reported that there were often delays in receiving notifications from human resources staff when a provider was favorably adjudicated, and there was confusion among some facility administrators regarding who to contact within the agency to obtain a current list of approved staff.

Already short-staffed, facility administrators described how they sometimes had to pull staff away from their normal duties to serve as chaperones for medical procedures and exams for which they were unfamiliar and lacked experience. As one administrator noted, “When you only have two people [who] have been adjudicated, you are running like a chicken to figure out the care.” To more easily identify chaperones, one facility reported developing a spreadsheet that supervisors could use to track favorably adjudicated providers. The facility was also in the process of assigning color-coded and numbered badges for staff to wear that would quickly identify which staff were cleared and which staff had pending background

investigations and required a chaperone. During interviews, administrators from several facilities expressed that they would like the agency's assistance to address the chaperone challenge by expediting the portions of the background investigations that are within the agency's control and prioritizing medical staff.

Twenty-eight facilities reported challenges ensuring anonymity of patient abuse victims, reporters, and alleged perpetrators, and some called for revisions to IHS reporting policies. During interviews, several administrators and staff expressed that the new policy guidelines in the IHM, which require all staff to report any incident or reasonable suspicion of sexual abuse of a child by a health care provider directly to their supervisor or facility CEO, compromised the anonymity of staff making the reports who may not want to disclose their identity to the supervisor or CEO. Some administrators also raised concerns about the requirement for staff to document patient abuse reports in the IHS incident reporting system because of the system's inability to adequately protect the identities of victims, reporters, and alleged perpetrators. As staff in one facility explained, "Everything that we have to submit has our name on it. Even if we put [the report] in WebCident, there are a number of people that also have access to it."

"Nothing is anonymous around here. There is always going to be a name. You can't report anything anonymously." –Facility Staff

To better protect the identities of all individuals involved in a patient abuse report, some administrators expressed that they would like IHS to revise the reporting structure outlined in the policy guidelines to require reporting through fewer channels that can ensure anonymity, such as the OIG hotline. Nearly all facilities (91 of 97) referenced the OIG hotline as the main anonymous method for reporting patient abuse; 83 of those facilities also listed the IHS hotline as an avenue for anonymous reporting. Additionally, some facilities suggested that IHS should expand on the methods available for reporting patient abuse anonymously to provide staff and patients with more options.

Eighteen facilities reported challenges coordinating with local law enforcement authorities on patient abuse matters, and some suggested that IHS could assist in building those relationships. The IHS policies require all staff to report any incidents or reasonable suspicion of sexual abuse of a child by a health care provider directly to the appropriate CPS and/or law enforcement authorities. The policies also instruct facility CEOs to cooperate with all law enforcement and administrative investigations regarding patient abuse incidents. Similar to what we found in our 2019 report, facilities reported that confusion about jurisdictional boundaries coupled with the remote location of some facilities could inhibit collaboration. One administrator explained that it could be difficult for facilities to identify which law enforcement agency to contact about an incident because the location of where the crime was committed or reported (i.e., on or off the reservation) would determine which law

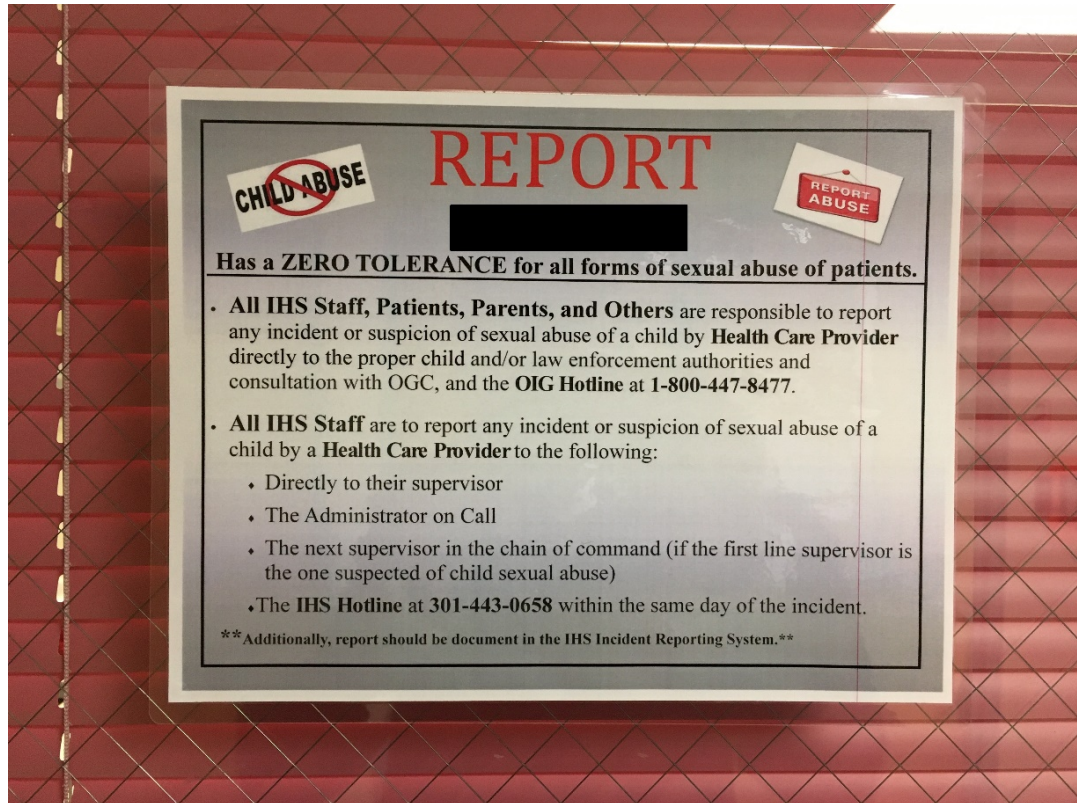
enforcement agency would have jurisdiction and respond to the incident. Another administrator described how the remoteness of some facilities, and the vast geographic area covered by law enforcement agencies, could delay the response time, as law enforcement officers would have to travel long distances to investigate an incident. Facility administrators also reported that confusion about roles and limited understanding of the processes involved in administrative or criminal investigations further affected facilities' ability to coordinate with law enforcement agencies.

To strengthen collaboration with law enforcement and improve facilities' understanding of jurisdictional boundaries, administrators expressed the need for assistance from IHS HQ and Area Offices to build on those relationships. Some facilities suggested that the assistance could be in the form of training, in which IHS could invite law enforcement agencies to educate facility staff on jurisdictional boundaries and processes involved in patient abuse investigations.

Sixteen facilities reported confusion regarding the policy content and coverage, and some suggested that IHS further clarify policies and improve guidance. Facility administrators reported that they found the new IHS policies to be unclear and lacking sufficient guidance on what facilities should include in their local facility policies and procedures to fully meet the agency requirements. Some facility administrators and staff reported confusion about what constitutes patient abuse and how to handle such allegations, including whom to notify about the allegation and what to report. For example, one administrator described how the new IHS policies lacked clarification for how they apply in other types of abuse cases that facility staff may encounter, such as incidents that occur in a patient's home. Staff in another facility reported that it was unclear whether the new policies applied to adult patients. An administrator in a different facility noted that the policies lacked guidelines on how to handle older patient abuse cases reported years after the alleged incident occurred.

To eliminate confusion regarding policy requirements for reporting and handling patient abuse allegations, administrators stated that they would like IHS to provide further clarification on the new policy provisions. For example, facilities reported that it would be helpful to have the agency provide facilities with standardized posters and templates that clearly outline the requirements. At the time of our review, 71 of 97 facilities reported that they had posted signage around the facility to enhance awareness of patient abuse reporting for both patients and staff, a requirement of the new policies, but we found that facility signs lacked uniformity in content and layout. (See Exhibit 5 for an example of a facility poster on patient abuse reporting.) Further, an administrator in one facility suggested that the agency should simplify the language in the policies to ensure that all staff, regardless of their educational background, understand the requirements. In addition to clarifying existing policies, some administrators expressed that they would like additional agencywide guidance on other types of abuse, victims, and perpetrators to ensure that all incidents are addressed properly and in a timely manner.

Exhibit 5: Signage of reporting requirements in one IHS facility.



Source: OIG photo of sign posted at an IHS facility.

All IHS facilities reported that staff completed mandatory training on the new policies; still, many facilities reported supplementing the training and wanting further training

In the months following the issuance of the new policies to protect children from sexual abuse by health care providers, IHS launched a web-based training on the new policy content. All IHS employees and contractors must complete the mandatory training as part of new employee orientation and annually. To ensure agencywide adherence to this training requirement, facilities must maintain records of employees and contractors who have completed the training. At the time of our review, all 97 facilities that we surveyed reported that staff, including contractors, completed the training and that only recently hired staff and those on extended leave had yet to complete the training. Although the mandatory training was well-received and largely deemed sufficient across facilities, most administrators reported providing supplementary discussions, trainings, and workshops for staff and expressed the need for additional policy information and training from IHS HQ or Area Offices.

More than two-thirds of all facilities supplemented the training with additional policy discussions and trainings at the local level

Administrators from 68 of 97 facilities reported expanding the mandatory training, using forums such as discussions, in-person trainings, and workshops, to enhance staff's understanding of their responsibilities under the new policies. For example, some administrators described using staff meetings and huddles (i.e., team meetings at the start of a work shift) to facilitate in-depth discussions regarding the policy content, which provided staff opportunities to ask questions about the requirements. Other administrators reported providing internal training to generate further discussions that covered material not in the agencywide training. These topics included whistleblower protections, retaliation, emotional intelligence, employee relations, and historical trauma. One facility described supplementing the mandatory training with a 3-day workshop for staff, which focused on enhancing communication regarding patient abuse, understanding and employing emotional intelligence, and working toward a cultural change in the provider-patient relationship.

In developing additional trainings for staff, some administrators reported inviting external agencies to lead the discussions and training sessions. For example, several facilities described coordinating with local CPS to train facility staff on mandatory reporting requirements and processes for handling patient abuse cases. One of these facilities indicated that it also had plans to coordinate in-person training with local adult protective services regarding reporting requirements for abuse related to adolescent and adult patients.

Most facilities reported wanting more training from IHS HQ and Area Offices to ensure full comprehension of reporting requirements and staff responsibilities

Although many facilities provided additional training on the new policies at the local level, 81 of 97 facilities reported wanting further agencywide training to assist facilities in addressing and preventing patient abuse. Specifically, facilities reported that they would like IHS HQ and Area Offices to provide training on administrative and criminal investigations to better understand the processes, roles, and responsibilities of law enforcement agencies and others involved in investigating patient abuse—areas which some facility administrators reported they found challenging in carrying out the policies. Many facilities also expressed the need for training specific to facility leadership in handling patient abuse allegations. (See Exhibit 6 for a list of training topics and the number of facilities that reported wanting more trainings.)

Exhibit 6: Eighty-one facilities reported wanting more training from IHS HQ and Area Offices on addressing and preventing patient abuse (n=97 facilities).



Source: OIG analysis of 97 IHS-operated facility survey responses, 2020.

Note: Chart is based on a multiple-choice survey question for which facilities could select more than one response.

To ensure that all facility staff, regardless of their position, understand and adhere to the new policy guidelines, some facility administrators suggested that IHS should provide in-person training for staff. During interviews, administrators from several facilities explained how in-person training would allow for interactive discussions and opportunities for staff to ask questions about specific guidelines and potential scenarios.^b As one administrator noted, "Training has to be reiterative. You don't change behaviors without context and meaning." An administrator in another facility expressed that even interactive training provided via Skype would be helpful to enhance staff knowledge about the policies and their reporting responsibilities. In our 2019 report, Area Office officials noted similar advantages for in-person training, such as clarifying expectations and gauging facility execution and staff understanding of policy guidelines.

^b In-person training may not be possible during the COVID-19 pandemic. The point of the respondents appeared to be that training should be more personal to allow for interactions and questions as opposed to using prerecorded materials.

IHS established avenues for reporting patient abuse and took steps to promote an organizational culture of transparency, although barriers remain that may discourage reporting

To ensure that patient abuse allegations receive immediate attention, IHS established multiple layers of reporting and oversight in the new IHM policies. Under the new policies, all IHS staff must report any incident or suspected sexual abuse of a child by a health care provider to a supervisor or CEO, the IHS and OIG hotlines, the appropriate CPS and/or law enforcement agencies, as well as document the report in the IHS incident reporting system. Facility leadership must also forward the report through their chain of command to ensure that senior leadership in IHS HQ is notified of the incident. (See Exhibit 2 on page 6 for a detailed outline of the reporting structure.) In addition to fulfilling IHS reporting requirements, some facility administrators noted that their staff, as well as patients, could also forward abuse allegations through other avenues, like submitting comment cards or contacting patient advocates. One facility also described how it routinely monitored the facility's social media accounts (e.g., Facebook) for potential concerns raised by staff, patients, or other community members.

The Weber case highlighted organizational failures within IHS, and the new reporting requirements in the IHM provided the agency with further oversight and accountability to address those failures. Several facilities reported a noticeable change in the organizational culture toward transparency following the Weber case. Specifically, facilities noted a strong emphasis from IHS leadership to improve communication and collaboration between IHS HQ, Area Offices, and facilities. A number of facility administrators described how they encouraged the same open dialogue within their facilities to empower staff to forward concerns, suggest improvements, and actively participate in the organizational culture change.

"Someone who witnesses abuse and doesn't report it, a policy doesn't change that. It's about what we do as leaders to change the culture of this dialogue." –Facility Administrator

To increase transparency and awareness of patient abuse reporting at the local level, many facilities reported conducting outreach to Tribal communities and other stakeholders. Administrators from 60 of the 97 facilities that we surveyed reported sharing the new patient protection policies with their Tribal communities. Administrators from 42 facilities also reported communicating the policies with local law enforcement and CPS. During interviews, a number of facilities expressed the need for additional outreach, particularly in schools, to further educate vulnerable community members about sexual abuse. Administrators from one facility described how they were in the process of developing training for students that combined material on sexual abuse with sex trafficking, a growing concern in many Tribal

communities, and specifically targeting at-risk youth. Another facility, also in the process of establishing more outreach efforts, described how it was planning to use public service announcements on the local radio and create a social media account to communicate the new policies and messages from IHS leadership on the related topic.

Despite these improvements, facilities noted that IHS must overcome a number of barriers to ensure that all allegations of patient abuse are reported and addressed in a timely and effective manner.

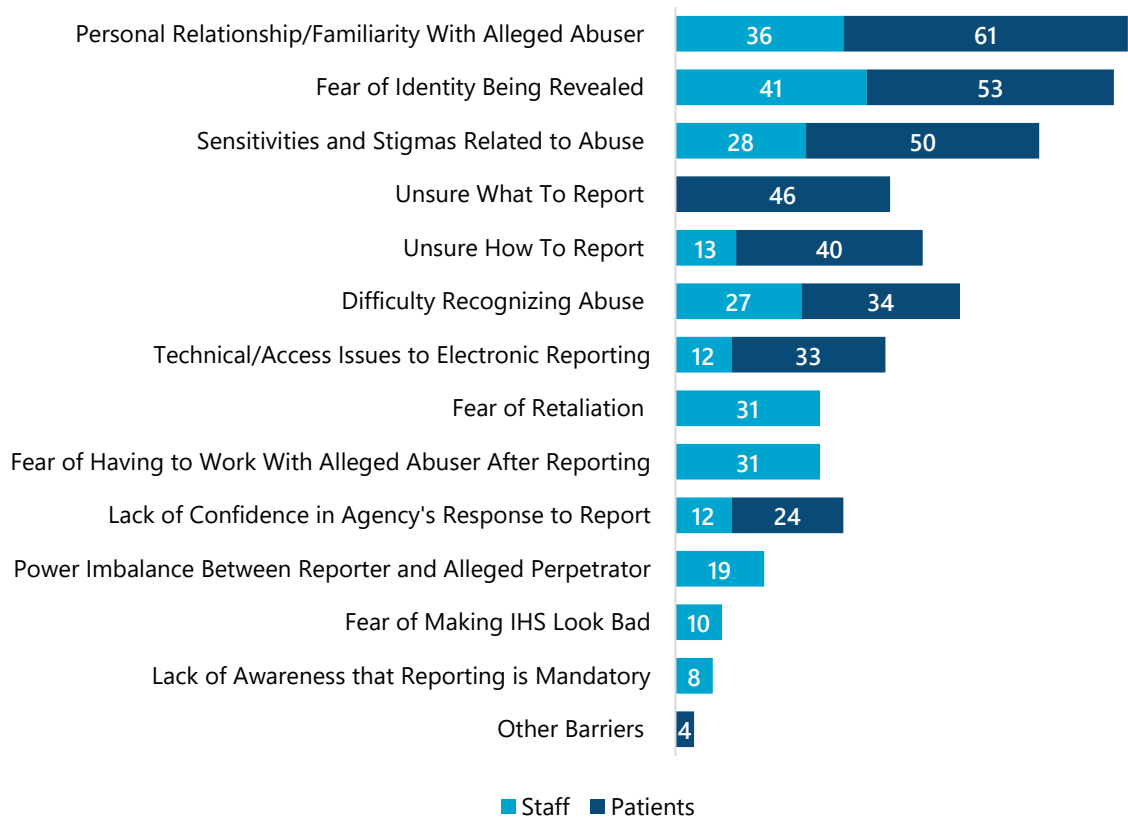
All facilities reported that they were very or somewhat confident that staff would report suspected patient abuse but acknowledged that barriers exist that may deter reporting

Of the 97 facilities that we surveyed, administrators at 82 facilities stated they were very confident that staff would report suspected patient abuse, and administrators at the remaining 15 facilities stated they were somewhat confident that staff would report. At the time of our review, administrators from 6 of 97 facilities reported that they had received at least one report of a patient abuse allegation since the issuance of the new policies in February 2019.^c

Although facilities were generally confident that staff would report suspected patient abuse using the available reporting avenues, 88 of 97 facilities noted that a number of barriers still exist, which may prevent staff and patients from reporting abuse. We identified similar reporting barriers in our 2019 report based on interviews with officials at IHS HQ and Area Offices. (See Exhibit 7 for a list of potential barriers and the number of facilities that reported such barriers.)

^c In total, the 6 facilities reported receiving 11 reports of patient abuse allegations. We did not review these reports or their related outcomes to determine whether the allegations were substantiated or addressed in accordance with the IHS policies.

Exhibit 7: Eighty-eight facilities reported one or more barriers that may discourage staff and/or patients from reporting abuse (n=97 facilities).



Source: OIG analysis of 97 facility survey responses, 2020.

Note: Chart is based on two multiple-choice survey questions that asked facility administrators about their perceived barriers to patient abuse reporting, with one question focusing on barriers for staff and the other question focusing on barriers for patients reporting abuse. We provided a list of potential barriers from which the facilities could select more than one response for each question.

Personal relationships with the alleged perpetrator, fear of having identities revealed, and concerns about retaliation may discourage reporting. Administrators from 61 facilities reported that personal relationships between patients and health care providers may deter patients and their families from reporting abuse involving a provider. These relationships can be particularly challenging in small facilities within isolated communities, where everyone knows everyone, and patient care options are sparse. Staff from several facilities described how their Tribal communities are close-knit and private—many staff are related, live in the communities they serve, and receive care from the same facilities at which they work. Given these relationship dynamics, administrators from 36 facilities reported that staff may also be hesitant to report suspicious behaviors involving facility providers.

The familial relationships, coupled with the challenges of ensuring anonymity of individuals involved in a patient abuse report, may raise concerns about privacy and retaliation for those who report patient abuse. As staff in one facility noted, some facilities are “run by family members,” which can make it difficult to elevate issues

because “if you upset one person, you upset them all.” Administrators from 53 facilities reported that fear of having identities revealed when filing a patient abuse report could discourage patients and their families from reporting; 41 facilities believed that it could inhibit staff from forwarding abuse allegations. Although IHS policies clearly state that reprisals are prohibited against any staff who report patient abuse, 31 of 97 facilities indicated that fear of retaliation was still a concern for some staff, which could affect reporting. In interviews, facility administrators explained that staff may fear losing their jobs or being ostracized or harassed by other staff or community members. In addition, staff may be concerned about the long-term effect on patient care if a provider is removed and the facility is unable to find a replacement.

“I think there is a general fear in IHS [facilities] for people to open their mouths [and report concerns] because they think they’re going to get in trouble.” –Facility Administrator

Similar to what IHS HQ and Area Office officials reported in our 2019 report, facility administrators also noted that patients may fear reprisal in the community if they file a report against a provider who is well-respected by other community members or they may be afraid that they will be treated differently by facility staff. Like staff, patients and their families may also worry about losing access to medical care if they report abuse and the facility removes the provider as a result.

Sensitivities and stigmas related to sexual abuse, and challenges recognizing abusive behaviors due to historical trauma, may inhibit reporting. Administrators from 50 facilities reported that the sensitive nature surrounding sexual abuse could pose a barrier to patient reporting; 28 facilities stated that it could deter staff from reporting. In interviews, several facility administrators and staff explained that shame may plague victims of sexual abuse and discourage them from coming forward, which could be exacerbated in small, isolated communities where people are private and less likely to speak out about issues, and where the topic of sexual abuse might be taboo. We found in our 2019 report that even creating signage on patient abuse reporting to post inside facilities was sometimes challenging for facilities because of sensitivities and stigmas.

Adding to this, if sexual abuse is never discussed, some patients may not recognize abuse to be able to identify inappropriate behaviors; the same is true for staff. One administrator explained her perception that there is a prevalence of being a victim of abuse in many Tribal communities and given that staff are often part of the communities they serve, some staff may be accustomed to abuse and could have a “clouded vision” of what constitutes abuse. With this in mind, the administrator stated that “it would be naive to assume or be overly confident that all staff would be comfortable in reporting abuse.” A staff member in another facility further explained

her perception that the historical trauma of sexual and physical abuse to which many community members have been subjected has become the norm for some staff.^d

"Historical trauma is high and there are many reports of abuse within families and friends. I fear the community is accustomed to abuse and reluctant to report abuse due to rampant occurrences and lack of law enforcement and judicial responses in the past."

—Facility Administrator

Lack of awareness of what and how to report patient abuse may prevent reporting, prompting some facilities to request additional guidance from IHS. Similar to the challenges that some facilities encountered in carrying out the new policies, many facilities noted that lack of awareness or understanding of patient abuse reporting could result in patients and staff not coming forward with abuse allegations. Specifically, 46 facilities reported that patients may be unsure about the types of incidents to report, which could hamper reporting. One facility explained how it has tried to communicate and educate the community on patient abuse and the avenues for reporting but noted that patients who do not frequent the facility may not be aware of this information. The facility recognized that having a patient advocate dedicated to this effort could help getting the message out and reported that it was in the process of hiring a full-time advocate for this purpose.

Along with being unsure on what types of incidents to report, administrators from 40 facilities reported that lack of understanding about how to report patient abuse presents a barrier to patient reporting; 13 facilities indicated that this was also a barrier to staff reporting. In providing an explanation as to why some staff may not forward patient abuse concerns, one administrator stated that if staff previously reported suspicious behaviors, but nothing happened, those staff may question the reporting structure and could be reluctant to come forward again. Another facility explained that hesitation to report may also stem from fear of inaction to address the issue. Given that staff have little insight into what happens after filing a report, the facility noted that "it can be perceived as going into a black hole." Although the facility stated that it may not be appropriate or possible to share the details of an investigation with staff, particularly when it is ongoing, the facility expressed that it would like additional guidance from IHS on what information can be shared with staff who report an incident, to assure staff that the issue is properly addressed.

^d According to a 2016 report issued by the Department of Justice, AI/ANs suffer disproportionately from physical violence, sexual abuse, and psychological aggression—about 84 percent of AI/AN women and 82 percent of AI/AN men experience violence in their lifetime. Department of Justice, Office of Justice Programs, National Institute of Justice, *Five Things About Violence Against American Indian and Alaska Native Women and Men*, May 2016. Accessed at <https://www.ncjrs.gov/pdffiles1/nij/249815.pdf> on September 10, 2020.

CONCLUSION and RECOMMENDATIONS

Since the indictment of Dr. Weber in 2017, IHS has made important strides to address and prevent child sexual abuse in its health care facilities, issuing new policies and training on patient protections and staff reporting responsibilities. At the local level, most facilities have taken measures to incorporate the agencywide policy provisions into their facility-specific policies and procedures, but some facilities are still early in implementation. Although facilities were generally confident that staff would report suspected patient abuse, many facilities reported challenges that may impede their ability to carry out the new policies and warrant further assistance and training. These challenges may have a direct impact on whether staff and patients feel safe to report patient abuse. Some of the barriers to reporting identified in this report, including fear of retaliation and stigma surrounding sexual abuse, align closely with those identified in our 2019 report and support our prior recommendations that IHS should work with urgency to resolve barriers to staff and patient reporting of abuse.

To address the issues identified in this report and further protect patients from abuse, we make four new recommendations to IHS.

We recommend that IHS:

Provide additional guidance and training to facilities on patient protection policies, including the role of law enforcement and the reporting process related to patient abuse

IHS should examine the new policies and revise the policy guidelines, as needed, to provide clarity on the specific requirements and eliminate confusion reported by facilities. Administrators and staff reported they were unclear about some aspects of the policies, such as the role of law enforcement, and also that they benefited from discussing the policies and related issues more in-depth. To ensure that all employees, regardless of their position and educational background, fully understand all aspects of the policies and reporting responsibilities, IHS should provide further guidance and training on the policy content and coverage. This could include interactive trainings (in-person or virtual) which would provide opportunities for staff to ask questions about the policy guidelines and discuss potential scenarios that may not be covered by the policies, such as how to address other types of abuse (e.g., physical, mental), adult victims, or older abuse incidents that may have occurred years before they were reported. IHS could also provide trainings specific to certain positions, particularly for those in leadership roles, to clarify expectations and responsibilities in the report process and during administrative and/or criminal investigations. Additionally, IHS could coordinate with other entities, such as local law

enforcement and CPS, to further educate staff on how to recognize, report, and address patient abuse and to identify ways in which facilities can enhance collaboration with those entities on patient abuse matters.

Improve the process and timeliness for conducting staff background investigations and notifying facilities when staff are approved

Given that staffing shortages and lengthy background investigations affect providers' ability to conduct exams and carry out the chaperone requirement as described in the new policies, IHS should review and improve, as needed, its process for notifying facilities of when pending background investigations of staff have cleared. This improved process could include standardizing and automating notifications, which would help facilities keep current rosters of staff who have been approved (favorably adjudicated) to conduct exams and to serve as chaperones (and perform medical exams without a chaperone, as necessary). To further address staffing shortages and chaperone challenges in facilities, IHS should also review the portions of the background investigations that are within the agency's control, to determine whether timeliness of such investigations can be improved, and make changes as needed.

Examine and revise, as needed, the reporting structure in the policies and the incident reporting system to ensure that staff and patients can report abuse anonymously

To address facilities' concerns about ensuring anonymity of staff, patients, and others who may report patient abuse, IHS should review the reporting requirements outlined in the new policies to determine whether revisions to the reporting structure are needed to enhance the protections of the identities of those involved in a patient abuse report. This review effort could include seeking input from facilities on how to improve the reporting structure and processes and make staff and patients feel safe to report abuse. IHS should also examine the agency's incident reporting system, and make changes as needed, to ensure that the system supports anonymous reporting. Additionally, IHS should provide further guidance on how staff and patients can forward patient abuse allegations anonymously. This guidance could include standardizing signage regarding patient abuse reporting to be posted throughout the facilities and distributed to Tribal communities.

Establish and enforce a deadline by which all facilities must fully incorporate the new requirements into their policies and procedures, and actively monitor facility adherence

For the new agencywide policies to meet their objectives, facilities must not only fully adopt the policies, but also understand and incorporate them into the facility's culture and practices, and promote adherence to the policies through training and discussion with both existing and new staff. Considering that IHS issued the new policies in February 2019 and that some facilities have yet to fully incorporate them at the local level, IHS should set a deadline by which all facilities must complete incorporation of the new requirements into facility policies and training for all staff.

Given the widespread challenges that facilities reported encountering when carrying out the new policies, IHS should also examine the challenges outlined in this report and develop strategies to improve the implementation process. IHS should consider facilitating discussions and information-sharing across facilities to identify best practices for incorporating the agencywide policy guidelines into facility-specific policies and procedures. Further, IHS should consider providing templates that facilities could use to ensure that policies are adopted consistently across the agency. Additionally, IHS should establish a process to verify that facilities have fully incorporated the policies and to monitor facility adherence to the policies ongoing.

This report also provides additional support to five prior OIG recommendations regarding IHS patient protection policies, issued in December 2019, not yet fully implemented by IHS.

Existing unimplemented OIG recommendations regarding IHS patient protection policies:

- › **Extend policies to address more types of perpetrators, victims, and abuse.**
- › **Ensure that the new incident reporting system is effective and addresses the risks identified in the current system.**
- › **Designate a central owner in IHS HQ to ensure clear roles and responsibilities for shared ownership in implementing patient protection policies, and managing and responding to abuse reports.**
- › **Continue to actively promote an organizational culture of transparency and work to resolve barriers to staff reporting of abuse.**
- › **Conduct additional outreach to Tribal communities to inform them of patient rights, solicit community concerns, and address barriers to reporting of patient abuse.**

AGENCY COMMENTS AND OIG RESPONSE

IHS concurred with our recommendations, and reported actions taken and planned to implement the recommendations. OIG values the steps that IHS has taken and will continue to monitor progress in implementing these recommendations as IHS continues its efforts to improve patient protections. (For the full text of IHS's comments, see Appendix.)

In response to our first recommendation to provide additional guidance and training to facilities, IHS reported that it is developing a plan for mandatory annual, in-person training of IHS employees that will cover child abuse reporting requirements and consequences for failing to report. IHS noted that the training will be conducted by instructors with law enforcement and/or child welfare experience.

In response to our second recommendation to improve the process for conducting staff background investigations and notifying facilities when staff are approved, IHS described a new system designed to enhance the process and timeliness of background investigations. IHS explained that the system streamlines the process across the agency and provides automated delivery of results to Area Offices, a process that was previously manual.

In response to our third recommendation to examine and revise the reporting structure to ensure that staff and patients can report abuse anonymously, IHS stated that its new I-STAR system allows for anonymous reporting. IHS noted that the system has been aligned with the IHM policies "Protecting Children From Sexual Abuse by Health Care Providers" to assist with documentation of abuse incidents and reinforce required reporting responsibilities. IHS also reported that it will include the option of anonymous reporting in its policies on adverse events reporting, which are currently under development.

In response to our fourth recommendation to establish and enforce a deadline by which all facilities must fully incorporate the new requirements and actively monitor adherence, IHS reported that all Area Offices and facilities are required to comply with requirements on the date they are issued. IHS also noted that in February 2020, it developed a framework for IHS HQ to conduct compliance reviews of each Area. IHS stated that it plans to conduct these reviews annually and that the focus of the reviews will be determined by the agency's highest risk areas. IHS noted that the 2021 HQ oversight review plan of IHS Areas will include patient safety, required reporting, and misconduct policies.

APPENDIX

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

NOV 30 2020

Indian Health Service
Rockville, MD 20857

TO: Inspector General

FROM: Director

SUBJECT: IHS Response to OIG Draft Report: *"Indian Health Service Facilities Made Progress Incorporating Patient Protection Policies, but Challenges Remain"* (OEI-06-19-00331), dated November 2020

We appreciate the opportunity to provide our official comments on the OIG Draft Report entitled, *"Indian Health Service Facilities Made Progress Incorporating Patient Protection Policies, but Challenges Remain"* (OEI-06-19-00331). The Indian Health Service (IHS) concurs with each of the four OIG recommendations. Our responses and planned actions to each recommendation are discussed below.

Recommendation No. 1: IHS concurs with this recommendation.

Provide additional guidance and training to facilities on patient protection policies, including the role of law enforcement and the reporting process related to patient abuse.

The IHS is responding to multiple sources of similar recommendations, both internal and external, including the recent White House Task Force on Protecting Indian Children (WHTF). An IHS plan is under development to require annual, in-person, standardized training of IHS employees, conducted by instructors with law enforcement and/or child welfare experience. Consistent with both the OIG recommendation and the WHTF recommendation, the IHS will establish mandatory training pertaining to Federal child abuse reporting requirements and the consequences for failing to report for its employees and contractors. The mandatory training is intended to be conducted by persons with law enforcement and/or child welfare experience, and will be conducted in coordination with IHS and human resources personnel.

Recommendation No. 2: IHS concurs with this recommendation.

Improve the process and timeliness for conducting staff background investigations and notifying facilities when staff are approved.

In January 2020, the IHS implemented the Department of Health and Human Services (HHS)/Office of National Security information tracking system called Security Manager. This system is an enterprise solution to enhance existing personnel security management capabilities. Security Manager supports the entire life cycle of HHS's personnel and administrative security and suitability processes. Security Manager improves the process and timeliness for submitting and receiving background investigations and notifying facilities once

investigations are favorably adjudicated. Security Manager allows the IHS to streamline the process across IHS Headquarters (HQ) and Areas by having a central location for personnel security data, as well as to improve Agency coordination for suitability and national security verification for all IHS employees, including Commissioned Corps Officers, contractors, and volunteers. Security Manager allows for immediate electronic delivery of closed investigations from the Defense Counterintelligence Security Agency for final review and adjudication by the IHS. Upon final adjudication, Security Manager generates an automatic notification to an Area's personnel security representatives that an investigation has been completed, and a signed certificate of investigation is available in Security Manager. This represents a significant improvement in efficiency over the previously manual process of mailing the certificates of investigation to the Areas. The IHS Office of Human Resources monitors and tracks the background investigations in Security Manager on a monthly basis.

Recommendation No. 3: IHS concurs with this recommendation.

Examine and revise, as needed, the reporting structure in the policies and the incident reporting system to ensure that staff and patients can report abuse anonymously.

As part of the customization of the IHS Safety Tracking & Response (I-STAR) system, any employee entering a report of an event, including physical or sexual abuse, is given the option to report the incident anonymously. Policies under development related to the reporting of adverse events will ensure awareness of this option. Additionally, I-STAR has been aligned with *Indian Health Manual* (IHM), Part 3, Chapter 20, to assist with documentation of sexual assault/abuse cases. The I-STAR-specific protocols reinforce required reporting responsibilities, and to whom a specific event should be reported, and include pop-up dialogue reminders. The I-STAR Team will release a sexual assault/abuse "job aide" in December 2020.

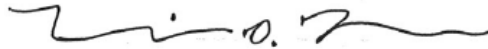
Recommendation No. 4: IHS concurs with this recommendation.

Establish and enforce a deadline by which all facilities must fully incorporate the new requirements into their policies and procedures, and actively monitor facility adherence.

The IHS is responding to multiple sources of similar recommendations, both internal and external, including a recent recommendation from the Government Accountability Office. As national policies are issued, all IHS Areas and facilities are required to comply with the policy requirements on the date they are issued. Supplemental policies at the local levels, including Area Office and Service Unit policies, may be developed, but they are intended to tailor national directives to local needs and processes. In February 2020, the 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 Oversight 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. The IHS plans to include a review of patient safety, required reporting, and misconduct policies in IHS Areas as a component of the 2021 HQ oversight review plan. HQ Reviewers for this portion of the oversight review will include senior officials from IHS HQ program offices.

Thank you for the opportunity to review and comment on this draft report. Please refer any follow-up questions you have regarding our comments to Ms. Athena Elliott, Chief Compliance Officer, IHS, by e-mail at athena.elliott@ihs.gov.



RADM Michael D. Weahkee, MBA, MHSA
Assistant Surgeon General, U.S. Public Health Service

ACKNOWLEDGMENTS AND CONTACT

Acknowledgments

Petra Nealy served as the team leader for this study, and John Van Der Schans served as the lead analyst. Others in the Office of Evaluation and Inspections who conducted the study include Charis Burger and Savanna Thielbar. Office of Evaluation and Inspections staff who provided support include Joe Chiarenzelli and Kevin Farber.

This report was prepared under the direction of Ruth Ann Dorrill, Regional Inspector General for Evaluation and Inspections in the Dallas regional office, and Petra Nealy, Deputy Regional Inspector General.

Contact

To obtain additional information concerning this report, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov. OIG reports and other information can be found on the OIG website at oig.hhs.gov.

Office of Inspector General
U.S. Department of Health and Human Services
330 Independence Avenue, SW
Washington, DC 20201

ABOUT THE OFFICE OF INSPECTOR GENERAL

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ENDNOTES

- ¹ IHS, *Justification of Estimates for Appropriations Committees*, Fiscal Year 2021, p. CJ-2, 7. Accessed at https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY_2021_Final_CJ-IHS.pdf on March 26, 2020.
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