S. HRG. 111–873

IN CRITICAL CONDITION: THE URGENT NEED TO REFORM THE INDIAN HEALTH SERVICE'S ABERDEEN AREA

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

SEPTEMBER 28, 2010

Printed for the use of the Committee on Indian Affairs

U.S. GOVERNMENT PRINTING OFFICE

63–826 PDF WASHINGTON : 2011

For sale by the Superintendent of Documents, U.S. Government Printing Office
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IN CRITICAL CONDITION: THE URGENT NEED TO REFORM THE INDIAN HEALTH SERVICE'S ABERDEEN AREA

TUESDAY, SEPTEMBER 28, 2010

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10 o'clock a.m. in room 628, Dirksen Senate Office Building, Hon. Byron L. Dorgan, Chairman of the Committee, presiding.

OPENING STATEMENT OF HON. BYRON L. DORGAN, U.S. SENATOR FROM NORTH DAKOTA

The CHAIRMAN. I am going to call the hearing to order. This is a hearing of the Indian Affairs Committee.

Today we are going to hold an oversight hearing entitled In Critical Condition: The Urgent Need to Reform the Indian Health Service's Aberdeen Area. We have focused, as many in this room know, on an investigation of the Aberdeen Area of the Indian Health Service. Two months ago, this Committee began this formal investigation. I initiated this investigation with the consent of the Committee after years of hearing about poor performance and mismanagement within the Area.

The investigation has focused on facilities operated by the IHS over the past five years especially, and today's hearing is going to discuss some of the initial finds and will give us the opportunity to hear from the Director of the IHS and others and understand what the Agency is doing at this point to address the problems.

Many of the allegations heard throughout these years were substantiated in the investigation. The Committee found increasingly high numbers of EEOC complaints and other workforce grievances being filed in this region, transfers and administrative leave commonly being used as a remedy for problem employees, doctors and nurses treating patients with expired licenses and certifications, several facilities on the brink of losing their accreditation or certification, frequent diversion of healthcare services and substantial amounts of missing or stolen narcotics, questionable management of contract health service funds, and mismanagement of billing Medicare, Medicaid or other private insurers.

I recognize these problems are not new and, in fact, have festered in some cases for decades. I know Director Roubideaux and Aberdeen Director Red Thunder inherited many of these problems

and only had a short time to address them. I believe, however, that it will take more than two Directors to make significant change to the system and it is my hope that Secretary Sebelius will make improving the Indian Health Service a priority during her tenure. We have met and talked about that and she has given me that commitment.

Let me say there are clearly many dedicated and hardworking employees in the Aberdeen Area working for Indian Health Service. I recognize that. I have said it publicly. I want it to be said again today. There are people I am sure working in the units who got up this morning and all they care about is treating patients. God bless them for their good work. This is not to cast aspersions on dedicated, loyal, good people who are working today in the Indian Health System. Lives are being saved because of their work.

But, it is the case and I know it to be the case and I have watched the Indian Health Service juggle all of these things around, that there are poor performing employees who, in my judgment, ill serve the very patients they are supposed to help. And I am convinced that problem employees are able to wreak havoc and demoralize those who fight so hard to provide quality healthcare. And I just think it is time to stop.

We found instances of employees working under impaired conditions, in some cases perhaps under the influence of alcohol. In one horrendous incident, a nurse was found to be assisting in a C-section in such an impaired state that she could not even hold the patient's skin for staples. And the nurse kept her job following this incident.

In 2002, this goes back some while, the former Service Unit Director of the Quentin Burdock Memorial Hospital was found by the Inspector General, the Office of the Inspector General, to have a pattern of mismanagement, discrimination and retaliation against employees, resulting in grievances and unwarranted civil suits. This is the report by the Inspector General.

Though several suits against this Director cost the Agency over $106,000, despite this the Service Unit Director did not receive a demotion or a suspension and in fact was reassigned to the Aberdeen Area office only to retire seven years later in 2009.

Sadly, this Committee found many, many more stories just like this one. Some employees repeatedly engaging in bad behavior or even illegal activity facing little or no disciplinary action. Instead, administrative leave or transferring employees is a solution.

The Committee found that 176 employees in the Aberdeen Area were placed on paid administrative leave in the past five years for a period of times that totals eight years. This chart will show the paid administrative leave at three facilities in the Aberdeen Region, Aberdeen, Sisseton and I cannot see the third, I guess it is Winnebago.

[The information referred to follows:]

Employees Placed on Administrative Leave: Aberdeen Area, 2005–2010

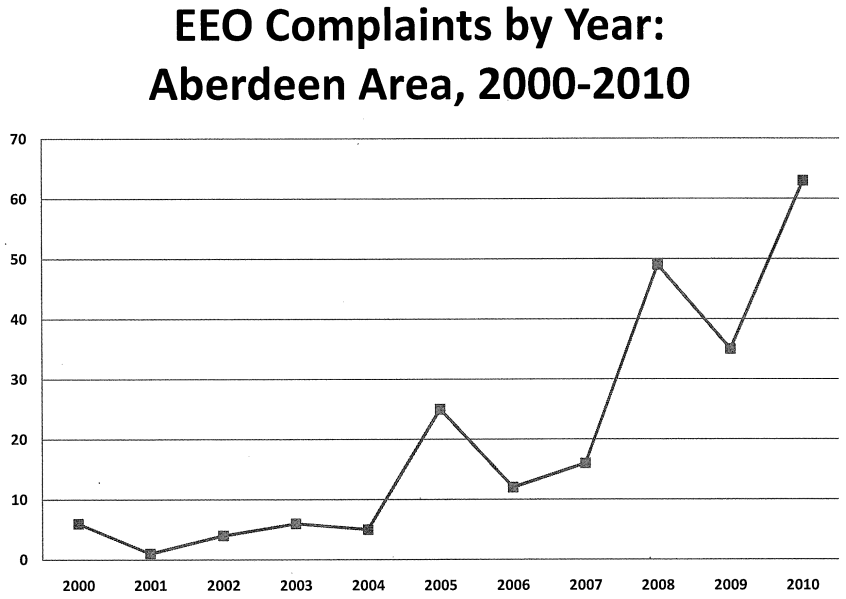
Service Unit	Number of Employees on Administrative Leave	Average Length of Administrative Leave
Belcourt	22	Nearly 1.5 Months
Sisseton	11	Nearly 1 Month
Winnebago	13	Nearly 3 Weeks

Source: Indian Health Service

The CHAIRMAN. The Committee found that in some cases a single individual was placed on administration leave for over eight months due to a pending investigation. I do not understand why the Federal Government would pay someone for eight months to stay home while something is being investigated.

The number of EEOC, Equal Employment Opportunity complaints in the Aberdeen Area has increased dramatically in the past five years. I hope my colleagues will look at this chart.

[The information referred to follows:]



Source: Indian Health Service

The CHAIRMAN. This chart shows the number of EEOC complaints being filed year by year in the Aberdeen Area. It has increased dramatically. Even worse, the number of complaints filed in the Aberdeen Area filed by July of this year has surpassed the number filed for the entire Agency in 2009. This problem is not getting any better. It is getting worse.

Additionally, five Agency facilities in the Aberdeen Area are at risk of losing their accreditation, that according to information that we have received. That is Chart Number 3.

[The information referred to follows:]

Aberdeen Area Indian Health Service
Administrative Review
April 2010

Recommendation — The Aberdeen Area needs to schedule Service Unit reviews of all administrative functions and ensure reports are completed timely and corrective actions are implemented to address identified deficiencies.

During the review, it was identified that five (5) Service Units are in jeopardy of losing accreditation from CMS. The loss of accreditation would have a devastating effect on these Service Unit budgets and severely restrict program operations.

[illegible] variances, should be provided to the Executive Officer for appropriate follow up and action.

Aberdeen Area Review 9 Final Report 2010

The CHAIRMAN. If accreditation is lost, these facilities would be unable to bill Medicaid, Medicare or other insurers.

Finally, these problems have also resulted in diverted healthcare services where a facility that would normally be able to take patients is no longer able to provide a service and must send a patient outside to obtain care. This fourth chart, I am running through these quickly, I am sorry, this fourth chart shows facilities in the Aberdeen Area that have recurring diverted or reduced services.

[The information referred to follows:]

Reduced or Diverted Health Care Services: Aberdeen Area, 2007–2010

Facility Name	Reduced or Diverted Services
Belcourt—Quentin Burdick Memorial Hospital (ND)	388 Days
Rapid City Hospital (SD)	385 Days
Eagle Butte Hospital (SD)	242 Days

Source: Indian Health Service

The CHAIRMAN. From 2007 to 2010, the Quentin Burdock Hospital in North Dakota diverted or reduced services 388 days, 45 percent of the time patients could not receive certain inpatient services at that hospital. The Rapid City IHS Hospital Eagle Butte Service also had hundreds of days of reduced or diverted services in the last three years.

The result of this is summed up well in a statement by an internal Agency document referring to its hospital in Rapid City, South Dakota. And here is what that statement said. Again, this is an internal document. If a patient needs to be seen today, they must start calling daily at 8:00 a.m. to try to secure an appointment

time. If the line is busy, they must keep trying, like a radio station giving away a prize. If the patient is lucky, they will secure an appointment.

[The information referred to follows:]

DRAFT
RAPID CITY SERVICE UNIT
OPERATIONAL IMPROVEMENT
Action Plan
Appointments/Patient Registration Should be Picture

2005

What: Patients should be able to get an appointment when they want one with their primary provider team.

about being unable to obtain an appointment. If a patient needs to be seen today, they must start calling in daily at 8:00 a.m. to try to secure an appointment time; if the line is busy they must keep trying. Like a radio station giving away a prize if the patient is lucky they would secure an appointment. If there are no appointments slots available the

[illegible] in compliance with the Indian eligibility requirements. We also could imp[illegible] third party collections by obtaining insurance information and signatures.

Who: The primary stakeholder is the patient and appointment/registration staff.

When: By the first payperiod in November.

Where: Business Office

Scheduling medical appointments should not be like trying to win a lottery on a radio station.

Let me just make a final comment. Ms. Red Thunder, you and I met at a hospital, the Quentin Burdock Hospital in Belcourt, I think it was a year and a half or two years ago now. I went there and sat around a table and spent a fair amount of time listening to everybody because it was dysfunctional, unbelievably dysfunctional.

It has now had six, six Directors for that hospital, in two years. Some of those were just Active Directors, but six of them, and the seventh will start this next month as I understand it. Everyone understands how unbelievably bankrupt that is for an institution to have seven Directors in two years.

You and I, I met you at that hospital because I said and believed at the time that Indians were being dis-served. These are people who expect good healthcare service and were not getting it, children, elders, and it was dysfunctional. In my judgment, nothing has changed in two years.

I do not call you all here to decide to say that the whole system is bankrupt, but I am determined, one at a time, to find out what is going on first with this Service District because I think it has not worked at all. You have seen the numbers. Anybody can justify to me what we are seeing in these, all these complaints and the stories I have just described? It is unbelievable and it has to stop.

Now, we have sent demand letters. I know there have been concerns that we have asked for too much information. Anything we

did not get, or will not get or do not get, we will subpoena. We intend to get all of the information and make judgments about it.

Ms. Roubideaux, you were confirmed by this Committee, supported by me and the Committee. We did that because we believe you have the capability to fix this. But I told you the day that you were before this Committee that this is a mess, and a big problem, and a big bureaucracy that does not want to change. It wants to not deal with problems. It wants to ship them to the next Reservation, the next Service Unit. That has got to stop and it is going to stop now.

Let me call on my colleagues for brief comments and then I will proceed to the witnesses.

Senator Franken?

STATEMENT OF HON. AL FRANKEN,
U.S. SENATOR FROM MINNESOTA

Senator FRANKEN. Mr. Chairman, thank you for holding this hearing on a topic of vital importance to our American Indian communities in Minnesota and across the Country. I want to thank you for initiating this investigation. It is an important step in what will be a difficult, but I hope successful, effort to reform IHS so it can be a model of delivering healthcare.

The VA came through this in the early 1990s and is now considered one of the very best healthcare systems in this Country. And I hope that we can say the same of the Indian Healthcare System.

However, over and over again I have heard from Minnesota tribes that health services are inaccessible and insufficient. We have serious shortages of all services, especially in substance abuse, mental health and dental services. Tribal members drive hours to get care and too many are on waiting lists for contract health services. They often wait hours, if not years, for urgent care like heart surgery and joint replacements.

That is why I am deeply concerned about the findings from the Committee's investigation. These findings indicate that there is serious dysfunction and mismanagement in the Indian Health Service. Instead of being good stewards of scarce and desperately needed Federal resources, there is blatant misconduct and a serious lack of accountability.

I truly hope that the findings of this investigation are not indicative of IHS nationwide, but I think we all know that if these problems are happening in Aberdeen, they are probably happening in Alaska, in Albuquerque, Billings, Phoenix, Oklahoma, Navaho Country, Nashville, California, Portland, Tucson and in Bemidji, Minnesota.

That is why I respectfully request that Secretary Sebelius and Acting Director of the Office of Management and Budget, Jeffrey Zients, take a serious look at the information presented here today. I would like them to conduct comparable investigations into all IHS areas. We need to do everything we can to provide tribal members with high quality healthcare which they are promised. And we need to know what is happening within our Federal agencies.

I will be submitting these requests in writing later today and welcome any other members of the Committee to join me on these letters.

Thank you again, Mr. Chairman, for your outstanding leadership and work on this matter. And thank you to the witnesses for joining us here today. I look forward to hearing your testimony.

The CHAIRMAN. Senator Franken, thank you very much.

Senator Johnson?

STATEMENT OF HON. TIM JOHNSON, U.S. SENATOR FROM SOUTH DAKOTA

Senator JOHNSON. Mr. Chairman, thank you for holding this hearing. As you know, the Aberdeen Area serves tribal members in both North and South Dakota and I believe this is a very important hearing.

For many years there have been questions surrounding the agencies that serve Indian Country. I consistently hear a variety of concerns from many of my individual Indian constituents. It is my hope that this hearing can provide the necessary insight into these problems and focus on solutions.

I would like to commend many of those who work in Indian Health Service. I am certain it is their goal to provide a high quality of care to our tribal members. While this hearing is to look at deficiencies at the IHS and the Aberdeen Area, it is critical to focus on moving forward and seeking positive solutions to solve these problems. We must do all that we can to uphold our treaty and trust responsibility to the American Indians.

I would like to thank the witnesses for being here today to provide important testimony and I look forward to working together to improve the healthcare delivered to American Indians.

Thank you.

The CHAIRMAN. Senator Johnson, thank you very much.

I want to make one additional comment, and then I am going to call on the witnesses and Dr. Roubideaux.

The Congress passed, for the first time in 17 years, the Indian Healthcare Improvement Act this year. I used a photograph of a little girl every day I was on the Senator Floor, a little girl named Ta'Shon Rain Little Light. I did that with the consent of her grandparents and her parents. Ta'Shon Rain Little Light, just to remind all of us what this subject is about, it is not about some academic dispute or some concern we have with this, with an Agency, it is about life and death.

[The photograph referred to follows:]

This little girl is not with us anymore. You can see the sparkle in her eyes. She loved to dance, her mother and her grandmother told me. She went to a Service Unit, not in this District by the way, was told three separate times that she was depressed, given medicine for depression. In fact, she had terminal cancer and she died. The night before she died in her mother's arms, she told her mother, mommy, I am sorry that I have been sick. And then she passed away.

This little girl probably should be alive today if she had better medical treatment. It happens. I understand that. It happens. Sometimes, diagnoses are missed. But, with the consent of the parents, I wanted to make sure that every day on the Floor of the Senate when we debated this subject of improving Indian Health Care that people understood what the stakes were. This is life and death for children, for elders and others.

Having passed the Indian Healthcare Improvement Act in the name of Ta'Shon Rain Little Light and so many others, I do not want Indian healthcare now to be delivered in a second class way. I want this to be the outstanding delivery of good healthcare to those who deserve it, expect it and need it.

With that, let me call on Dr. Yvette Roubideaux, the Director of the Indian Health Service. Dr. Roubideaux, you may proceed.

We have three witnesses today I should say, Dr. Roubideaux, Charlene Red Thunder and Gerald Roy. Charlene Red Thunder is the Aberdeen Area Director of the Indian Health Service. Gerald Roy is the Deputy Inspector General for Investigations of the Office of Inspector General. Following that, we will have testimony by Ron His Horse Is Thunder, the Executive Director of the Aberdeen Area Tribal Chairman's Health Board.

Dr. Roubideaux, you may proceed.

STATEMENT OF YVETTE ROUBIDEAUX, M.D., M.P.H., DIRECTOR, INDIAN HEALTH SERVICES

Dr. ROUBIDEAUX. Great. Well, thank you, Mr. Chairman, and members of the Committee.

My name is Dr. Yvette Roubideaux and I am the Director of the Indian Health Service. I am pleased to have the opportunity to testify on the review of the Aberdeen Area Indian Health Service.

I would first like to thank you, Chairman Dorgan, for your advocacy for Indian people over the years. You have worked tirelessly to improve the healthcare of Indian people. And I agree with you. We have a serious problem in the Aberdeen Area and we are here to talk about how we are going to fix it. And so I would like to summarize my testimony.

I am a member of the Rosebud Sioux Tribe of South Dakota and I was raised in Rapid City. I have a long history with the Aberdeen Area Indian Health Service and I am acutely aware of the longstanding challenges facing the Area.

There has been insufficient accountability with respect to performance and financial management. There have been difficulties providing care in rural and remote and impoverished communities and limited resources to address the problem. I have witnessed these problems firsthand and seen the consequences for Indian people and seen the consequences for my own family.

While many would like to believe that Agency funding levels are the sole reason for the Area's management problems, that simply is not true. Without question, funding plays a significant role. But we can and we must make meaningful progress toward addressing these issues utilizing the resources we currently have. We cannot pay for services with money we do not have, but we can manage our human and financial resources more capably. And that is what I am committed to doing.

Chairman Dorgan, I know you are committed to the same goal. I deeply appreciate your efforts over the years to provide the Agency with the resources it needs to address its longstanding problems and your support for my own efforts to bring reform to the Indian Health Services, meaningful and lasting change. With your continued support, I know we can make substantial progress.

One of the main reasons I became a physician was my desire to help and improve the quality of healthcare for my people. Thirty years later, I accepted President Obama's nomination to be the Director of the Indian Health Service and to begin this very important but very difficult work. In the time since I was sworn in as the Director, we have already taken a number of important steps to address the challenges facing the Aberdeen Area of the IHS and to reform the IHS as a whole.

Chairman Dorgan, you and I share a mutual belief. We both believe that the Aberdeen Area Indian Health Service must do a better job of serving its communities. We also share a mutual conviction. Our management policies and principles must continue the change. I have four management priorities that will bring about the changes that we both want.

My first priority is to renew and strengthen our partnership with the Tribes. I really believe the only way we are going to improve the health of our communities and address these types of problems

is to work in partnership with the Tribes. I personally conducted more than 270 tribal delegation meetings and visited 11 of 12 areas. Just last month I visited the Aberdeen Area and met with tribal leaders and heard their specific input about needed improvements.

The second priority is to reform the management practices and the organizational culture of IHS in order to create lasting changes. This starts with a strong tone at the top of the organization. I have communicated clearly to all IHS employees the importance of improving our customer service, professionalism and ethics, and the importance of holding employees accountable for poor performance.

We are also improving financial management by holding leadership and management accountable for specific improvements and more consistency in managing our budgets. We have implemented a stronger performance management process, including setting expectations, holding people accountable for poor performance and establishing more specific and measurable performance goals. I will see the outcomes of that in the next couple of months as we evaluate our employees for this past year.

And now we have a property management system that holds leadership and all employees financially and personally accountable for property lent to them.

My third priority of reform focuses on improving the quality of and access to care for patients we serve. We are improving our customer service and expanding our medical home initiative. We are also supporting our facilities to ensure that 100 percent of all IHS facilities continue to meet accreditation standards.

In addition, I am assembling a group of senior leadership this month to develop recommendations on how to improve the quality of healthcare in our facilities and in our system as a whole.

The fourth priority is to make all of our work transparent, accountable, fair and inclusive and I firmly believe that creating a culture of openness at IHS is an important part of meeting these objectives.

Chairman Dorgan, while I believe that these four priorities for reform will help bring meaningful, lasting change throughout the IHS, as I mentioned earlier in my testimony, I recognize that the Aberdeen Area faces severe challenges. I would like to discuss our progress to date in clearly defining and addressing these challenges.

In 2009, I launched a series of comprehensive management reviews for the 12 IHS areas. Given the severity of the problems it faces, the Aberdeen Area was the second on the list and the review was completed in April 2010 by an independent internal team and contained 54 specific recommendations for improvement. As of today, significant progress has been made on each of these recommendations. And there is still more work to do.

That progress is due in large part to the efforts of our Aberdeen Area Director, Charlene Red Thunder. Ms. Red Thunder is committed to bringing reform at the Area level and is holding managers and employees accountable for their performance. She is making progress under very difficult and challenging circumstances and I am so grateful that she has been willing to step up to this very difficult challenge.

In her two years as Director, Ms. Red Thunder's specific accomplishments include taking disciplinary action against five Service Unit Directors and achieving complete area wide fiscal solvency with no budget deficits at the Service Unit level. This is a performance accountability result that has not been accomplished in over 20 years; resolution of past Service Unit debt going back 20 years; increased third party collections by $30 million in the last year; and regained the trust of area tribal leadership by being more transparent about Agency business.

Well, despite the progress to date, we obviously have a long way to go. While the situation at IHS is improving every day, the kind of change that we want to see will not happen overnight. In order to achieve our shared goals for IHS and the Aberdeen Area, I believe an effective collaboration between IHS and Congress is essential. And IHS is committed to cooperating fully with your investigation.

Secretary Sebelius asked me to tell you that she and the rest of the Department fully support IHS in remedying these important issues that you have helped to raise. Her program Integrity Initiative is assisting us in addressing these concerns about the Aberdeen Area.

Mr. Chairman, this concludes my statement. Thank you again for your longstanding commitment to the Indian Health Service, improving it overall and the Aberdeen Area, and the opportunity to testify today.

Thank you.

[The prepared statement of Ms. Roubideaux follows:]

PREPARED STATEMENT OF YVETTE ROUBIDEAUX, M.D., M.P.H., DIRECTOR, INDIAN HEALTH SERVICES

Good Morning. I am Dr. Yvette Roubideaux, Director of the Indian Health Service (IHS). Today I am accompanied by Charlene Red Thunder, Area Director of the Aberdeen Area Indian Health Service. I am pleased to have the opportunity to testify on the Senate Committee on Indian Affairs' ongoing review of the Aberdeen Area Indian Health Service programs and operations.

As I noted in my confirmation before this Committee in the spring of 2009, I am a member of the Rosebud Sioux Tribe of South Dakota, and was raised in Rapid City. I have a long history with the Aberdeen Area Indian Health Service, and am acutely aware of the longstanding challenges facing the Area, including insufficient accountability with respect to performance and financial management; the difficulties of providing care in rural, remote, and impoverished communities; and limited resources to address the problem. I've witnessed these problems firsthand and seen the consequences for Indian people.

While some believe agency funding levels are the sole reason for the Area's management problems, that simply isn't true. Without question, funding plays a significant role, but we can and must make meaningful progress toward addressing these issues utilizing the resources we currently have. We cannot pay for services with money we don't have, but we can manage our human and financial resources more capably, and that is what I am committed to doing.

Chairman Dorgan, I know you are committed to this same goal. I deeply appreciate your efforts over the years to provide the agency with the resources it needs to address its longstanding problems, and your support for my own efforts to bring meaningful and lasting change to IHS. With your continued support, I know we can make substantial progress.

The main reason I became a physician was my desire to help improve the quality of health care for my people. Thirty years later, I accepted the President's nomination to be IHS Director and begin this important but difficult work. In the time since I was sworn in as Director, we have already taken a number of important steps to address the challenges facing the Aberdeen Area of the IHS—and to reform the IHS as a whole.

My testimony begins with a general overview of where IHS stands today and a status report on my priority goals for the agency. It then discusses the specific challenges facing the Aberdeen Area and our efforts to work with the Committee to address them.

The Indian Health Service Today

The Indian Health Service has demonstrated that it can provide quality healthcare with limited resources and staff. It has many dedicated health professionals providing important services.

This Indian health system serves nearly 1.9 million American Indians and Alaska Natives through hospitals, health centers, and clinics located in 35 States, often representing the only source of health care for many American Indian and Alaska Native individuals, especially for those who live in the most remote and povertystricken areas of the United States.

This is, as we all recognize, a difficult mission—and one that has grown more challenging as a result of population growth, rising healthcare costs, and greater incidence of chronic conditions and their underlying risk factors, such as diabetes and childhood obesity, among Indian people. The circumstances of too many of our communities—poverty, unemployment, and crime—often exacerbate the challenges we face. We have made great strides in facilitating Tribes taking over management of health programs through the Indian Self-Determination and Educational Assistance Act (Public Law 93–638); Tribes now manage over half of the Indian Health Service budget, and are demonstrating how new ideas and increased flexibility in managing these healthcare services can result in innovative and more effective healthcare programs. At the same time, this transition has resulted in significant reorganization, which has changed the approach we use to manage the direct service component of IHS.

Priorities for IHS Reform

Since I was confirmed in May 2009, I have responded to a call from Tribal leaders, staff and patients to change and improve the Indian Health Service. While bringing fundamental reform to IHS may seem like a daunting task, I believe this is a unique time in history, and that, with a supportive President and bipartisan support in Congress for reform, we have an opportunity to bring lasting change to an agency that desperately needs it. Accordingly, upon being confirmed as Director, I set four priorities to guide the work of the agency in the coming years, and I am pleased to say that we are beginning to make real progress.

Renew and Strengthen the IHS Partnership with Tribes

The first priority is to renew and strengthen our partnership with Tribes. I believe the only way we are going to improve the health of our communities is to work in partnership with them. The first step in strengthening that partnership is through face-to-face meetings. I have personally conducted more than 270 Tribal Delegation Meetings since being sworn in over a year ago, and have visited 11 of 12 IHS Areas to visit with Tribes. Just last month, I visited the Aberdeen Area to meet with tribal leaders and heard their input and comments about needed improvements. Because not all Tribes can afford to travel to Washington, DC, these Area visits are critical to make sure all Tribal voices are heard. Building on these meetings, I instructed my Director's Workgroup on Tribal Consultation to develop detailed recommendations for improvement. We have already begun implementing those recommendations. For example, I have prohibited the practice of shifting Area resources and funds without consulting tribes directly. Under my watch, no tribe is going to lose or gain from shifts in funds without being part of process.

Reform Indian Health Service Management

The second priority is about reforming the management of the IHS, which I have already begun to do. It is clear we must improve the way we do business and lead and manage our staff, by putting in place fundamental reforms in management practices and organizational culture to create lasting change.

This starts with a strong tone at the top of the organization. I have communicated clearly to all IHS employees the importance of improving our customer service, professionalism, and ethics, and I have insisted that we do a better job of holding employees accountable for poor performance or improper conduct in the context of a fair process. I have received hundreds of emails from employees thanking me for setting a strong tone at the top on areas where we need to improve. It is the first step toward organizational change, and I believe it has made an important difference.

We are making a number of other specific improvements in the way we conduct the business of the agency. Leadership and managers are being held accountable to

balance budgets, justify expenses, and do better fiscal planning. We have trained senior leaders and program managers to better use our financial accounting system and are implementing a consistent budget template agency-wide in our federal administered sites. We are also requiring greater transparency in agreements between programs with regard to funding transfers. These steps will help strengthen financial management and ensure the consistency and effectiveness of business practices throughout IHS.

In terms of personnel, we are streamlining the hiring process. I convened a group of IHS employees in July to make recommendations for shortening the hiring process to enable the agency to compete for qualified candidates and bring them onboard more quickly, and we are currently implementing those recommendations. Recruiting qualified health care providers for many of our sites, including remote and rural health facilities, is already a challenge; we must not let the process contribute to the problem. We are also working on improvements in pay systems and strategies to improve recruitment and retention.

I have also worked to address concerns about staff performance by implementing a stronger performance management process. All employees have been notified that staff performance and accountability are top priorities for reform, and expectations about how we manage performance have been issued to all staff. In the past, we did not hold employees sufficiently accountable for poor performance. You cannot improve performance or remove problem employees if you do not set standards and then hold them to those standards. After becoming Director, I established new, higher performance standards for our employees, including measurable goals to ensure that we can more effectively manage performance.

I am committed to holding our employees to these new standards. At the same time, we will continue to follow policies and regulations to allow employees due process, and to ensure that employee performance issues are dealt with fairly. When allegations are made, our managers will act swiftly to investigate them, and, if the allegations are found to be true, they will take appropriate action.

Property management within IHS has been a particular concern of the Committee. We share that concern, and in response to recommendations from the recent GAO investigation, we have made many improvements, including implementing an electronic property management system, holding senior leadership responsible for completion of annual inventories and boards of survey, and updating policies and procedures with the assistance of an outside consulting group. We also now hold all individual employees accountable for the property they use by implementation of a hand-receipt system. All property, including our Blackberrys, are marked with a sticker that documents who is responsible for it, and employees sign a form stating they will be held financially responsible if the property is lost. In 2009 and 2010, 100 percent of inventories were completed, boards of surveys (a panel of IHS employees determining liability for lost, damaged or destruction of IHS property) are being conducted. These system-wide improvements have created an unprecedented level of accountability for property in the IHS.

Improve the Quality Of and Access to Care

My third priority for reform focuses on improving the quality of and access to care for the patients we serve. I started by identifying the importance of customer service, emphasizing that we must treat our patients—and each other—with dignity and respect. As with other management responsibilities, I have made specific and measurable improvements in customer service a key feature of our performance evaluations. This kind of cultural change is critical to improving the way the agency does business—both internally and externally—and I have already begun to see improvements throughout the IHS system.

We are also improving the quality of care by expanding efforts to create a medical home for our patients so that our teams of providers can make care more centered on an individual patient's needs. We are expanding our Improving Patient Care Initiative to 100 more sites over the next three years.

Quality of care is also demonstrated by meeting standards, and 100 percent of all IHS facilities continue to meet accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and other appropriate accrediting bodies. Our facilities must also meet standards to receive reimbursement from Medicare and Medicaid, something that can be more challenging for IHS than some providers due to limited resources, staff, or provider turnover. If facilities have problems in these areas, we help them make improvements. In addition, I am assembling a group of senior clinical leaders this month to develop recommendations for how to improve the quality of health care in our facilities and our system as a whole, and have required that each IHS Area report to me by next month concrete examples of improvements of quality of care.

Make Our Work More Transparent, Accountable, Fair and Inclusive

The fourth priority is to make all our work more transparent, accountable, fair and inclusive. I firmly believe that creating a culture of openness at IHS is an important part of meeting all of these objectives. For example, telling the story of how we are working to bring change to the agency will reassure our patient population that health reform is also happening for the Indian Health Service. Examples include working more closely with the media, sending more email messages on key management and personnel issues, and *Dear Tribal Leader* letters. We have also enhanced our website with the IHS Reform page, Director's Corner, and Director's Blog, which contain important updates and information about reform activities. We are looking at ways to improve IHS-wide communication among Areas, Service Units, and Headquarters. I personally send emails to all IHS staff to provide important updates that help promote better communication, which will in turn help us improve as an organization.

Overview of the Aberdeen Area Indian Health Service

As you know, the Aberdeen Area Indian Health Service was established to serve the Indian tribes in North Dakota, South Dakota, Nebraska, and Iowa. Within the Aberdeen Area, IHS brings health care to approximately 122,000 Indians living in both rural and urban areas. The Area Office in Aberdeen, SD, is the administrative headquarters for nineteen service units consisting of nine hospitals, fifteen health centers, two school health stations, and several smaller health stations and satellite clinics.

Each facility incorporates a comprehensive health care delivery system. The hospitals, health centers, and satellite clinics provide inpatient and outpatient care and conduct preventive and curative clinics. Direct care and contract care expenditures are used to augment care not available in the local Indian Health Service facilities. The Aberdeen Area also operates an active research effort through its Area Epidemiology Program. Research projects deal with diabetes, cardiovascular disease, cancer, and the application of health risk appraisals in all communities.

Indian and tribal involvement is a major objective of the program, and several tribes do assume partial or full responsibility for their own health care through contractual arrangements with the Aberdeen Area IHS. Tribally managed facilities include the Carl T. Curtis Health Center in Macy, NE, an ambulatory care and nursing home facility, and health centers in Trenton, ND, and Tama, IA.

As I mentioned earlier in my testimony, and as the members of this Committee know well, the Aberdeen Area faces severe challenges, including insufficient accountability with respect to performance and financial management; difficulties associated with providing care in rural, remote, and impoverished communities; and limited resources to address the problem. We can and must make meaningful progress toward addressing these issues utilizing the resources we currently have, and that is what I am committed to doing.

I would like to discuss our progress to date in clearly defining and effectively addressing the challenges facing the Aberdeen Area.

Aberdeen Area Management Review

In 2009, with the goal of developing Area-specific plans for improvement, I launched a series of comprehensive management reviews for each of the 12 Areas of the IHS. Recognizing the seriousness of the problems it faces, I made the Aberdeen Area review the second of the 12 Area reviews. The review was conducted by an independent, internal team, and was completed in April 2010.

Several areas were covered in the Aberdeen Area Management Review, including Area leadership, Tribal relations/consultation, administration, finance, acquisitions, property, human resources, Equal Employment Opportunity (EEO), Ethics, Business Office, Information Technology, and the Contract Health Service program. The review team issued its final report in June and made a follow-up site visit in September to assess the Area's progress in addressing the 54 recommendations of the review.

The Aberdeen Area recently submitted a 90-day progress report on implementation of the recommendations. IHS senior staff receives weekly and monthly reports by the Aberdeen Area on specific actions taken to address the recommendations for three broad categories of Leadership; Tribal Relationships/Consultation; and Administration. Significant progress has been made in the last 90 days. Of the 54 recommendations, 38 have been completed and by the end of the year, 14 more will have been completed, with the remaining two slated for completion next year.

Aberdeen Area Improvements in Program Management and Accountability

The review team found that the Aberdeen Area Director had made improvements in strengthening Tribal relations and could now focus on overall structure, system, and process improvements supporting the health care programs. We have created an operational plan to institutionalize the recommended improvements into the structure and operations of the Aberdeen Area Office and the Service Units Improvements have touched every element of the Aberdeen Area organization, and include:

- Leading the IHS in obligations and disbursements of ARRA funding. Of the $107,543,000, the Aberdeen Area has fully obligated all ARRA funds. This achievement outpaces that of other Areas within the IHS.
- The Cheyenne River Health Care Facility is on track to open in late 2011.
- Information Technology reduced high-risk vulnerabilities by 74 percent, medium-risk by 9 percent, and low-risk by 10 percent.
- Established a process for leave balance reconciliation that reduced the number of discrepancies and errors by 33 percent.
- The Northern Plains Regional Human Resources Division has fully implemented HHS's requirement of 100 percent utilization of Quick Hire for all vacancy Announcements and leads the IHS in HR Quick Hire recruiting actions that will reduce critical clinical vacancies.

I also believe that we have an Aberdeen Area Director who is committed to bringing the same kinds of changes at the Area level by working in specific ways to hold individuals accountable for their performance. It is not surprising that there have been complaints, or that there is resistance to change. However, the efforts to identify and address the management problems in the Aberdeen Area over the past year demonstrate a commitment by the Area Director to make meaningful progress under difficult circumstances, and I am grateful that she has been willing to step up to this challenge. I have assessed the Area Director's performance in part based on her ability to accomplish the specific recommendations made by the review team. Both the review team and I have observed demonstrable progress. At the same time, the Area Director must also respond to unexpected demands, including emergencies due to severe weather and crises due to surprise staffing shortages.

Specific steps taken by the Area Director in her first two years of leadership include:

- Taking disciplinary action against five service unit directors related to management or fiscal incompetence, conduct and misuse of authority, and lack of Tribal consultation and poor communication. All five service unit directors either resigned or were terminated.
- Transferring the supervision of the EEO program from the Area to Headquarters.
- Achieving complete Area-wide fiscal solvency in FY 2010 with no budget deficits at the service unit level—a performance accountability result that had not been accomplished in over 20 years. This has been achieved by requiring more fiscal accountability of CEOs and Area Program managers. Past service unit debt going back 20 years has been resolved.
- Recording fiscal year 2010 collections totaling $95.5 million as of September 20, 2010—an increase of $30 million compared to FY 2009 collections of $66 million. This reflects a 45.4 percent increase in collections from FY 2009 to FY 2010. This increase in third party revenue can be attributed to use of the Area-wide third party contract to supplement IHS staff in collection efforts. A targeted campaign was developed to collect past due accounts receivable and to increase staff competencies through focused training and skills development. The Aberdeen Area Director increased management oversight of business office operations utilizing the Internal Controls Reporting tool, the Accounts Receivable Dashboard metrics, and continuous feedback to Service Unit CEOs.
- Initiating and implementing key organizational protocols related to human capital management improvements, communication, and customer service measurement and improvement. Area-wide high turnover rates of clinicians continue to occur; but the Area continues to address, plan for, and take actions to fill vacancies at health care delivery sites.
- Regaining the trust of Area Tribal leadership by being more transparent about agency business.

Finally, I have already discussed some of the specific changes I am working to implement across IHS in an effort to improve the way we do business, and I believe these changes will contribute to our efforts to address the specific problems in the Aberdeen Area.

Aberdeen Area Investigation by Senator Dorgan

Despite the progress we have made to date, we have a long way to go. I believe effective collaboration between IHS and Congress is essential to helping us achieve our shared goals, and I am grateful for the commitment this Committee has made to highlighting the challenges facing the Aberdeen Area and working with IHS to develop solutions.

IHS is committed to cooperating fully with the Chairman's investigation. My staff and I have worked to be as responsive as possible within the timeframes provide to the Committee's requests for documents, and to answer follow-up questions and requests for clarification expeditiously. Providing complete and timely agency responses to all the Committee's information requests is and will continue to be a top priority of mine through the completion of the Committee's review of the Aberdeen Area operations.

Conclusion

In the past year, I have brought a new leadership focus on providing better customer service, promoting ethical behavior, ensuring fairness and accountability in performance management, strengthening financial management, improving Tribal consultation, and improving the quality of services delivered to IHS's patients. While the situation at IHS is improving every day, the transformative cultural and organizational change I am working to bring to the agency won't happen overnight, and it may face resistance from some corners. Nevertheless, I have made it clear to senior leadership within the agency—including Area Directors—that we must implement specific improvements in a number of areas, and I am committed to making visible, measurable progress in the coming weeks, months, and years.

Secretary Sebelius has asked me to tell you that she and the rest of the Department fully support IHS in remedying the important issues that you have helped to raise, Mr. Chairman. In May of this year, the Secretary undertook a major, Departmentwide initiative to ensure that all of HHS's agencies live up to the public's trust that they will operate with maximum integrity, effectiveness, and efficiency as responsible stewards of taxpayer funds. Specifically, Secretary Sebelius established a Program Integrity Initiative that includes all HHS agencies and staff divisions, including IHS. This Initiative has been working to further integrate program integrity in all HHS programs and business processes to reduce fraud, waste, and abuse and ensure that our budgeted resources provide maximum impact for those we serve. The Secretary's Council on Program Integrity (SCPI) oversees the Initiative. One of the first major undertakings of SCPI has been to launch a Program Integrity Task Force for the Aberdeen Area of IHS, comprised of senior officials from across the department, specifically to address the important issues we are discussing today. This task force will ensure that IHS benefits from the expertise and support of professionals in other parts of the Department who can assist in addressing concerns you have identified and support IHS's efforts to implement corrective actions as needed.

Mr. Chairman, this concludes my statement. Thank you again for your long-standing commitment to improve Indian health, both in the Aberdeen Area and throughout IHS, and for the opportunity to testify today on the Aberdeen Area Indian Health Service programs.

I will be happy to answer any questions you may have.

The CHAIRMAN. Dr. Roubideaux, thank you very much. We appreciate your testimony.

Next, we will hear from the Aberdeen Area Director of the Indian Health Service, Charlene Red Thunder.

Ms. Red Thunder?

STATEMENT OF CHARLENE RED THUNDER, M.S., AREA DIRECTOR, ABERDEEN AREA INDIAN HEALTH SERVICE

Ms. RED THUNDER. [Greeting in native tongue.] Mr. Chairman and members of the Committee, good morning. I am Charlene Red Thunder, Area Director of the Aberdeen Area Indian Health Service.

I am an enrolled member of the Cheyenne River Sioux Tribe of South Dakota. I was born and raised at the Cheyenne Agency. I have a Master's Degree in Education from Northern State University in Aberdeen, South Dakota.

In the 30 years I have served in the Indian Health Service, I have held positions of various degrees and various responsibilities. In addition, I strongly support Dr. Roubideaux's priorities for the Agency, including improving consultation with the Tribes, reforming management and employee performance in IHS, improving quality of and access to care, and making our work more accountable, transparent, fair and inclusive.

I am already working to improve fiscal management. In my first year as Director of the Aberdeen Area, I successfully increased third party collections by $30 million.

I am pleased to have this opportunity to testify on the Senate Committee on Indian Affairs' review of the Aberdeen Area Indian Health Service programs and operations. Let me start by saying that I recognize the serious challenges facing the Aberdeen Area IHS. And I am working closely with Dr. Roubideaux, the Tribes, managers, employees and patients on a daily basis to address them.

I believe that it is my role as Area Director to make some hard decisions necessary to hold employees accountable, strengthen our financial management and ensure the quality and availability of healthcare to our customers. In addition, I am responsible for advancing Dr. Roubideaux's priorities for the Agency by implementing specific strategies at the Area level. I am grateful for Dr. Roubideaux's support and believe the priorities she has set provide the best framework for achieving significant and lasting change in the Aberdeen Area.

My own top priority as Aberdeen Area Director has been to create meaningful relationships between the Office of the Area Director and the Tribal governments and nations. The efforts to achieve a meaningful dialogue between the programs of the Area Office and Tribal governments include active engagement of our Service Unit Executive Teams.

There are good and hardworking women and men in the hospitals and clinics and management programs in the Aberdeen Area in both Tribal and Federal programs. I would like to take this opportunity to acknowledge and thank them before I proceed.

Staff in these hospitals and clinics and Area office programs is also predominantly members of the nations and the people that we serve. The range of cultural diversity among our bands and tribes, along with their commitment to building and maintaining health communities is a hallmark and strength of Indian Country. I understand this and believe Dr. Roubideaux has defined important priorities to improve clinical care while supporting and promoting self determination of the Great Plains Tribes.

Since I became Director of the Aberdeen Area, I have made it a priority to consult with every Tribe in the Area. Coordinating the priorities of Tribal governments and administrative and clinical programs of the Indian Health Service happens every day and, mostly, seamlessly.

However, there are times when the reality of traumatic injury, severe weather, and the hardship of the poorest of the poor in this Country play out in our emergency and treatment rooms of IHS and our Tribal healthcare facilities.

I am personally committed to ensuring the Aberdeen Area Office serves its Tribes in a manner consistent with the mission of the IHS. And I am pleased to report that, in my two years as Director, we have had some important successes at the Area level. These include leading the IHS in obligations and disbursement of the Recovery Act funding, reducing IT vulnerabilities, strengthening financial management, addressing clinical vacancies through accelerated hiring practices, increasing collections from third parties, and achieving complete Area-wide fiscal solvency in FY 2010 with no budget deficits at the Service Unit level.

In addition, I have not been afraid to take strong disciplinary actions against poor-performing employees, including managers. Specifically, I have taken action against top executive individuals related to management or fiscal incompetence, misconduct, misuse of authority, and lack of Tribal consultation and poor communication.

Despite our progress, as the members of this Committee know, the Aberdeen Area still has a long way to go to address its most serious problems. I was born in an Indian Health facility and have received the majority of my care from the Indian Health Service. I understand the challenges that American Indians and Alaska Natives experience in accessing quality healthcare. And I have made it my life's work to improve the system.

I will maintain my focus by empowering and supporting Tribal governments to design and manage their healthcare systems. And I am equally committed to bringing change to management and operations of the Aberdeen Area Indian Health Service.

Thank you. I am happy to answer any questions that you may have.

[The prepared statement of Ms. Red Thunder follows:]

PREPARED STATEMENT OF CHARLENE RED THUNDER, M.S., AREA DIRECTOR, ABERDEEN AREA INDIAN HEALTH SERVICE

Good Morning. I am Charlene Red Thunder, Area Director of the Aberdeen Area Indian Health Service. I am an enrolled tribal member of the Cheyenne River Sioux Tribe of South Dakota. I was born and raised at the Cheyenne Agency. I have a Masters Degree in Education from Northern State University in Aberdeen, South Dakota, and have augmented my knowledge by participating in executive leadership development in numerous courses during my career.

In the thirty years I have served in the Indian Health Service, I have held positions as a budget analyst, administrative officer, Chief Executive Officer, and Area executive officer. In addition, I strongly support Dr. Roubideaux's priorities for the agency, including: (1) improving consultation with Tribes; (2) reforming management and employee performance in IHS; (3) improving quality of and access to care; and, (4) making our work more accountable, transparent, fair and inclusive. I'm already working to improve fiscal management, and in my first year as Director of the Aberdeen Area, I successfully increased third party collections by $30 million.

I am pleased to have the opportunity to testify on the Senate Committee on Indian Affairs review of the Aberdeen Area Indian Health Service programs and oper-

ations. Let me start by saying that I recognize the serious challenges facing the Aberdeen Area IHS, and am working closely with Dr. Roubideaux, the Tribes, managers, employees, and patients on a daily basis to address them. I believe it is my role as Area Director to make the hard decisions necessary to hold employees accountable, strengthen our financial management, and ensure the quality and availability of health care to our customers. In addition, I am responsible for advancing Dr. Roubideaux's priorities for the agency by implementing specific strategies at the Area level. I am grateful for Dr. Roubideaux's support, and believe the priorities she has set provide the best framework for achieving significant and lasting change in the Aberdeen Area.

My own top priority as Aberdeen Area Director has been to create meaningful relationships between the Office of the Area Director and the Tribal governments and nations. The efforts to achieve meaningful dialogue between the programs of the Area Office and Tribal Governments include the active engagement of Service Unit Executive Teams. There are good and hard working women and men in the hospitals and clinics and management programs of the Aberdeen Area in both tribal and federal programs. I would like to take this opportunity to acknowledge and thank them before I proceed.

Staff in these hospitals and clinics and area office programs are also predominantly members of the nations and the people that we serve. The range of cultural diversity among bands and tribes along with their commitment to building and maintaining health communities is a hallmark and strength of Indian Country. I understand this and believe Dr. Roubideaux has defined important priorities to improve clinical care while supporting and promoting self determination of the Great Plains Tribes.

Since I became Director of the Aberdeen Area, I've made it a priority to consult with every Tribe in the Area. Coordinating the priorities of tribal governments and the administrative and clinical programs of the Indian Health Service happens every day and, mostly, seamlessly. However, there are times when the reality of traumatic injury, severe weather, and the hardships of the poorest of the poor in this country play out in the emergency and treatment rooms of IHS and tribal health care facilities.

I am personally committed to ensuring the Aberdeen Area Office serves its Tribes in a manner consistent with the mission of the IHS. And I'm pleased to report that, in my two years as Director, we've had some important successes at the Area level. These include leading the IHS in obligations and disbursements of Recovery Act funding, reducing IT vulnerabilities, strengthening financial management, addressing clinical vacancies through accelerated hiring practices, increasing collections from third parties, and achieving complete Area-wide fiscal solvency in FY 2010 with no budget deficits at the service unit level.

In addition, I have not been afraid to take strong disciplinary actions against poorperforming employees, including managers. Specifically, I have taken action against five service unit directors related to management or fiscal incompetence, conduct and misuse of authority, and lack of Tribal consultation and poor communication. All five service unit directors either resigned or were terminated.

Despite our progress, as the members of this Committee know, the Aberdeen Area still has a long way to go to address its most serious problems. I was born in an Indian Health facility and have received the majority of my health care, from the Indian Health Service. I understand the challenges that American Indians and Alaska Native experience in accessing quality health care, and I have made it my life's work to improve the system. I will maintain my focus by empowering and supporting tribal governments to design and manage their health care systems, and I am equally committed to bringing change to management and operations of the Aberdeen Area IHS.

Thank you. I am happy to answer any questions that you may have.

The CHAIRMAN. Ms. Red Thunder, thank you very much. We appreciate your testimony.

Next we will hear from Mr. Gerald Roy who is the Deputy Inspector General for Investigations at the Office of Inspector General, HHS.

Mr. Roy?

STATEMENT OF GERALD ROY, DEPUTY INSPECTOR GENERAL FOR INVESTIGATIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. ROY. Good morning, Chairman Dorgan and other distinguished members of the Committee.

I am Gerald Roy, Deputy Inspector General for Investigations as the U.S. Department of Health and Human Services Office of Inspector General. I appreciate the opportunity to testify about OIG work relating to the Indian Health Service.

I have the privilege of having with me today OIG Special Agent Curt Muller, who has served in the Aberdeen Area since 2000 and is familiar with many of the issues I expect will be raised at today's hearing.

OIG is an independent, nonpartisan agency committed to protecting the integrity of more than 300 programs administered by HHS. We are the Nation's premiere healthcare fraud enforcement agency, providing oversight to all agencies and programs of our vast Department.

OIG consists of five components, our offices of Audit Services, Evaluation and Inspections, Counsel to the Inspector General, Management and Policy, and Investigations, which I oversee. OIG has a significant body of work on IHS issues which I am happy to submit for the record. But my testimony today is focused solely today on the work of the Office of Investigations.

The Office of Investigations employs nearly 400 highly-skilled special agents trained to conduct investigations of fraud and abuse related to HHS programs and operations. Our special agents utilize state of the art technologies and effectuate a wide range of law enforcement actions including service of subpoenas and execution of search and arrest warrants.

Our constituents are the American people and we work hard to ensure their money is not stolen or misspent. Thanks to the work of our dedicated professionals, over the past fiscal year OIG has opened nearly 1,700 investigations and obtained over 570 criminal convictions. OIG investigations have also resulted in over $3 billion in expected criminal and civil recoveries.

Over the last 10 years, my office opened nearly 300 investigations related to or affecting IHS. Many of these cases also involved allegations of Medicare and Medicaid fraud. In the course of these investigations, OIG has identified three general areas of vulnerability that threaten IHS. These areas are mismanagement, employee misconduct and drug diversion. I will now provide examples of investigative findings in each of these three areas.

With respect to mismanagement, our investigations have uncovered insufficient internal controls, lack of documentation relating to employee misconduct, and prohibited personnel practices, including the hiring of excluded individuals to provide items or services to beneficiaries.

OIG protects beneficiaries and the integrity of Federal healthcare programs, including IHS, by excluding individuals for fraud and abuse violations such as drug diversion and patient abuse. IHS must be vigilant in ensuring that it does not hire excluded individuals. Otherwise, vulnerable patient populations may be put at risk,

and Federal healthcare programs could inappropriately pay for the salaries and services of excluded individuals.

In 2008, the Aberdeen Area Personnel Office identified two employees who were excluded by OIG from participation in Federal healthcare programs. One employee was excluded based on a criminal conviction for embezzlement in 2001 that was the result of an investigation conducted by our special agents. While still excluded, this employee was subsequently rehired by the same department within the Aberdeen Area Office where she committed her illegal acts. The other employee was a nurse convicted of drug diversion charges.

During the course of this investigation, we discovered that IHS had no policy in place to verify employees and contractors against the list of excluded individuals and entities. As a result, we recommended that IHS immediately review the names of all current employees and contractors against the excluded individuals and entities lists and issue exclusion guidance to employees. IHS agreed to implement OIG's recommendations.

Concerning employee misconduct, OIG investigations have resulted in numeral criminal convictions. These investigations have focused on a variety of criminal violations, including conspiracy, healthcare fraud and embezzlement. In 2005, we investigated allegations that an IHS employee unlawfully altered government records of IHS beneficiaries for personal gain. The employee and co-conspirators replaced beneficiaries' names with their own on medical records and filed claims for payment to a private insurance company.

Five of the individuals were indicted, including two IHS employees who were charged with conspiracy and healthcare fraud. One employee was sentenced to 12 months in prison. The other, an IHS supervisor, was sentenced to 18 months in prison. They are jointly responsible for paying the insurance company over $99,000 in restitution.

In drug diversion, we have determined that IHS pharmacies are vulnerable to controlled substance abuses, including diversion and trafficking by employees, contract providers and patients.

In 2008, we investigated an allegation that a Sioux San pharmacy technician in Rapid City, South Dakota stole large quantities of Vicodin and Tramadol. When questioned by our special agents, the employees admitted to stealing large quantities of narcotics from the IHS pharmacy which she then sold on the street for cash. During a search of her home, our special agents found additional evidence of stolen narcotics. The employee pled guilty to a felony count of theft.

During the course of our investigation, we discovered that the IHS pharmacy lacked effective security controls to prevent and detect drug diversion, including security cameras and two person inventory counts.

The work I have testified about today reflects OIG's serious commitment to ensuring the integrity of IHS programs. Our Sioux Falls Office has considerable expertise with these issues and dedicates a significant amount of time to investigating fraud and abuse in IHS.

Additionally, the Inspector General serves on the Secretary's Interdepartmental Council on Native American Affairs and has personally toured Indian Country. Through the dedicated efforts of our OIG professionals, we will continue working to deter fraud, waste and abuse within IHS and Tribal programs.

Thank you for your support of this mission. I welcome any questions you may have.

[The prepared statement of Mr. Roy follows:]

PREPARED STATEMENT OF GERALD ROY, DEPUTY INSPECTOR GENERAL FOR INVESTIGATIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning Chairman Dorgan, Vice Chairman Barrasso, and other distinguished Members of the Committee. I am Gerald Roy, Deputy Inspector General for Investigations at the U.S. Department of Health & Human Services' (HHS) Office of Inspector General (OIG). I appreciate the opportunity to testify about OIG work relating to the Indian Health Service (IHS). I have the privilege of having with me today OIG Special Agent Curt Muller who has served in the Aberdeen area since 2000 and is familiar with many of the issues I expect will be raised at this hearing.

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Over the last 10 years, my office opened nearly 300 investigations related to, or affecting IHS. Many of these cases also involved allegations of Medicare or Medicaid fraud. In the course of these investigations, OIG has identified three general areas of vulnerability that threaten IHS. These areas are: (1) mismanagement, (2) employee misconduct, and (3) drug diversion.

I will now provide examples of investigative findings in each of these three areas.

Mismanagement

Our investigations have uncovered insufficient internal controls, lack of documentation relating to employee misconduct, and prohibited personnel practices, including hiring excluded individuals to provide items or services to Federal program beneficiaries. OIG protects beneficiaries and the integrity of Federal health care programs, including IHS, by excluding individuals for fraud and abuse violations, such as drug diversion and patient abuse. IHS must be vigilant in ensuring that it does not hire excluded individuals. Otherwise, vulnerable patient populations may be put at risk, and Federal health care program funds could inappropriately pay for the salaries and services of excluded individuals.

In 2008, the Aberdeen Area personnel office identified two employees who were excluded by OIG from participation in federally funded health care programs. One of the employees was excluded based on a criminal conviction for embezzlement in 2001 that was the result of an investigation conducted by our special agents. While still excluded, this employee was subsequently rehired by the same department within the Aberdeen Area Office where she committed her illegal acts. The other employee was a nurse convicted of drug diversion charges.

During the course of this investigation, we discovered that IHS had no policy in place to verify employees and contractors against the List of Excluded Individuals and Entities. As a result, we recommended that IHS immediately review the names

of all current employees and contractors against the excluded individuals and entities lists and issue exclusions guidance to employees. IHS agreed to implement OIG's recommendations.

Employee Misconduct

OIG investigations have resulted in numerous criminal convictions relating to employee misconduct. These investigations have focused on a variety of criminal violations, including conspiracy, health care fraud, and embezzlement. In 2005, we investigated allegations that an IHS employee unlawfully altered government medical records of IHS beneficiaries for personal gain. The employee and co-conspirators replaced beneficiaries' names with their own on medical records and filed claims for payment to a private insurance company. Five individuals were indicted, including two IHS employees, who were charged with conspiracy and health care fraud. One employee was sentenced to 12 months in prison. The other, an IHS supervisor, was sentenced to 18 months in prison. They are jointly responsible for paying the insurance company over $99,000 in restitution.

Drug Diversion

We have determined that IHS pharmacies are vulnerable to controlled substance abuses, including diversion and trafficking by employees, contract providers, and patients. In 2008, we investigated an allegation that a Sioux San pharmacy technician in Rapid City, South Dakota, stole large quantities of Vicodin and Tramadol. When questioned by our special agents, the employee admitted to stealing large quantities of narcotics from the IHS pharmacy, which she then sold on the street for cash. During a search of her home, our special agents found additional evidence of stolen narcotics. The employee pled guilty to a felony count of theft. During the course of our investigation, we discovered that the IHS pharmacy lacked effective security controls to prevent and detect drug diversion, such as security cameras and two-person inventory counts.

Conclusion

The work I have testified about today reflects OIG's serious commitment to ensuring the integrity of IHS programs. Our Sioux Falls office has significant expertise with these issues and dedicates over 30 percent of its workload to investigating fraud and abuse in IHS. Additionally, the Inspector General serves on the Secretary's Intradepartmental Council on Native American Affairs and has personally toured Indian country. Through the dedicated efforts of OIG professionals, we will continue working to deter fraud, waste, and abuse within IHS and the tribal programs. Thank you for your support of this mission. I welcome any questions you may have.

The CHAIRMAN. Mr. Roy, thank you very much for your testimony as well.

We have one additional witness but I think we will have to do that after this first panel.

Let me begin to ask some questions and try to understand what is happening in this Area Office. If I might, let me put up the EEOC complaints for the Aberdeen Region, if I can use that chart.

Ms. Red Thunder, let me ask you to talk us through, what do you think is happening in this Agency when you see that trend with respect to EEO complaints by year? These are people at the workplace, in the IHS in the Aberdeen Region, saying, I am alleging the following, and all kinds of allegations. So, it seems to me this appears to be a completely dysfunctional Agency just based on those lines. Your reaction?

Ms. RED THUNDER. Every Indian Health Service employee has a right to file an EEO complaint and I believe, I also am committed to having a fair workplace, and I support Dr. Roubideaux's high expectation of our employees. And some of this, I believe, is a push back from employees in the standards that we have set as of this past year.

In addition, we have provided more training. Rather than on an annual basis to our supervisors, we are providing quarterly train-

ing to our supervisors so they can take action at the local level and resolve those complaints at the local Service Unit level.

The CHAIRMAN. Let me ask you about, now this is an example of troublesome things that I see throughout this time period, 2008. November 2008, the Aberdeen Office conducted a review of the Quentin Burdock Memorial Hospital after there had been significant diversions of patients so that patients could not get access to that hospital. They had to drive 100 and some miles one way or the other to find another hospital.

The reviewing, this is an internal review by the Aberdeen Area, concluded that two individuals had made the decision to divert services without a proactive effort to identify the root causes of the problem or find alternative means. The reviewer also found that one of those individuals had created an intimidating work environment where the subordinates were in fear of retaliation. The report says, eliminating the bad behaviors of these two employees is critical to changing the facility to being patient focused.

Then, that particular employee that your internal report has as an intimidating work environment, subordinates in fear of retaliation, that person was never disciplined. In fact, was given a $4,000 bonus.

Tell me, how does that happen? How does that work? I mean, you do your own internal evaluation and they say, you know what? We have got a couple of employees here that are trouble. And not only does the employee not get confronted or there is no discipline, but the employee gets a bonus.

Ms. RED THUNDER. I understand your concern, Senator Dorgan. When we do a local review, there is a corrective action plan that is required for the CEO to complete. And we have established some controls where those corrective action plans are now submitted to the Area and we track those on a regular basis. And, if they are not held accountable, then disciplinary action is taken against the Service Unit Director. So, stronger oversight has been in place since I have been Area Director.

The CHAIRMAN. Well, except you were the Area Director when I showed up at the hospital because there were massive problems there. We knew it. You were there. You sat around a table with me. And nothing has changed.

Ms. RED THUNDER. We actually disciplined this Service Unit Director.

The CHAIRMAN. Well, yes, you do that. Actually, that person was on paid leave for some long while and then, that is part of the having now seven new Directors in two years. But the other people that have been cited in internal reports and so on as creating intimidating circumstances for employees, which I suppose probably provokes this spike in EEO complaints, nothing has been done in those areas.

I just, I find all of this very difficult. When I just asked you the question, I did not describe the title of the people just for their own, I probably should have. But you said, well, it goes to this and that process. Does it ever go to a circumstance where when you have an internal report that says this employee is not functioning in the way an employee is expected to function, that somebody

says, wait a second, this person is put on notice right now and may well be terminated as a result moving forward?

And I ask that question because we had a case in North Dakota, which you are familiar with, someone was sent to run the Spirit Lake Nation health facility, and the Tribe actually took the unusual action of banishing that person from their Reservation they were so furious at the way she behaved.

As I began to look at that to find out what is going on here, I found out that this is the third place that that person had been and the first two places she had been a failure and the person had, I believe, four EEO complaints filed against her, adjudicated, taxpayers paid the bill, and then she is sent to Spirit Lake Nation and does such a poor job that, and by the way, that was taken care of because the Tribe not only wanted to banish her but finally you all decided to transfer her. She still works for you.

My point is, I do not think it works unless you decide that employees who are not functioning the way you expect them to function are going to be gone. Describe to me why someone is working in a circumstance where you see multiple EEO complaints adjudicated against someone and they are still on your payroll.

Ms. RED THUNDER. I have to take a minute, Senator Dorgan, to process. My first language is Lakota, so I have to process that.

The CHAIRMAN. While you are thinking about it, I will give you a chance to think about that, we were told that the Deputy Director, your Deputy Director of the Aberdeen Area, Shelly Harris, has been on paid administrative leave for some while. Is that the case?

Ms. RED THUNDER. Yes, sir.

The CHAIRMAN. And you did not report, that was not in the reports we received about paid administrative leave. We had asked for reports on who is on paid administrative leave and where because there has been substantial amounts of it. That was not in the report that was sent to us. So, why is the Deputy Director of the Aberdeen Area on paid administrative leave? Or, is she still on paid administrative leave?

Ms. RED THUNDER. She is on paid administrative leave. But I am uncomfortable talking about that particular case because it is a personnel issue.

The CHAIRMAN. But, but, look, I have been told that for 10 years. Everybody's uncomfortable talking about something. If your Deputy Director is on paid administrative leave, how long has she been on paid administrative leave?

Ms. RED THUNDER. I believe for the last 12 months.

The CHAIRMAN. So for 12 months your Deputy Director has been paid by the American taxpayers and not working because you put her on paid administrative leave?

Ms. RED THUNDER. She has actually been assigned work, so she is actually working from home currently until this investigation has been resolved.

The CHAIRMAN. What kind of an investigation takes 12 months to resolve?

Ms. RED THUNDER. With the HR system, I guess I am not really——

The CHAIRMAN. Well, then maybe we need to change the system. I watched this happen at Quentin Burdock. I am just asking the

question. I did not know the answer that you were going to give me today but, because I had somebody call me and say the Deputy Director in Aberdeen has been on paid administrative leave and I said, no, I do not think so because the material they sent to us does not include that.

So, first of all, somebody made a mistake in sending us information. I want the right information, I want accurate information and complete information. That was not the case. So how did that happen? Were you aware that the information you sent us did not include that?

Ms. RED THUNDER. Not all of the information. There were dozens of documents that were sent and I did not have a chance to review all the documents that were submitted.

The CHAIRMAN. I understand. You and I, two years ago, were at Quentin Burdock and you and the Director of the Health Service at that point indicated they were going to give me a report on Quentin Burdock. I never received it.

And let me just say to you, I do not know you and I am not suggesting you are either fit or unfit for the job you are performing. All I am saying is, can you understand how some of us look at this system and then think for a moment about what if we were on the other end of this trying to get healthcare from a system that does not work?

I went through three affiliated Tribes' clinic one day in North Dakota and the doctor, a wonderful man, said to me, this is where our new x-ray machine is going to be and it is going to change everything. I am so excited. This is the space, he said, as soon as we get it. I said, how long have your been waiting? He said about a year and a half. I said, well, what are you waiting for? He said, it has all been approved. It is just waiting for the signatures of the Aberdeen Office. We just cannot get it through the Aberdeen Office. It is going to get done. It is just delayed because of bureaucracy.

So, for a year and a half, patients do not get this because the Aberdeen Office apparently is like a big morass of glue. Papers come in and never come out. And so, do you understand, when you look at this through the lens of somebody who is wanting healthcare from the system, let us say somebody at Spirit Lake that shows up with a woman that has been transferred two additional times because she was not capable of doing the job and has complaints against her, and then she is still working for you all these years later?

I mean, that is, you know, I am not trying to browbeat you. I am just telling you this system is not working. It just is not working. And you have been there two years. And I think, I suggested to Dr. Roubideaux when she was here, you are going to have to tip this upside down and shake it and make sure the ones that should fall out fall out and you got the good people left and you run a first class system that people can be proud of.

It is not the case now. And I think Senator Franken asked the question, with what we are learning about Aberdeen, what would we learn about other agencies, other regions if we did the same investigation? I fear that I know the answer. But I believed that we had to do this because things just stuck out like big thumbs to say you have got to get a hold of this.

Ms. RED THUNDER. Yes.

The CHAIRMAN. So, how does the Committee begin to have some confidence? I have not gone through hardly any of the questions I have, unfortunately, and I have got to turn to my colleagues here because I have overstayed my welcome on questions. But there are so many questions, stolen narcotics, you know, we have all of this evidence of what has gone on and it all comes back to effective management, someone on top saying, here is our expectation, meet it or leave. Be a part of a team that wins and works and does good jobs and does the job we expect or you are gone.

But what I see is people being rewarded despite the fact that complaints are lodged against them, adjudicated against them, and they get a bonus. So now, yes Dr. Roubideaux?

Dr. ROUBIDEAUX. Senator Dorgan, we absolutely agree with you that what has happened over the years in the Aberdeen Area is absolutely unacceptable. And we thank you for this investigation to help bring some of these issues to light.

You are right. Strong management is needed at the top to say this is unacceptable and employees will be held accountable. So, as we are reviewing the information from the investigation, I do believe that what we are doing now is creating the foundation for longstanding and real change in the Indian Health Service.

The issue about the EEO complaints, EEO complaints are allegations that an individual has been discriminated against and it is usually related to a conflict between a manager and an employee. I actually am not surprised that EEO complaints are going up because we are starting to hold people more accountable and people will complain when they are getting disciplinary action. But I know that the problem with the process related to EEO complaints we can improve. We can do more training. We are actually trying to do that.

I have confidence in Ms. Red Thunder because she realized that the EEO Program in the Aberdeen Area needs more support and within the last month she requested that the headquarters take over the management of the EEO Program in the Aberdeen Area and we have come to an agreement on that. That is the first step in improving the process to try to make sure we are handling these issues fairly, but also holding people accountable.

In terms of this issue of administrative leave, there are some cases where we do have to put people on leave while investigations are pending, but it should be the very minimal time. I agree with you. We cannot continue to have people on administrative leave for long bits of time.

All of these issues at some of these more troubled Service Units, I really think that the relationships that we are trying to develop with the Tribes will help. And, I do think that the efforts of holding people accountable will send a message throughout the organization. The Aberdeen Area Director has already disciplined five CEOs. I am aware there are others that are not following her directives and that may be at risk for disciplinary action and I encourage her to take action against them.

The situation in Aberdeen is unacceptable and it is a part of my priorities throughout the entire IHS to hold more employees accountable.

The CHAIRMAN. Let me, with the indulgence of my colleagues, say one more thing.

Ms. Red Thunder, the number two person in the Aberdeen District is your Deputy. Your Deputy is not at work, apparently has been on leave paid by the taxpayer for a year. You did not tell us that when you were asked. And now you come here and you say you are uncomfortable telling us what has taken a year. And I am saying, I am uncomfortable having this Area service with the number two person not at work for 12 months and being paid and you cannot tell us because you are uncomfortable.

We will subpoena the records and you will answer the subpoena, of course. But, you must, surely, all of you sitting there, understand the angst we have about this.

Does anybody, do you believe that if my two colleagues had somebody on their staff that there was problem with that 12 months later they would be at home being paid by the taxpayer? Not on your life. And that would be the case in any organization I am aware of.

You make decisions. What are the facts, what is the requirement as a result of those facts and then make decisions. But, you know, I have so many questions. I am going to submit a rather lengthy list of questions and I know that you all have chafed at the fact we have asked so much of you.

We are not asking nearly as much of you as a sick person is who comes to the IHS asking for help. They are the ones that are asking a lot of you, and too often they have not been satisfied.

Senator Franken?

Senator FRANKEN. Thank you, Mr. Chairman. Dr. Roubideaux, I respect your efforts to address deficiencies within the Agency. But I am concerned that internal reviews have not been sufficient. For example, many of the issues described in the Committee investigation are not included in your April 2010 review, including missing narcotics, administrative leaves, reassignments and licensure issues. Can you please comment on the discrepancies between the two reviews?

Dr. ROUBIDEAUX. Right. Well, the Aberdeen Area review that we completed in April was as a part of a greater look at how we do business in the Indian Health Service and was primarily focused on business practices. We also are very concerned about the quality of care and other issues related to that.

But what I heard in the input from my employees when I asked for input during the past year, when I said what are the things you want us to focus now on, to improve in the Indian Health System, the vast majority of comments were about improving our business practices. And very little, actually, was about clinical care. Because I can understand it. The doctors are frustrated, the nurses are frustrated, everybody is frustrated by some of these problems we have with administrative issues.

And so, I asked one of my deputies to develop a team that would develop a tool to do administrative reviews. The investigation has been actually very helpful for me to know that these are items of interest to the Committee and we can certainly do more of a review on these issues around the entire system because I know it is a very important issue.

I was just responding to the issues that were brought up to me from the input that we got from our staff. But those other issues are incredibly important, they are unacceptable, and we will be working on improving those areas.

Senator FRANKEN. Well, let me express frustration that I think you heard from the Chairman. When I first got here, I remember talking to a member of this Committee on the other side and I wish he were here today. And he really, he knew I was going to be on this Committee and he seemed very dedicated to the work of this Committee.

Then I went to visit him and we were talking about funding. And I know that you have, you know, not adequate funding in many cases. But he said, why should I vote for more funding when the bureaucracy is dysfunctional?

So, we have kind of a Catch 22. We have members who do not want to increase funding because the bureaucracy is dysfunctional and you have got a situation where you feel under funded but you are not going to get it unless, you know, I see this tremendous discrepancy between your own internal reviews and then the review that this Committee initiated. And it just, it just feels like unless we can trust you to crack down and make this, the Health Service, work, we are in a conundrum here, we are in a Catch 22. Do you understand that?

Dr. ROUBIDEAUX. Absolutely. Senator Franken, I completely agree with you. And I have publicly stated that in order to get the support we need, we must demonstrate a willingness and real progress and improvement. We are accountable for our public resources and we need to show improvement.

The OIG, the things that were mentioned in the OIG report, things that have been mentioned by the Committee, the things that were discovered in our review, I have been aware of those for many years. And now that I am the Director, I have the opportunity to make a difference and to start to make real progress on these issues. And we are starting. But I am not going to say that we can fix this overnight. It is a huge problem.

But I am committed to making as much progress as possible. And can I be that strong one to be able to do this job? Absolutely. I have disciplined employees, I have stopped transferring problem employees. I have made it clear to our employees that we are going to hold people accountable, and I have implemented a number of reforms in the performance management system.

So, I do think that I, I have to work as hard as I can. These are my people as well and I am just as concerned as you are as well.

Senator FRANKEN. If you have been aware of all of these problems, why did you not focus on them in your review?

Dr. ROUBIDEAUX. The review that we did of the areas was for a different focus, more on some of the technical management issues.

Senator FRANKEN. I understand that. You said that. I am asking, if you are aware of these issues and these issues, I mean, there are narcotics that are completely out of control that go, you know, and we know that we have abuse problems of narcotics in Indian Country.

I mean, these are all kinds of, you now, listen, I also have so many questions here that, and I am already past my time. But it

seems to me that if you are aware of these problems, that you would not have done a review that was so narrow that it did not go into these problems.

Dr. ROUBIDEAUX. Well, we are actually addressing those issues other ways. I do believe that the performance management process and the lack of accountability is a bigger overriding issue that surrounds all of these issues. And if we can work on the root cause of holding people accountable for bad behavior and poor performance as well as improving the quality, I think that we can address the root causes of some of these issues.

Accountability is a huge issue for me and we are implementing a number of activities to improve that accountability. And that really is fundamentally what is wrong with the system, is that there is a lack of accountability.

And if we can implement a stronger performance management process, encourage our managers to take care of problems rather than transferring them around, and to really address what is important, which is improving the quality of care. I have actually met with the OIG and I have presented our issues to the IHS and have, am really looking forward to them assisting us as we move forward to improve these issues.

Senator FRANKEN. Well, I am out of time and I am going to submit a lot of questions in writing. I suggest that this be done in a way that convinces us that it is going to be done because I despair.

You know, you are from, I just went to, I did not go to Rosebud but I went to Pine Ridge. And 85 percent unemployment there, you know. I did not have meetings about healthcare there, I had them about housing. But unbelievable deprivation, unbelievable problems. And many, many of them in this kind of cycle of mismanagement.

Therefore, why throw more money at it? And we, you know, we need to turn this stuff around. And I am going to end my questions, but I will submit a number of questions, both for you and for all of you, Ms. Red Thunder and for Mr. Roy.

Thank you very much.

The CHAIRMAN. Senator Franken, thank you very much.

Before I call on Senator Johnson, I wanted to just mention that I have to take a conference call in the back with Vice President Biden and my colleague, Senator Conrad, which was scheduled after I scheduled this hearing. So, Senator Franken has agreed to chair while I am on the conference call with Vice President Biden.

Senator Johnson?

Senator JOHNSON. Thank you. Dr. Roubideaux, the review conducted by the IHS indicated the need to take immediate action to ensure preservation of CMS accreditation. What are these specific action items?

Dr. ROUBIDEAUX. Well, the one thing we are proud of in Indian Country is that 100 percent of our facilities are accredited and we want to do everything we can to make sure that that continues.

What we do is that we have an internal process of technical assistance and ongoing survey preparedness to help our sites and then when there are either surprise surveys or regular surveys that have findings, we have a team go and help the facility to cor-

rect some of those so that they can have a corrective action plan to avoid losing their accreditation.

So far, we have not lost accreditation and we are very serious and very aggressively looking into these recommendations that happen as a result of some of the surveys and unplanned visits. We are very committed to providing good quality of care and the 100 percent accreditation that we have been able to maintain is very important to use.

Senator JOHNSON. Ms. Red Thunder, it is my understanding that only the hospital in Rosebud has a policy on diversion in healthcare services. Are you familiar with the policy and can you explain some more about it?

Ms. RED THUNDER. Yes. Most recently it came to my attention that Rosebud was the only hospital that had a policy on diversion. That is being shared with the other facilities in Aberdeen Area, so we do have a policy.

Senator JOHNSON. What are the greatest challenges that contribute to diversion of healthcare services?

Ms. RED THUNDER. Staffing is our major issue. I believe we want to provide safe patient care and if there is not nursing staff or providers, then we do not admit. We never close our ERs. Inpatient, we do not take any admissions but we refer to a higher level of care.

Senator JOHNSON. Mr. Roy, based upon your review of IHS, what recommendations could you make about how to prevent and detect drug diversion?

Mr. ROY. Well, we have made several recommendations to IHS, specifically, security measures. We are talking about changing locks on doors when there is a staff change and when there is staff turnover. We have also recommended the two person inventory counts.

With respect to drug diversion, IHS has done a pretty good job of controlling Schedule 2 Narcotics, the Oxycontin and executions. What we still see an issue with is in respect to Schedule 3 drugs and non-schedule drugs because they are used on the street. They have a street value as well and they are an addictive drug as well.

I would recommend, again, tighter security measures. For instance, in one of our management implication reports, we recommended cameras in a certain facility. We also recommended, again, this two person count. And although we have seen the two person count take place, we have yet to see cameras installed in that particular facility. We would hope to see those recommendations acted upon to better secure and help deter drug diversion.

Senator JOHNSON. Is there any way of knowing the follow up on your recommendations?

Mr. ROY. Well, when we submit a management implication report to an operating division of our department, we have an expectation that we receive a response in writing. And I would like to see better control of that.

With respect to my special agents in the field, they are often at these facilities and there is eyes on where they certainly will notice if certain parameters, certain recommendations, have taken place. I think overall my special agents have a good rapport. They work well in Indian Country on these Reservations and have a rapport

with managers and that facilitates this communication process and also the ability to check and see if our recommendations have been implemented.

Senator JOHNSON. Dr. Roubideaux, what factors account for the Aberdeen Area's success at obligating the Stimulus Funding?

Dr. ROUBIDEAUX. Well, I am really proud of the Aberdeen Area for leading the other areas in obligating the ARRA funding. I think that this is an incredible accomplishment. It has been very important for us to make sure that we get this funding out so that it can benefit the programs that will be benefitting from equipment or sanitation or maintenance and improvements. And I know that they have worked very hard and have worked very hard with the business functions that are necessary to get that money obligated.

This has been a big priority of mine. All of the Area Directors have this in their performance plans, that they had to obligate 100 percent of those funds by the end of the fiscal year in order to receive a good evaluation. And this has been a priority of ours.

Senator JOHNSON. Ms. Red Thunder, how have you been able to increase third party collection during your service as Director?

Ms. RED THUNDER. At some of our locations, there is inadequate staffing. And so we have actually procured an area-wide contractor to assist. Through that contractor, they do coding and billing, back billing, and we also have been successful with the State of South Dakota and the State of North Dakota to negotiate multiple encounter rates. And so that has helped in the increase in our collections.

Senator JOHNSON. My time has expired.

Senator FRANKEN. [Presiding.] Thank you, Senator.

Right now, I would like the witnesses to stay seated if you will. Thank you for your testimony and I would like to keep you there so that we can continue asking questions.

I would like now to call Mr. Ron His Horse Is Thunder to provide his testimony. Thank you, sir.

STATEMENT OF RON HIS HORSE IS THUNDER, EXECUTIVE DIRECTOR, GREAT PLAINS TRIBAL CHAIRMEN'S HEALTH BOARD

Mr. HIS HORSE IS THUNDER. Mr. Chairman, members of the Committee, thank you for giving me this opportunity to testify before you today. Thank you, especially, for having this hearing and this investigation to bring out the disparities in healthcare in the Aberdeen Area.

As a Tribal member and a former Tribal Chairman, I have had to deal over and over with my constituents coming to me and complaining, expressing their concerns about the inadequate healthcare that they have received.

I am absolutely amazed at some of the information that this Committee has been able to glean from its investigation, especially the Inspector General's report in terms of some of his findings. And I also am appalled, as you are, by the idea of having someone who has been on administrative leave for over a year, that some decision should have been made by now in terms of the investigation of this person so that either they are on board or they are not on board any longer.

So, thank you again for the information that you have gleaned during your investigation and allowing me this opportunity to testify.

One of the things we have consistently heard, and it is true, is that Indian Health Service is under funded. When you have more appropriations going to the Federal prisons for healthcare for prisoners than you do for Indian Health Service, then yes, there is a problem in disparity in funding.

However, Mr. Chairman, as you have pointed out, your colleagues in the Senate and on the House side are a little bit more than reluctant to give additional appropriations to an agency that obviously has problems in managing the services given the appropriations it currently has and some of the misspending, etcetera, that you have found that yes, it is hard to convince the rest of your colleagues that they need to give the additional funds to IHS.

And so throwing more money at the problem, yes, will guaranty some additional services, more quantity, but truly what I think we need to take a look at is the quality of services that are currently being given, given the appropriations that we have. There are obviously some changes that need to be made so that current appropriation levels can give better quality care.

And once that is established, if you can give better quality care, then I think it is going to be easier for the Senate and the House to give additional appropriations. I know that this past year there has been an increase of 13 percent in the appropriations to IHS, particularly to contract health services. And as my predecessor, Carol Ann Hart, used to say, and Senator Dorgan is fond of quoting her, do not get sick after June because the appropriation could run out.

Well, the 13 percent increase has ensured that contract health services, at leastwise for this year, will hopefully make it to the end of the year. But, given that, there are other problems with Indian Health Service that need to be taken care of so that more appropriations can be had by Congress.

One of the areas we think can be shored up and provide additional funding to the Area without an increase from Congress is in third party billing. That was mentioned here. I think Charlene mentioned that there was a $30 million increase this year in recovering from third party payers.

But I also am aware of this, that in this year, part of that $30 million actually is a total of $80 million that has been collected from October of last year to June of this year, $80 million has been collected. I am also aware though that at least another $10 million per month could have been collected. Why was it not collected? Because, as has been mentioned, there is under-staffing and under-training. And so, they are reliant on consultants to help them process this third party billing.

It is through talking with them, the consultants, that I am aware that there is additional dollars left on the table. If we are talking $10 million additional dollars on the table per month, we are talking about $120 million still available within our Service Area that could be collected if we had a better system and better training. So, that is one of the problems that we see.

One of the other problems that we have with the local IHS is this, although with Charlene and Dr. Roubideaux there has been additional consultation with the Tribe. There has been more of a partnership, if you will. However, there still are some unanswered questions that some Tribes have.

In my testimony, we provided at least one example, an anecdote of one Tribe which believes they have not had the transparency that they need and that was the Wagner Service Unit on the Yankton Sioux Tribe where a good portion of their funding was given to another Tribe and they were not told why. It has not been transparent to them, at leastwise to the Yankton Sioux Tribe, as to the reason why 30 percent of their funding went to another Tribe.

The Yankton Sioux Tribe believes that the budget formulation is based on outdated data. And so, data collection needs to be shored up so that you have good data to make budget formulation questions. The Yankton Sioux Tribe specifically says that they have 18,000 open cases of clients coming through their doors. The data that IHS is using is saying only 3,500, you only have a 3,500 user population. Therefore, their budget is based on 3,500 as opposed to the 18,000. That is a problem.

One of the other issues that has been discussed is personnel. There seems to be either a revolving door there or they are on administrative leave for so long. Part of that does go back to the idea of lack of adequate funding to attract and retain good service providers at the local areas. Local Service Units cannot attract them and cannot retain them and therefore they are reliant on contracting for those services, which takes actually, in my opinion and in many of the Tribal Chairmen's opinions, much more money as well as having the clients and patients having to travel such a long way to get services.

One of the other problems that Tribal Chairmen wish to express is the idea of transportation for contract health services. In the past, prior to the 13 percent increase, if you had a patient who had cancer and had to leave from Standing Rock Reservation, any Reservation in South Dakota, and go to Rochester, Minnesota, sometimes a 500 mile drive, there was no transportation provided for many of those clients.

I had a 13-year-old girl come into my office as Tribal Chairman, she did not have any money to go to Rochester to have a CAT scan done for a brain tumor. Our Tribe did not have the money to give to her either. And so what happened to the young girl? I do not know. I know that I reached into my pocket as Tribal Chairman and gave her some of funds out of my pocket, but I know it was not enough to get to Rochester.

So, that is a problem, transportation of clients to get to these contract health services off the Reservation. I know that they are providing services, transportation, now if you are Medicaid eligible because Medicaid will pay for a one-way trip. But once they get there, there is no money to get these people back home.

One instance that I am aware of, and I forget the young man's name, is a 15 year old diagnosed with cancer, going to be sent off, off the Reservation. He will be transported, yes, but he will not be transported home.

So, the Tribe, at its last celebration, had what we call Blanket Downs, and that is to go around and ask all the Tribal members who are currently at that celebration to reach into their pocket and give a dollar or two so that that young man could have his mother transported with him and have transportation back home. This is in fact the young man and he is 16 years old.

And that is the celebration where people are coming out and giving their last dollar. This on one of the poorest reservations in the United States. These are the poorest of the poor people in this Country reaching into their own pocket to help with transportation for this young man so he can get to his services. So, transportation is a problem.

There are a host of other problems as well. But even with all the problems, Mr. Chairman, we believe that Charlene Red Thunder is probably the best Regional Director that IHS has provided us since its inception. She needs more time, and some additional resources, but we think she can do an adequate job.

There are problems with the system that she has to deal with that Dr. Roubideaux will hopefully find some solutions for. Part of it is, how do you, selection of employees takes six months, at a minimum six months. So, you have a vacancy and you do not have a healthcare provider who is filling that position for at least six months. That is six months at a minimum. Many times it takes longer than that.

At Standing Rock Sioux Reservation, for example, the mental health position was unfilled for more than two years. Standing Rock Reservation has suffered one of the highest suicide rates in this Country and needs a mental health provider. But that position on our Reservation had gone unfilled for almost two years. Why?

Part of it is just the process and selection, recruitment, not only the money but the selection process itself is at fault. It should not take six months to hire somebody, a qualified person who is willing to come.

I see that I am out of time. Thank you very much for having me.

[The prepared statement of Mr. His Horse Is Thunder follows:]

PREPARED STATEMENT OF RON HIS HORSE IS THUNDER, EXECUTIVE DIRECTOR, GREAT PLAINS TRIBAL CHAIRMEN'S HEALTH BOARD

Introduction

Mr. Chairman and other Members of the Committee:

I am pleased to be here and want to thank you for your hard work to ensure that the appropriate authority and funding for healthcare services is available to meet the needs of the 17 Tribal Nations of the Great Plains. I am Ron His Horse Is Thunder, Executive Director of the Great Plains Tribal Chairman's Health Board an association of 17 Sovereign Indian Tribes in the four-state region of SD, ND, NE and IA. I am an enrolled member of the Standing Rock Sioux Tribe, The Great Plains Region, aka Aberdeen Area Indian Health Care has 18 IHS and Tribally managed service units.

We are the largest Land based area served of all the Regions with land holdings of Reservation Trust Land of over 11 million acres. There are 17 Federally Recognized Tribes with an estimated enrolled membership of 150,000. To serve the healthcare needs of the Great Plains there are 7 IHS Hospitals, 9 Health Centers operated by IHS and 5 Tribally operated Health Centers. There are 7 Health Stations under IHS and 7 Tribal Health Stations. There is one Residential Treatment Center and 2 Urban Health Clinics. The Tribes of the Great Plains are greatly underserved by the IHS and other federal agencies with the IHS Budget decreasing in FY 2008 over the FY 2007 amount. This is in spite of increased populations and

need. The GPTCA/AATCHB is committed to a strengthening comprehensive public healthcare and direct healthcare systems for our enrolled members.

Health Data and Overview

As documented in many Reports, the Tribes in the Great Plains region suffer from among the worst health disparities in the Nation, including several-fold greater rates of death from numerous causes, including diabetes, alcoholism, suicide and infant mortality. For example, the National Infant Mortality Rate is about 6.9 per 1,000 live births, and it is over 13.1 per 1,000 live births in the Aberdeen Area of the Indian Health Service—more than double the National rate. The life expectancy for our Area is 66.8 years—more than 10 years less than the National life expectancy, and the lowest in the Indian Health Service (IHS) population. Leading causes of death in our Area include heart disease, unintentional injuries, diabetes, liver disease and cancer incidents as a whole has increased. In most cases in the Northern Plains cancer is diagnosed in the late stages, which makes it harder to diagnose and treat as well as poor access to early screening. While these numbers are heartbreaking to us, as Tribal leaders, these causes of death are preventable in most cases. They, therefore, represent an opportunity to intervene and to improve the health of our people. Additional challenges we face, and which add to our health disparities, include high rates of poverty, lwer levels of educational attainment, and high rates of unemployment.

All of these social factors are embedded within a healthcare system that is severely underfunded. As you have heard before, per capita expenditures for healthcare under the Indian Health Service is significantly lower than other federally funded systems. In FY 2005, IHS was funded at $2,130 per person per year. This is compared to per capita expenditures for Medicare beneficiaries at over $7,600, Veterans Administration at over $5,200, Medicaid at over $5,000 and the Bureau of Prisons at nearly $4,000. Obviously, our system is severely underfunded. It is important to note that as Tribal members, we are the only population in the United States that is born with a legal right to healthcare. Tribes view the Indian Health Service as being the largest pre-paid health plan in history.

Great Plains Indian Health Hearing Objectives

Mr. Chairman, Members of the Committee, this hearing provides a significant opportunity to (1) identify Indian Health Service (IHS) administrative areas of concern, (2) submit Tribal comments on detrimental effects of IHS administrative weaknesses, (3) suggest possible constructive action, and (4) express urgency for congressional support for strengthening agency operations in light of recently enacted Indian health reforms.

You, and others of this Committee, have been very instrumental in promoting needed Indian health legislative provisions in the recently enacted Affordable Care Act (ACA). Our Tribal leaders are grateful for your efforts to secure passage of the Indian Health Care Improvement Act reauthorization as part of the ACA, as well as Tribal specific language in the national ACA provisions.

However, as you may realize, if these new authorities are overlaid on agency operations and staff protocols that are weak or impaired, these new provisions' benefits are immediately lessened.

Secondly, our Great Plains Tribes are Direct Service Tribes, whose partnerships with the IHS should be strengthened, without our Tribes resorting to Indian Self Determination Act (aka "638") compacting. If there were greater transparency, in the IHS Area's administrative decision-making process, and greater joint IHS-Tribal program decision-making, this improved partnering could act to ensure accountability and deter certain mismanagement conduct. Such Joint Venturing will be vital in this new era of Health Reform implementation.

Most importantly, when there is agency mismanagement of programs or resources, it is our tribal patients and communities who suffer. When there is inequity in resource allocations, preferential treatment or delayed decision-making, it is our tribal members' whose health is immediately harmed.

I will, today, provide some broad areas of agency program operation concern and, then a few examples of the consequences of poor performance, whether through neglect or mismanagement.

Indian Health Service (IHS) Aberdeen Area

Staffing. Our Area has been plagued by inadequate staffing, due to poor recruitment, rural and climate conditions, difficult facility and equipment conditions. Staffing that is obtained is often poorly trained and not prepared for the difficult conditions in their facility postings. Our Area suffers from insufficient funds for both recruitment and retention bonuses. We are in need of quality health professionals for

chronic, behavioral or preventive health care services, which services can act to forestall more critical or acute care and costs.

Business Office. This function is critical to ensuring that we maximize all funding and reimbursements for patient care. This office will also be especially important in the new health reform endeavors. However, our direct service staff are often poorly trained, resulting in the untimely processing of billing and collection and missed appeal deadlines for disputed Medicaid reimbursement denials. It is our understanding that if our Area were to appeal initial Medicaid denials for coverage, we could likely recover up to 50 percent or more of disputed claims. These are Service Unit claims for reimbursement that run afoul of technical deficiencies that could be corrected with a more thorough documentation or clarification.

What will happen if this trend continues, under the new Affordable Care Act (ACA) or the new VA-IHS coverage authorities and reimbursement protocols? Answer: lost income due to deficient staff training and lack of performance accountability; AND continuing tribal health disparities that were supposed to be alleviated by these new authorities.

Human Resources (HR). HR office problems contribute to poor health services on many levels. HR staff, who are asked to prioritize assistance to one Service Unit over another, adjust quickly to inequitable staffing allocations and assistance. HR staff, who are not held to fast timelines for filling vacancies, contribute to (1) rising Contract Health Services' (CHS) costs, (2) delayed patient treatments, and (3) higher morbidity and mortality levels. HR staff, who do not help Management use appropriate Employee Performance Management criteria and evaluation, contribute to discouraged and dispirited staff. Such demoralized or unfairly targeted staff can delay or improperly fulfill their responsibilities.

Budget Formulation. Area Office budget formula inadequacies, such as insufficient or outdated patient workload data, can cause Service Unit to Service Unit, or Area to Area funding inequities. Area staff who do not ensure that data is current or uniform make it very difficult to secure needed funding increases. Area Staff who do not understand these various budget formulas or the national formula distribution factors place our Area at a disadvantage in any national program resource allocation.

Area leadership is important in fighting for Area increases. Area Leadership cannot arbitrarily withhold monies from one Service Unit, though, to assist another Service Unit. Decisions to withhold Service Unit allocations cannot be made behind closed doors, nor to favor one community at expense of another [E.g. One SU with serious shortfall was only aided by taking monies away from only one other SU, when such shortfall could have been overcome by taking a little from each SU. Decision not satisfactorily explained to affected Tribe.]

Pharmaceutical. Our Area has insufficient supplies and relies on older medication type. There seems to be an unwillingness to secure new medications (for heart, diabetes, skin graft treatment for diabetes related sores). This outdated pharmacy schedule (inventory) becomes a costly problem, both financially and patient healthwise. If older type medicines are inadequate, then patient is sent to a private provider who recommends more up to date drugs. Yet, these medicines are often not covered under Contract Health Service (CHS) referrals. Patients are often unable to pay for these meds and, so, do without. Again, this interrupts ongoing care and results in patient moving into an acute care stage when his/her health deteriorates.

A modern pharmaceutical is not only important to our Tribal patients, but it will be critical for a more seamless melding between the IHS and any Affordable Care Act (ACA) coverage and reimbursement activities. It seems that a modern pharmaceutical, such as enjoyed by rest of the U.S., can only come to Indian country if it chooses to "638" compact. This is not the right mind set for improving our federal health care delivery system. Area Management should be advocating for proper drug supplies and treatment, and not be satisfied with status quo.

Patient Transportation. There is simply not enough Emergency Medical Transport (EMT) or Community Health Representative (CHR) funding for this purpose. We have patients who are discouraged from seeking care because they have no way to travel to this care, aware of the long waits on arrival at a clinic or hospital; then need to walk many miles home after seeking such care. Our EMT vehicles must cope with rugged conditions and weather, and Medicaid or other funding is not adequate to rising gas, vehicle maintenance or replacement. Budget planning and funding on this front is critical.

IHS staff are losing their compassion when they allow elderly patients to walk, wait and walk long distance again, after securing minimal care. At Sioux Sanitarium, one Health Board staff did decide to take action when she learned of such an instance. She drove out to find an elderly patient who had left the clinic to walk home on a long, dark road. Yet, how many others did not have this help? In another

instance, staff at the Sioux Sanitation facility told a disabled patient to take the city bus in for his appointment. This statement was made knowing that the patient's neurological disorder (myasenthia gravis) was so disabling that he could not drive or stand to wait for a bus. There appears to be no budget being developed for patient transportation purposes, resulting in patients not receiving care until their condition has gone critical. Such poor planning and callous patient treatment increases preventable deaths or leads to other health crisis.

Contract Health Services (CHS). Our Tribal Leaders have previously addressed the current CHS formula , and which we believe unfairly favors certain regions. The current formula directs an immediate and significant percent of new CHS funds (up to 20 percent) to Areas that do not contain inpatient facilities. These Areas then participate in the national allocation on the remaining funds, giving them two shots at the same budget.

We all recognize that Indian health funding has been, until this Administration, squeezed painfully shut. This includes the CHS program. While a Tribal community may have an inpatient facility, this does not mean that this Tribe is not equally reliant on CHS for inpatient care services. First, such inpatient care facilities are, as we have noted, poorly staffed and equipped. Secondly, such staffing and equipment as exist are very basic. Thirdly, our large populations which helped justify the need for an inpatient care facility, also means that we have an equally large need for specialty or other care not available in our under-funded sites (heart, physical therapy, OB/GYN, etc.).

This CHS formula is a prime example of the many inter-connecting problems afflicting the Area's effective program management, and of this vital program in particular. If CHS program staff do not do a thorough job on documenting patient workloads, new budget and increases are difficult to obtain. If CHS staff do not do a thorough job on documenting denials or timely processing appeals, a false picture of the true CHS need is presented. Likewise, if CHS staff does not share with the Budget Formulation and Clinical Care team, the types of patient care being sought from private providers, funding for in-house staffing and equipment are difficult to come by too.

Poorly trained staff, demoralized staff, or overburdened staff, in CHS or other programs, contributes directly to the amount of patient care is available to our communities.

Conclusion

Mr. Chairman, and other Members of this Committee, as you have seen, any mismanagement costs lives. Any mismanagement, whether staffing inequities, employee performance problems, budget and data deficiencies, billing and reimbursement weakness, or patient access difficulties, all lead down the same path of poor Indian patient health care.

We ask that the Committee work with us to devise Direct Service Tribal and IHS partnerships, appropriate to our circumstances. We support improved transparency and joint Tribal-IHS decision-making to improve accountability and better Tribal awareness. There is an urgent need for these activities to be accompanied by needed resources, so that we are able to carry our weight in the new ACA structure and with the new Indian Health Care Improvement Act reauthorization authorities.

Thank you for this opportunity and we look forward to working with you and others on the Committee on strengthening our health care services.

Senator FRANKEN. Thank you, Mr. His Horse Is Thunder.

You mentioned, sort of, disbursement of funds. Dr. Roubideaux, as I mentioned in my statement, we have a serious shortage of Contract Health Services funds in Minnesota. So, when I hear that Aberdeen has surpluses and has been transferring CHS funds to other programs as recently as this year, it kind of makes me a little peeved. This, especially, since many of my colleagues and I have been advocating for increased CHS funding.

Do you believe IHS currently has the authority to transfer CHS funds for other uses? And what do we need to make these transfers stop?

Dr. ROUBIDEAUX. Well, Senator Franken, I can understand why you would be concerned about that issue. I think it is important to note that I have testified that we are under funded overall in

the Contract Health Service Program by over $300 million. That is nationwide. And I want to reassure you that in the Aberdeen Area overall, there are huge needs and very limited resources.

I think what you may have heard about is an unusual case where a facility changed from a hospital to an outpatient clinic. Our current Contract Health Service formula right now favors giving more funding to clinics because they do not have hospitals so they have to refer out more.

I know there are lots of questions about how we distribute the Contract Health Services funds. I called for a consultation on this during the past year and have a work group of Tribal elected representatives and Federal representatives from each area that has met several times to talk about how we improve the business of the Contract Health Services Program so that we can bill for more dollars, so that we can negotiate better rates, so that we can be more efficient in the process.

But they are also looking at the formula, and what they are looking at is the distribution of Contract Health Service funds, the small amount that we get, is that equitable? Is that fair? Are the right programs getting more of the resources?

The current formula right now gives more if you have more users. It gives more based on if you have higher costs in the area. But it also has an access factor which favors giving more funding to clinics that do not have inpatient services. And so, I think that that was an inadvertent problem related to that.

In terms of funding transfers between facilities, that is something that I have heard a lot of Tribal complaints about in the entire system. I have heard them complaining that they hear that some of their funds went somewhere else and they did not know what happened. Well, to me that is unacceptable. So, I have made it clear to all my area Directors that they should not be transferring funds unless they have a justified reason, they have agreement of both Service Units, and agreement of all the Tribes involved.

And the Aberdeen Area Director has just started implementing that policy. I know, and confirmed last night, that our other Area Directors know that that is our new policy in the Indian Health Service. There are to be no transfers unless everybody is in agreement and they pay them back. So, that is one of the improvements that we have made in this area.

Senator FRANKEN. Okay. Thank you.

Mr. Roy, Mr. His Horse Is Thunder spoke to a lot of the frustrations that are reflected in the report and the dysfunction that is reflected in the report. And the widespread problems you uncovered in your investigation are overwhelmingly.

Can you please comment on where you think is the best place to start reforming IHS and any specific recommendations you have for this Committee as we try to improve the Agency.

Mr. ROY. Sir, please understand that from an investigative standpoint, we operate under the guise of criminal investigations and a fact finding mission. But with respect to the three areas that I discussed in my testimony, mismanagement is something that the IHS should certainly look at.

With respect to how the operation runs, I would suggest, again, the Committee here has done a great job at focusing a light on these issues and I would certainly hope that this focus continues. And I believe that, with the proper leadership and management in place, you will see improvement in the Indian Health Service, specifically with the Aberdeen Area.

Senator FRANKEN. Again, just any specific recommendations from having done this report?

Mr. ROY. I have spoken about the drug diversion issue with respect to the security angle of that. Misconduct, there is a myriad of misconduct issues that organizations see. I guess why I described it as a point that we need to be aware of is certainly because of the amount of allegations that come into OIG pertaining to misconduct.

But in terms of specific changes, you know, I would like to submit additional testimony and utilize our management implication reports to give you a better sense of what the OIG would feel would be in the best interests of IHS.

Senator FRANKEN. Thank you. I want to ask Senator Johnson, I know I am over my time but I have not been Chairman very often.

[Laughter.]

Senator FRANKEN. So I have the prerogative to ask an extra question or two. Would you indulge me?

Senator JOHNSON. Yes, I will.

Senator FRANKEN. Thank you. I am sorry.

I was curious, because Mr. His Horse Is Thunder spoke very eloquently about the problems that we have all been talking about today, and yet at the end said that Ms. Red Thunder is the best administrator that you have had. How long have you been there? How long have you been in charge?

Ms. RED THUNDER. Two years.

Senator FRANKEN. Three years.

Ms. RED THUNDER. Two years, 2008.

Senator FRANKEN. Two years. Okay. I guess my question is, we have a pretty devastating report here and yet, and I would feel on the defensive if I were you and I would not blame you for feeling that, and I would not blame us for putting you on the defensive for this bad report, and yet Mr. His Horse Is Thunder spoke very highly of you and in your defense.

And I would like to ask him, if this is the case, what do you, what do we do? If we get such a bad report out of an area that has been administered by a person you think is the best administrator you have ever had, where do we begin here?

Mr. HIS HORSE IS THUNDER. Thank you, Mr. Chairman. Let me start by saying this. The slide that was put up earlier in terms of EEOC complaints, and I know that Dr. Roubideaux addressed that, and the spike that we are seeing, actually the climb and climb and climb in the EEOC complaints, truly, as the policies changes, and I have been an administrator for 20 years of my life for Tribe and college, et cetera, one of the things I know for sure about personalities and management of people is this, that when you change a system and they are so used to the old system that they do not like to change.

Change is inevitable and there needs to be change in the system, absolutely. But changes that they are marking, the current administration is making, people are balking at them, people are complaining about. They are so used to doing things the old way which, in many ways, is the sloppy way and inefficient manner of doing things, and as they are being called on to be more efficient, to be more accountable, they are fighting back, if you will, and they are complaining. That is human nature.

Senator FRANKEN. So, in other words, that chart that was given as evidence of dysfunction is actually evidence that that dysfunction is being addressed?

Mr. HIS HORSE IS THUNDER. I believe so.

Senator FRANKEN. Okay. As Dr. Roubideaux said and as Director Red Thunder probably would have said had we come to her.

Well, listen, I want to thank you all, really. And I really hope that what you are suggesting is right, that we are beginning to address this. Because we need to, desperately.

And we desperately need to reform all the areas in Indian Affairs so that my colleagues who truly want to fund Indian Health Services, Indian education, housing, that they feel that the money is being spent wisely.

So, I want to thank you all for your testimony and this hearing is adjourned.

[Whereupon, at 11:35 a.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF DONALD WARNE, MD, MPH, SENIOR POLICY ADVISOR, GREAT PLAINS TRIBAL CHAIRMEN'S HEALTH BOARD

I would like to start with the story of William Sutton, a 16-year-old Oglala Lakota young man. William attended the Sherman Indian High School—a boarding school located in Riverside, CA, where as a freshman he was thriving scholastically and athletically. He is a straight-A student and on the honor roll. He has gone from a desire to be an NBA star, to being a pediatric oncologist. While playing basketball, his knee began hurting. He was diagnosed with osteosarcoma in February in Riverside, CA. He had to leave school and was sent home.

After returning to Pine Ridge, he was a patient at the Pine Ridge Hospital. His doctor said that he needed to go to either Denver or Minneapolis for cancer treatment. His first treatment in Minnesota was in March. The treatment for William has been 3 weeks in Minneapolis and then 2 weeks at home. William will return to Pine Ridge on September 30th and returns to Minneapolis again on October 17th, with the chemotherapy beginning on October 18th—again, for 3 weeks.

The Oglala Sioux Tribe is one of the most impoverished communities in the nation, and they have minimal resources to provide to the family for transportation. His grandmother has been transporting him every month to Minneapolis from Pine Ridge at a significant cost to the family. William's mother, Jolynn Two Eagle, was working as a cook at the Cohen Home (the local assisted living facility), but had to quit her job to be with William.

Beginning in August, the Tribal Ambulance Service have been driving them to Minneapolis, but *will not* transport them back home; they are on their own. The reason they could take them was that they had a referral from IHS and a receiving letter from his doctor in Minneapolis. With this documentation they can be reimbursed by Medicaid. Since there is no reimbursement for the trip back they are on their own to get William home in between cancer treatments.

As a result, the community held a Blanket Dance to raise funds for William and his family at the Pine Ridge Pow-Wow in August. The blanket dance is an old tradition that is done for people that are sick or maybe lost everything in a fire or a storm. It is a great tradition in which even small children will give their last dime. It shows the generosity of our people, which is one of our strong virtues. However, Pine Ridge is among the most impoverished communities in the nation, and despite the generosity, community members generally have very little money to give.

The treatment protocol for William at this point changes, and he will be given the chemotherapy for 3 weeks and he will be off of it for only week before resuming again for another 3 weeks. With only a week off the therapy, the family will remain in Minneapolis, and be ready to begin on November 5th, hopefully returning back to Pine Ridge on December 5th or 6th. At that time, the oncologist will determine if William is finished with the chemotherapy, or not.

William receives an SSI check for $646, but out of that, the University of MN Hospital automatically deducts money for his room at the Ronald McDonald House and food, which leaves him only $30.00 to live on. This family is guilty of nothing but the misfortune of illness and poverty. This is an instance where the Indian Health Service and the Federal Government need to step up and assist this family to ensure that William has the opportunity for a full recovery. William and his family should not have to worry about getting to and from the hospital for treatment, and they should not be worrying about how they will pay for their next meal while this young man should be focusing on healing.

Unfortunately, this story is not unique. It is a story repeated many times in Indian Country, and much of the problem is directly related to underfunding of the IHS.

I recognize that there is a Senate investigation of the management of the Aberdeen Area IHS. I know there have been concerns about mismanagement of funds and delays in hiring processes and personnel issues. However, these issues have been long-standing and largely ignored for many years. And, like in the case of Wil-

liam Sutton, many of the problems are rooted in chronic and sustained underfunding of the IHS. With limited resources, the IHS is forced to choose between investing those resources into improved administrative processes or to expand clinical services. We do not have the resources to do both.

Most of the tribal leaders in our region have expressed confidence in the IHS leadership and frustration with the system. IHS is not a broken agency, it is a starved agency, and the management issues identified in many ways are a symptom of a larger problem of underfunding.

Another issue we face is the challenge of recruiting health professionals and managers into the IHS. In many cases, we cannot offer salaries that can compete with the private sector. Also, our remote locations pose a challenge to recruitment. As a proactive step to improve the Aberdeen Area's ability to recruit health professionals, the Great Plains Tribal Chairmen's Health Board voted to encourage the IHS to move the Area Office from Aberdeen, SD to Rapid City, SD. It will be much easier to recruit highly qualified professionals to Rapid City than to Aberdeen.

Despite our challenges, we have seen improvements in the management of the Aberdeen Area IHS in a number of arenas, for example:

- Third party revenue is significantly increased in 2010 as compared to any previous year. These resources will lead directly to additional services.
- The tribal consultation process is better than it has ever been, and the Area Director attends these meetings quarterly and is open and transparent with the tribal leaders.
- The budgeting processes and circumstances are more transparent now than they have ever been.
- All of the senior leadership at the Area Office are members of local tribes for the first time in history.

Although improvements still need to be made, the Area is going in the right direction. Thank you.

Attachment

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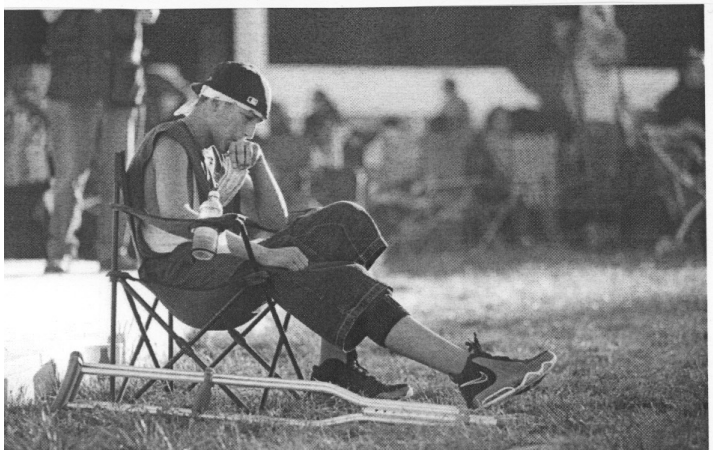

PREPARED STATEMENT OF GERARD P. GARCIA, PSY.D., LICENSED PSYCHOLOGIST

Greetings,

Hopefully, some of the comments will be helpful in understanding operations in the Albuquerque area.

- Clandestinely, the program director at NSRTC in Acoma, NM was quickly removed after news of the Aberdeen investigation.
- At the facilities, bullying continues to go on.
- The clinical director is not allowed final decisions on clinical matters.
- When the state licensing board visited site, administration was not forthcoming with information, nor did they follow the state's mandates.
- Opened group home without a state license at New Sunrise Regional Treatment Center, unsupervised by clinician.
- Numerous medical errors concealed from state.
- Whistle blowers threatened and warned not to contact anyone outside facility.
- Clinical director threatened with loss of position in aim of controlling decisions.
- Facility accepts psychiatric patients with psychiatrist only attending patient care 6 hours per month.
- New Sunrise Regional Treatment Center should not be licensed as a psychiatric treatment center when staff is untrained (Only two experienced staff members have worked in a psychiatric hospital).
- Administrative flow chart is not observed, non-clinical staff making clinical decisions and charged with keeping clinicians in check.

PREPARED STATEMENT OF DR. STEVEN MILLER, BUSINESS MANAGER, INDIAN HEALTH SERVICE NATIONAL COUNCIL LABORERS' INTERNATIONAL UNION OF NORTH AMERICA

On behalf of the Indian Health Service National Council of the Laborers' International Union of North America (LIUNA), the union thanks the Committee for holding this hearing on the critically important issue of mismanagement in the Aberdeen Area of the Indian Health Service (IHS).

LIUNA proudly represents approximately 500,000 workers in the United States and Canada. While primarily in the construction industry, the union also represents 65,000 workers in federal, healthcare, and public employment. LIUNA has represented federal employees at the Indian Health Service since 1977. We represent 9,600 employees at IHS nationwide, including over 1,300 employees in the Aberdeen Area. We represent employees of all job classifications at IHS, including physicians, nurses, social workers, patient care advocates, billing technicians, laborers, maintenance workers, cooks, and public health educators. The vast majority of workers LIUNA represents at IHS are Native American. The employees LIUNA represents are very dedicated to IHS's mission as part of their jobs and because of the important role the agency plays in providing health care to them and their families as enrolled tribal members.

Despite their dedication to the IHS mission, employees at the agency are challenged on a daily basis by chronic mismanagement. There is a huge contrast between the excellent work done by the rank and file employees LIUNA represents, and IHS management. In the 2010 "Best Places to Work in the Federal Government" survey, in which 223 agencies were reviewed, IHS employees were rated in the top 7 percent for the match of employee skills to the agency's Mission. However, IHS is rated in the bottom 6 percent for effective supervision and leadership. In other words, employees feel that their skills and abilities are valuable and gain satisfaction from contributing to the organizational mission, but also that they work in an environment where ineffective supervision frustrates them. This is a combination that causes multiple problems including difficulty in recruitment and retention, adequate staffing, consistency and continuity in care, and impact on patient outcomes.

LIUNA wishes to highlight three issues of concern to the Union in the Aberdeen Area:

1) diversion of services;
2) violations of employee rights and misconduct/mismanagement by supervisors, including discrimination and EEO cases; and
3) management interference with employee communications with the Senate.

Diversion of Services

Diversion of services at IHS impacts patient care and also employees' jobs. Typically, diversions at IHS facilities are decided with little notice to, and no input by, the facility's health care providers. The law requires IHS management to notify the union when changes in working conditions, such as a diversion, occur. However, IHS has consistently failed to follow its legal obligation on this matter. Diversions mean that IHS employees can lose their jobs, or be reassigned. Notice is therefore critical to these workers to make the necessary arrangements if their job is being eliminated or significantly changed due to a diversion of services. Diversions also can compromise patient care. Most IHS facilities are in rural areas. When an IHS facility closes in whole or part, Native American patients cannot simply go to the next closest health care facility for care. Federal laws providing for health care for Native Americans only allow them to attend IHS facilities for covered care. Even if a private hospital is nearby, Native patients usually cannot access those facilities because they typically lack private insurance. Thus, diversions at IHS facilities can require Native patients to be diverted 60 or more miles away; this delay can have a devastating impact on patients, especially in emergency situations.

From January 2008 to November 2009, the Quentin Burdick Hospital in Belcourt, North Dakota, intermittently closed the inpatient ward. Existing patients were transferred by ambulance, and any patient needing admission from the emergency room or clinic was also admitted elsewhere. The facility only had one full-time physician, despite the fact that it serves more than 30,000 Native Americans in a remote, economically depressed/agricultural area that have no other options for care. Women in labor were diverted even though the next closest health care facility is more than 60 miles away. The clinic ran out of IV catheters and alcohol wipes, and had to borrow X-ray film. During this period, employee morale was terrible, and over 40 percent of the nursing staff resigned because they feared the hospital would close permanently.

On January 15, 2009, Union was notified by an employee at Rosebud, South Dakota, that the CEO informed staff that the facility only had enough funding to stay open for five more days, and that the facility would potentially have to close its doors at that time. The Union contacted the Aberdeen Area Director, Charlene Red Thunder to determine what was happening. Ms. Red Thunder never contacted the union about this closure until after the union had to resort to going to the press. Finally, on Saturday, January 17, Ms. Red Thunder informed the Union that the facility would not close due to funds provided by the Area Office. This "near miss" is an example of the ineptitude of IHS If the facility would have closed, 188 Bargaining Unit employees would have been affected. The next closest facility is 96 miles away. IHS failed to follow a number of laws requiring notification to the Union about how this potential closure would have affected the employees we represent and the patients that we serve.

In both these instances, IHS employees' jobs were compromised, as well as patient care. These examples highlight the chronic mismanagement both at the service unit and at the Aberdeen Area office with regard to failure to budget, account for revenue, and to notify the Union about changes in working conditions.

Violations of Employees' Rights and Misconduct/Mismanagement by Supervisors

Supervisors at every level at the Aberdeen Area of IHS—from a first-line supervisor to a CEO—are typically either poorly trained and/or uninformed about laws governing employee rights. This results in the Union having to file a huge number of grievances, unfair labor practices (ULPs), equal employment opportunity (EEO) complaints, and disciplinary appeals at the Merit Systems Protection Board (MSPB). In just the first nine months of 2010, the LIUNA IHSNC has filed over 60 grievances, 20 ULPs, 24 EEO cases, and 3 MSPB appeals in the Aberdeen Area—a huge number compared to other federal agencies at which the Union represents federal employees.

At Rapid City, South Dakota, contract workers from the VA Compensated Work Therapy program, (CWT) were stalking, making physical threats, and sexually harassing IHS employees. The union received reports that a CWT employee was distributing marijuana and methamphetamine at work. The Aberdeen Area Human Resources Office told the Union they were too busy with the Senate investigation to deal with these issues.

Examples of workplace grievances that the Union has filed in the Aberdeen Area include a nursing director blaming nursing staff for the department losing accreditation, threatening the staff with losing their licenses for cooperating with CMS inspectors (Pine Ridge, South Dakota), and a manager who hired his spouse as a contractor, violating federal nepotism regulations (Kyle, South Dakota). Employees con-

stantly face issues such as improper leave denials/FMLA violations and denials for employees to attend the funeral of a close family member. One of the most egregious examples of blatant disregard for employee rights in the Aberdeen Area was a case in Eagle Butte, South Dakota, where a female IHS employee who was very ill with diabetes collapsed in her home during an ice storm when her power and water went out. She had to leave her home to be cared for by her children. Despite properly requesting leave, she was fired for being absent without leave.

Aberdeen Area Managers are slow to address basic problems causing employees to work under primitive, unsafe working conditions. Nurses are forced to report to work and see patients in facilities that have faulty electrical systems (Eagle Butte, South Dakota) or intermittent running water and functioning sewer system (Wanblee, South Dakota). Nurses are forced to work in understaffed units. Nine of fourteen nurses quit after management refused to comply with CMS directives to improve patient care in the emergency room (Pine Ridge, South Dakota). Just last month, the Winnebago Indian Hospital (Winnebago, NE), forced employees to work all day with no running water. This meant no functioning toilets for patients or employees (other than porta-johns that were finally provided hours later). Patients were forced to use red hazard bags to urinate; nursing staff then had to dump those bags for urine samples—which compromises infection control. The Union reported this incident to OHSA and is pursuing further legal action against the facility for jeopardizing the health and safety of both the employees and the patients. All of these issues compromise patient care and happen far too often at IHS.

The Union has stewards at Aberdeen Area facilities to carry out functions relating to our collective bargaining obligations. The stewards are federal employees who volunteer their time. However, they are often retaliated against for Union activities by supervisors and CEOs. Just this month, one of our union stewards resigned her position as a steward due to pervasive harassment by management at Rapid City, South Dakota. During the past year, this 21-year veteran of IHS was denied leave for her mother's funeral; denied leave for her own surgery; harassed for reporting substance abuse of IHS employees; denied compensatory and overtime; and received a low rating for the first time in 21 years on her performance evaluation—likely in retaliation for these other issues. This employee is not alone in receiving this kind of treatment at Rapid City. In 2010, over half the union grievances and unfair labor practices filed in the entire Aberdeen Area were at Rapid City.

Workers should not have to fear coming to work or retaliation for helping their co-workers deal with problems at work. Union representatives on the job solve problems, give workers a say in working conditions, resolve conflicts, increase morale and improve patient care. Management's resistance to employees having a say at work,failing to respond to grievances and problems andintentionally ignoring issues causes conflict, increases fear, hurts morale and negatively affects patient care.

Despite all of this evidence of blatant mismanagement by Aberdeen Area supervisors, the union is very concerned and disappointed that Director Roubideaux accused IHS employees at the hearing of filing EEO cases because they do not want to be "held accountable" for new agency policies. It is unconscionable that Dr. Roubideaux resorted to a strategy of "blaming the victim" instead of committing to investigate the real reason for the spike in discrimination allegations at her agency or taking responsibility for these civil rights violations under her watch. Until IHS makes a true effort to address the serious issue of discrimination at the agency, one of Dr. Roubideaux's own key priorities will not be able to be addressed—that of recruitment and retention of quality employees. What health care provider would want to come work for an agency with such an alarming increase in discrimination cases?

Finally, LIUNA would like to address another issue raised by Dr. Roubideaux at the hearing—the IHS performance management processes for agency employees. Dr. Roubideaux testified that she has "implemented a stronger performance management process." There are two problems with this statement. First, the union was not provided notice of these changes. Under the federal labor-management statute, IHS must provide notice to the union about changes affecting working conditions; the performance management system falls into this category. Further, the agency and the union just completed a five-year negotiation for a collective bargaining agreement (CBA) covering conditions of employment for the 9,600 employees the union represents; that CBA established procedures for the performance management system that cannot be changed without negotiating with the union. Neither of these things occurred. Instead, the union was forwarded a memo from one of our members that Dr. Roubideaux to all IHS employees on September 13, 2010 about performance management. That memo stated: "Our performance management plans this year contain more specific measures that require leadership and staff to demonstrate how they are helping advance the priorities of the agency." The addition

of "more specific measures" is clearly a change to the current system and a violation of both federal law and our CBA. However, when the union contacted IHS to determine what these new measures are, the union was told that no changes in fact are being made to the current system. The second problem, then, with Dr. Roubideaux's testimony is that she told the Committee that IHS is making changes to the performance management system while simultaneously telling the union the agency is not making changes. This performance management memo, along with the customer service memo that Dr. Roubideaux referred to, are also examples of a "blame the rank and file employee" mentality by IHS management. Both memos have a condescending tone and fail to note the role of IHS management in improving the agency.

Dr. Roubideaux testified that she wants to set a positive "tone from the top." To do that, the union believes she should solicit input from all interested and affected parties, including LIUNA. However, despite repeated requests for a meeting to discuss working together to reform and improve IHS, Dr. Roubideaux has ignored the union's request to meet. LIUNA hopes that the Senate Committee can encourage Dr. Roubideaux to reconsider and understand the value of meeting with the organization representing the vast majority of her employees. Leadership at IHS must start at the top. The union looks forward to hopefully establishing a productive and cooperative relationship with the Director to move the agency in a positive direction and help her address her key priorities, including recruitment and retention of the exceptional workers the union represents at the agency.

Management Interference with Employee Communications with the Senate

Despite the fact that federal workers have a legal right to communicate workplace concerns with their Members of Congress, management in the Aberdeen Area interfered with those rights during the course of the Senate investigation this year. The Union was told that Fred Koebrick, the CEO of Rapid City, notified the staff at a general staff meeting that they were not to talk to the Senate about the Aberdeen Area investigation. He later recanted that story. At the Woodrow Wilson Keeble Memorial Health Care Center in Sisseton, South Dakota, a nurse mentioned the Senate investigation to her supervisor (the Acting Director of Nursing). The supervisor told the nurse that she was not allowed to talk to the Senate investigators. It is unclear whether the CEO at Sisseton has taken action against this supervisor.

To try to mitigate the problem of interference by management officials, the Union sent a notice to all bargaining unit employees in the Aberdeen Area reminding them of their legal right to communicate with the Senate investigators. The Union hopes this action contributed to less interference during the rest of the investigation.

Conclusion and Recommendations

LIUNA and our IHS National Council very much appreciate the Senate Committee on Indian Affairs shedding light on management problems in the Aberdeen Area. The Union and those that it represents should be seen as a resource willing to work with Congress and IHS to remedy these problems. Ultimately, the patients that we serve will benefit. To this end, we recommend the following:

1. Involve the union and the workforce in plans to reform IHS This would not only allow for the agency to hear from the rank and file workers on the ground, but also would give IHS employees confidence in Dr. Roubideaux's leadership and ability to improve morale. Set a tone from the top that the union is a partner in reform at the agency. One significant step would be to aggressively implement President's Obama's Executive Order (13522) which encourages Labor-Management cooperation through pre-decisional involvement and Labor-Management Forums.

2. Determine best practices for management at IHS and work with the union and agency employees to implement those practices throughout the Aberdeen Area and nationwide.

3. Hold poor managers accountable.

4. Include budgeting, financial planning, and accounting as part of the reform process to avoid diversion of services.

5. Conduct an inventory of the numbers and types of grievances, unfair labor practices, EEO complaints, and MSPB disciplinary cases and work with the union to determine the cause of these problems and how to eliminate them.

Review why IHS employees are consistently ranked in the top 10 percent of federal employees while IHS management is ranked in the bottom 10 percent of agencies.

7. Commit to recruitment and retention of federal workers at the agency (rather than reliance on contract workers) to save costs, improve morale, and ensure

consistency of care. Ensure that all managers receive training on labor-management issues, including performance management systems and the collective bargaining agreement with the union.

UNITED STATES SENATE COMMITTEE ON

INDIAN AFFAIRS

IN CRITICAL CONDITION:

THE URGENT NEEED TO REFORM THE INDIAN HEALTH SERVICE'S ABERDEEN AREA

REPORT OF CHAIRMAN BYRON L. DORGAN

TO THE

COMMITTEE ON INDIAN AFFAIRS

ONE HUNDRED AND ELEVENTH CONGRESS

SECOND SESSION

DECEMBER 28, 2010

PRINTED FOR THE USE OF THE COMMITTEE ON INDIAN AFFAIRS

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RELEVANT ACRONYMS

AAOPD: Aberdeen Area Office Personnel Director
ACLS: Advanced Life Support
ADR: alternative dispute resolution
AO: Administrative Officer
ASFR: Assistant Secretary for Financial Resources
CAP: Corrective Action Plan
CCNACI: Child Care National Agency Check and Inquiries
CD: Clinical Director
CDA: community development agency
CEO: Chief Executive Officer
CHS: Contract Health Services
CMS: Centers for Medicare and Medicaid Services
COP: conditions of participation
CPR: cardiopulmonary resuscitation
CSRA: Civil Service Reform Act of 1978
DEA: Drug Enforcement Administration
DON: Director of Nursing
DPHN: Director of Public Health Nursing
EEO: Equal Employee Opportunity
EEOC: Equal Employment Opportunity Commission
EMLATA: Emergency Medical Treatment and Active Labor Act
ESC: Evidence of Standards Compliance
FAD: Final Agency Decision
FBI: Federal Bureau of Investigation
FY: Fiscal Year
HHS: Department of Health and Human Services
IHS: Indian Health Service
JC: Joint Commission
LEIE: List of Excluded Individuals/Entities
MIR: Management Implication Report
MSPB: Merit Systems Protection Board
NPDB: National Practitioner Data Bank
NRP: Neonatal Resuscitation Program
OGC: Office of General Counsel
OIG: Office of Inspector General
PMAP: Performance Management Appraisal Program
RMOs: responsible management officials
RPMS: Resource and Patient Management System
ULP: Unfair Labor Practice

INTRODUCTION

On June 23, 2010, Chairman Byron Dorgan initiated a formal investigation of the Indian Health Service's (IHS) Aberdeen Area (hereafter "the Area") in response to years of hearing from individual American Indians/Alaska Natives, Indian tribes and IHS employees about substandard health care services and mismanagement. Chairman Dorgan received complaints about Aberdeen Area IHS-run facilities plagued by frequent reduced or diverted services, mismanagement, poor performing employees, lack of employee accountability, and malfeasance. These conditions negatively impact the care provided to individuals and produce a work environment riddled with waste, fraud and abuse.

The Chairman initiated an investigation in order to identify these problems and their causes. The investigation included: reviewing over 140,000 pages of documents submitted by IHS and the Department of Health and Human Services' Office of Inspector General (OIG), visiting three IHS service units, meeting with tribes and interviewing individual IHS employees. In addition, nearly 200 individuals contacted the Committee regarding mismanagement of facilities in the Area. This report provides an overview of the Chairman's investigative findings.

On September 28, 2010, the Committee held a hearing on its investigative findings. During the course of this hearing the Chairman identified deficiencies in management, employee accountability, financial integrity, and oversight of IHS' Aberdeen Area facilities. The Chairman determined that these weaknesses have contributed to reduced access and quality of health care services available to patients served in the Area.

The Committee was scheduled to have a subsequent hearing on December 8, 2010 regarding IHS' initiatives to address the findings of the Chairman's investigation. However, due to United States Senate scheduling conflicts the hearing was canceled. As a result, provided in the Appendix of this report as Exhibits "A" and "B," respectively, are the testimony submitted by Dr. Yvette Roubideaux, Director of IHS, and the statement for the record submitted by the Laborers' International Union of North America (LIUNA), a union that represents the majority of non-management civil service IHS employees.

BACKGROUND

The Aberdeen Area is comprised of 20 IHS and tribally-managed service units.[1] The Area employs 1,955 individuals and has an annual budget of $293 million.[2] The Area also has two urban programs that provide services in five locations ranging from community health to comprehensive primary health care services.

The Area serves 18 Indian tribes in four states: South Dakota, North Dakota, Nebraska, and Iowa. The annual estimated workload for the Area includes: 3,475 inpatient admissions, 859,163 outpatient visits and 77,039 dental visits.[3]

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[1] Indian Health Service, "Aberdeen Area Administrative Review," April 2010 at 1.
[2] Id at 1.
[3] Ibid.

The Majority Staff concentrated the investigation on the following nine IHS-run service units and facilities in the Aberdeen Area:

- Belcourt Service Unit of North Dakota (Turtle Mountain Band of Chippewa);
- Fort Totten Health Center of North Dakota (Spirit Lake Sioux Tribe);
- Fort Yates Service Unit of North Dakota (Standing Rock Sioux Tribe);
- Winnebago Service Unit of Nebraska (Winnebago Tribe of Nebraska);
- Sisseton Service Unit of South Dakota (Sisseton-Wahpeton Oyate Tribe);
- Pine Ridge Service Unit of South Dakota (Oglala Sioux Tribe);
- Rapid City Service Unit of South Dakota (urban Indian health facility);
- Rosebud Service Unit of South Dakota (Rosebud Sioux Tribe); and,
- Aberdeen Area Office, located in Aberdeen, South Dakota.

FINDINGS

The investigation identified mismanagement, lack of employee accountability and financial integrity, as well as insufficient oversight of IHS' Aberdeen Area facilities. These issues impact overall access and quality of health care services provided to Native American patients in the Aberdeen Area. Many of these issues may stem from a greater lack of oversight by the Area office and IHS headquarters fostering an environment where employees and management are not held accountable for poor performance.

Provided below is a detailed summary of the findings of the investigation. In brief, the Chairman found:

- Over the course of the last ten years, IHS repeatedly used transfers, reassignments, details, or lengthy administrative leave to deal with employees who had a record of misconduct or poor performance.

- There were higher numbers of Equal Employee Opportunity (EEO) complaints in the Aberdeen Area in comparison to the entire IHS, as well as insufficient numbers of EEO counselors and mediators.

- Three service units have a history of missing or stolen narcotics and nearly all facilities failed to provide evidence of performing consistent monthly pharmaceutical audits of narcotics and other controlled substances.

- Three service units experienced substantial and recurring diversions or reduced health care services from 2007 to 2010, which negatively impacts patients and quickly diminishes limited Contract Health Service (CHS) funding.

- Mismanagement of CHS program funding has resulted in some facilities having funding surpluses and the transfer of dollars to likely non-CHS programs.

- Five IHS hospitals are at risk of losing their accreditation or certification from the Centers for Medicare and Medicaid Services (CMS) or other deeming entities. Several

Aberdeen Area facilities were cited as having providers with licensure and credentialing problems, Emergency Medical Treatment and Active Labor Act (EMTALA) violations, emergency department deficiencies or other conditions that could place a patient's safety at risk.

- IHS lacks an adequate system to detect instances of IHS health care providers whose licenses have been revoked, suspended or under other disciplinary actions by licensing boards.

- IHS health care providers treating patients with expired state licenses and/or other certifications on numerous occasions, which violates federal regulations and internal IHS policies.

- Particular health facilities continue to have significant backlogs in posting, billing and collecting claims from third party insurers (i.e., Medicare, Medicaid and private insurers). One facility repeatedly transferred its third party payments to other facilities in the Aberdeen Area.

- There were lengthy periods of senior staff vacancies in the Clinical Director and Chief Executive Officer positions, resulting in inconsistent management and leadership at Aberdeen Area facilities.

- The use of contract providers (locum tenens) is costly ($17.2 million in the last three years). While the overall cost of contract providers has decreased in comparison to last year, two facilities have increased their locum tenens expenses this year.

- IHS policies and directives discourage employees from communicating with Congress.

Transfers, Details and Reassignments. There are a number of federal regulations governing the transfer, detail and reassignment of employees. Specifically, a federal agency may appoint by transfer to a competitive service position, without a break in service of a single workday, a current career or career-conditional employee of another federal agency.[4] A detail is a temporary assignment to a different position for a specified period, with the employee returning to his or her regular duties at the end of the detail.[5] A reassignment is the "change of an employee, while serving continuously within the same federal agency, from one position to another without promotion or demotion."[6]

The investigation revealed that between 2002 and August 2010 there were a total of 364 reassignments, 235 details and 31 employee transfers. Additionally, the available documentation suggests that employees who filed EEO complaints were more likely to be detailed or reassigned

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[4] Office of Personnel Management's (OPM) "Guide to Processing Personnel Action," (Processing Guide); 5 U.S.C. § 3503; and, 5 CFR § 351.302.
[5] 5 U.S.C. § 3341; OPM Processing Guide.
[6] 5 CFR § 210.102(b)(12); OPM Processing Guide. Reassignment to a position with more promotion potential than the present position requires competition under the agency's merit staffing plan.

compared to those that did not. The following is a list of our key findings on the transfer, detail and reassignment of employees.

- Reassignments:
  - Nearly 11 percent of total reassigned employees had filed an EEO complaint (formal or informal).
  - Nearly 8 percent of the employees were placed on administrative leave prior to reassignment.
  - About 3 percent of the employees had filed a grievance or other filing prior to their reassignment.

- Details:
  - About 13 percent of the total detailed employees had filed an EEO complaint (formal or informal).
  - No employees were placed on administrative leave prior to being detailed.
  - 6 percent of the employees had filed a grievance or other filing prior to being detailed.

- Transfers:
  - 3 percent of the total transferred employees had filed an EEO complaint (formal or informal).
  - 3 percent of the total transferred employees were placed on administrative leave prior to transfer.
  - No employees had filed a grievance prior to transfer.

Information the Chairman received only includes the employees who were transferred, detailed or reassigned to facilities located within the Aberdeen Area; it does not provide information on individuals employed in the Area but who were transferred, detailed or reassigned to facilities outside the Area. Furthermore, the Chairman requested that IHS submit all letters pertaining to a direct reassignment in the last 10 years. IHS only submitted 8 reassignment letters, despite IHS data indicating that it performed over 364 reassignment actions pertaining to 306 employees in the Aberdeen Area since 2002.

Employees Placed on Lengthy Periods of Administrative Leave. Through the investigation it was determined that 176 employees were placed on paid administrative leave between 2005 and 2010 in the Aberdeen Area. Leave for any individual varied greatly, ranging from eight hours to over eight consecutive months.

The IHS defines administrative leave as an excused absence from duty, administratively authorized, without loss of pay.[7] Administrative leave is "granted at the discretion of the manager, or the official with delegated authority, for reasonable periods of time for a variety of special situations."[8] Situations where excused absence may be authorized include, but are not limited to, voting and registration, military service registration, blood donations, and inclement weather.

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[7] IHS, Orientation Handbook, August 10, 2010 at 72.
[8] Ibid.

IHS policy does not expressly cite administrative leave for the purposes of a pending personnel investigation, but as described further below, numerous instances were found of employees being placed on administrative leave pending the performance of an investigation.

The use of administrative leave has grown significantly over the past few years. The data submitted by IHS demonstrates that in 2005 only eight employees were placed on administrative leave, due to "management election" or for training purposes. However, by 2009 that number increased to 35 employees, during which time several employees were placed on leave multiple times. One employee was placed on administrative leave for at least 1,200 hours. This trend has not changed in 2010. As of September 2010, 34 employees have been placed on leave with an average length of 97.4 hours.

The following chart provides the number of employees on administrative leave and the average length of leave from January 2005 to September 2010 for the facilities the investigation focused on in the Aberdeen Area.

FACILITY	NUMBER OF EMPLOYEES ON ADMINISTRATIVE LEAVE	AVERAGE LENGTH OF ADMINISTRATIVE LEAVE
	1/2005 – 9/2010	1/2005 – 9/2010
Aberdeen Area Office	22	1.4 Weeks
Belcourt	22	6 Weeks
Fort Totten	5	1.8 Weeks
Fort Yates	8	1.8 Weeks
Kyle	3	1.3 Weeks
Lower Brule	4	7.8 Weeks
McLaughlin	1	1.8 Week
New Town	6	4 Days
Pine Ridge	23	2.2 Weeks
Rapid City	24	1.5 Weeks
Rosebud	26	1.4 Weeks
Sisseton	11	4 Weeks
Wagner	1	1 Week
Winnebago	13	3 Weeks
TOTAL	**169**	**2.6 Weeks (Average)**

The most common reason for placing an employee on administrative leave is a pending investigation of the employee or management election, meaning it was the supervisor's determination to place the employee on administrative leave.

Further, the frequent use of administrative leave for purposes of a pending investigation may demonstrate unreasonably lengthy investigations. Attached as "Exhibit C" in the Appendix is a list of particular employees with the lengthiest administrative leave hours. Overall, the 11

employees who were placed on administrative leave due to pending investigations between 2005 and 2010 averaged over 560 hours of leave (more than 4 ½ months).

One employee at Sisseton Service Unit's Woodrow Wilson Keeble Memorial Health Care Center had the lengthiest consecutive leave period, totaling over eight months in 2009 due to a pending investigation. Specifically, this particular employee was under investigation due to allegations of sexual harassment and creation of a hostile work environment.

The documents submitted by IHS demonstrate that many employees were placed on administrative leave multiple times. For instance, a senior level employee at Belcourt Service Unit's Quentin N. Burdick Memorial Hospital was placed on leave during 12 pay periods in 2009 and one pay period in 2006, totaling nearly six months. IHS' documents indicate that the individual was placed on leave pending an investigation involving allegations of misconduct. Another employee at the same hospital was placed on leave during the course of eight pay periods in 2006, and 19 pay periods in 2007, totaling over one year.

The investigation also revealed that the Area Director failed to remain informed of whether a subordinate employee was on administrative leave. In this case, during the Committee's hearing on September 28, 2010, the Aberdeen Area Director, Charlene Red Thunder, testified that an Aberdeen Area employee was on administrative leave for over 12 months. After reviewing additional documents that IHS submitted, the Chairman determined that this was inaccurate. It was determined that the employee was not on administrative leave for 12 months, but instead had taken a combination of personal and sick leave and was assigned to work from home to perform "unclassified duties." Ultimately, the employee worked from home for 28.5 days in 2009 and 149 days in 2010. However, the IHS failed to have a formal telework agreement with that employee as is commonly required before an employee can work from home for such an extensive period of time.

Increased Equal Employment Opportunity Complaints. The investigation found that the number of Equal Employment Opportunity (EEO) complaints filed in the Aberdeen Area has increased at a faster rate than for the entire IHS. In addition, certain individuals were repeatedly the primary subject of multiple EEO infractions. Finally, the Chairman identified one instance where IHS failed to implement its own EEO Final Agency Decision for over seven months.

Filings with the Equal Employment Opportunity Commission (EEOC) generally stem from an informal complaint filed with IHS. Such complaints include allegations involving discrimination against an employee because of the person's race, color, religion, sex (including pregnancy), national origin, age (40 or older), disability, or genetic information.

Employees in a local facility generally file complaints with their onsite Equal Employment Opportunity (EEO) counselor. Employees are encouraged to resolve their claims through alternative dispute resolution (ADR), such as mediation. EEO mediators or contractors are utilized during the ADR process. The EEO counselor submits the final report of the EEO complaint to the EEO manager located in the Area Office. If ADR is not effective, the employee may file a formal complaint with the EEOC.

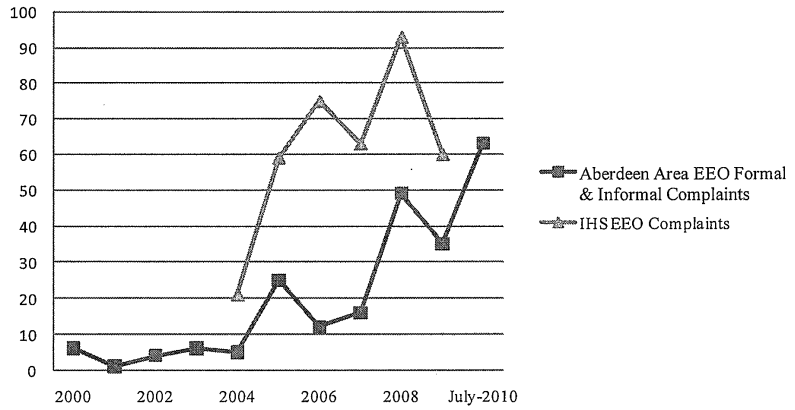
In addition, IHS recommends that each facility have at least two EEO counselors or more if the facility has greater than 100 employees. Employees volunteer to become EEO counselors as a part of their collateral duties. EEO counselors are required to receive 32 hours of training prior to assuming counseling duties, as well as eight hours of additional training each year. Employees can also volunteer to become EEO mediators as part of their collateral duties, and they will accept a case for mediation as their primary workload permits.

The Chairman received information from IHS regarding both formal and informal EEO complaints. The data demonstrates that the Area has experienced an upward trend in EEO filings and suffers from an inadequate level of trained EEO counselors and mediators. Further, certain employees were the subject of multiple EEO complaints, in which they were alleged to have discriminated against a colleague or subordinate.

The investigation revealed that employees in the Aberdeen Area have filed 222 formal or informal EEOs from 2000 to July 23, 2010. Further, based upon IHS data from January 2005 to July 2010 there were 53 EEO open cases (matters that had not resolved) and 159 closed EEO cases (matters that had been resolved).

As illustrated in the graph below, IHS data demonstrates that EEOs filed for the Aberdeen Area as of July 23, 2010 had already surpassed overall filings for the entire IHS in 2009. The Chairman identified that the number of EEOs in the Area increased from six in 2000, 25 in 2005, and 35 in 2009, to 63 as of July 23, 2010. As illustrated in the below graph, although EEO filings decreased in 2009, filings as of July 23, 2010 nearly doubled.

EEO Complaints by Year in Aberdeen Area



At certain facilities in the Aberdeen Area, EEO complaints have increased considerably in the past five years. By far, Belcourt has had the greatest number of EEO filings, totaling 50 over the last five years, escalating from two in 2005 to 15 as of July 23, 2010. The Area Office has the second highest amount of EEOs as of July 23, 2010, totaling 29. Data for Pine Ridge (28),

Rosebud (27), and Rapid City (26) demonstrate that the total number of EEOs for these facilities did not lag far behind.

Based upon data received by IHS, the Majority Staff also found the primary reason that employees in the Aberdeen Area filed EEO complaints was due to gender discrimination, reprisal or retaliation. EEO filings that allege reprisal or retaliation account for 44 percent of all EEO complaints in the past ten years. From 2008 to 2010, the number of EEO complaints based on reprisal or retaliation was substantially greater than those filed years prior. For instance, in 2005 there were five filings based on reprisal/retaliation; however, by 2008 the number of filings was 20 and from January 2010 to July 23, 2010 there have been 19.

Despite the rising number of EEOs and IHS' recommendation that each facility have a minimum of two EEO counselors, the Chairman found there was a lack of sufficient EEO counselors and mediators in the entire Area. Specifically, as of September 2010 only 13 certified EEO counselors and three EEO mediators are employed in the Aberdeen Area. The Area also has only one EEO manager and one EEO specialist located in the Area Office as of September 2010. The Area set a goal of training 15 more EEO counselors by October 2010. However, as of November 2010 the IHS had not met this goal.

Through the investigation one instance was identified in which the IHS failed to fully implement its Final Agency Decision regarding an EEO complaint filed by an employee at a facility in the Aberdeen Area. On September 18, 2007, an employee filed an EEO complaint claiming an illegal suspension and ultimate denial of privileges due to their national origin. On April 6, 2009, the IHS determined that the EEO complainant had been harassed, the hospital's medical by-laws were not followed, and derogatory comments were made about the employee's national origin. Ultimately, the Agency determined that the employee was exposed to an environment that was "unduly harsh and extreme, bordering on the hellish."[9] One individual interviewed by the Agency described the work environment at the hospital as "toxic" and further explained that nurses had ignored the EEO complainant's pleas for assistance during surgical procedures. The nurses' behavior was ultimately reported to their superiors but "it was ignored."[10] The April 6, 2009 Financial Agency Decision details that the EEO complainant identified three senior level employees as the management officials responsible for creating a hostile work environment.[11]

In a subsequent Final Agency Decision dated March 4, 2010, the IHS determined that the EEO complainant should be reinstated to their position at the same Aberdeen Area facility or reinstated at another facility in the IHS system. However, despite several requests from the complainant and their attorney over a period of 8 months, IHS failed to reinstate the complainant. In addition, the EEO complainant was awarded over $150,000 in equitable relief, back pay, compensatory damages, attorney's fees, and other costs. In November 2010 the Agency began to adhere to its Final Agency Decision by taking proper action to reinstate the complainant.

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[9] Agency File No. HHS-IHS-0511-2007, April 6, 2009 at 16.
[10] Id. at 14.
[11] Id. at 10.

The Chairman requested that IHS submit certain documents related to EEO filings in order to identify employees that were the subject of multiple EEO complaints. The Chairman received documents from IHS relating to 81 of the 159 closed EEO cases from 2005 to 2010. The Chairman determined that 12 employees on two or more occasions were alleged to have discriminated against their subordinate, colleague or other employee. These 12 employees were the subject of 31 EEO complaints, nine of which were resolved through a settlement agreement and three were adjudicated with a finding of discrimination.

The IHS confirmed to the Majority Staff that it does not have a policy for dealing with employees who are repeatedly the prime subject of EEO cases where there is a finding of discrimination. IHS' policies are limited to requiring EEO office staff to share the findings of discrimination and the named responsible management officials (RMOs) with IHS leadership. The EEO office advises the named RMOs of the findings and requests that the RMOs take corrective, curative or preventive action to ensure that violations of the law do not reoccur.

Based on the information IHS provided the following are examples of employees that were the subject of multiple EEO complaints.

- Employee 1 and 2

Two senior level employees at a facility in the Aberdeen Area were each the subject of multiple EEO complaints. In two EEO cases both employees were the primary subject of the EEO complaints. As described earlier, one EEO complainant was awarded over $150,000 in damages and other fees due to the hostile environment that was alleged to be created by these two senior level employees and an additional former employee.[12]

Another provider at the same facility in the Aberdeen Area identified the same two senior level employees, among others, as the prime subject of an EEO complaint filed on May 15, 2008. On May 14, 2010, the EEO Commission found that the complainant was subjected to a hostile work environment due to the employee's race and was retaliated against for prior EEO activity.[13] The Commission noted that the two senior level employees failed to take proper action and continued to support false complaints made by another employee even after the true facts were ascertained.[14] The judge found that when the EEO complainant told one of the senior level employees about the harassment the individual failed to conduct an investigation into the complainant's accusations, and ultimately disciplined the complainant for acts the person did not commit.[15] The Commission ultimately awarded the EEO complainant $50,000 in damages.

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[12] IHS Agency File No. HHS-IHS-0511-2007, April 6, 2009.
[13] EEOC No. 443-2010-00153X, May 14, 2010.
[14] Id. at 15 – 21.
[15] Ibid.

- Employee 3

A former senior level employee at a facility in the Aberdeen Area was identified in six different EEO case files as the official alleged to have discriminated against other employees.[16] The alleged misconduct occurred in each of these cases between 2006 and 2008, including during the employee's tenure as a senior level official. Ultimately, in five of the six EEO case files the IHS determined that no discrimination occurred, while the sixth claim was dismissed because the complainant failed to file within the time frame required.

- Employee 4

Another former senior level employee at a facility in the Aberdeen Area was the primary subject of alleged discriminatory misconduct on three occasions.[17] Two of the three EEO complaints were ultimately dismissed in 2007 and 2008, respectively. The third complaint was dismissed because the claimant entered into a settlement agreement of non-monetary value.

- Employee 5

A former senior level employee at a facility in the Aberdeen Area was named the primary subject of three EEO complaints filed between 2006 and 2008.[18] Of the three EEOs filed, no discriminatory act was found in two cases, while the third case was settled and the complainant was awarded over $22,000.

- Employee 6

Another former senior level employee at a facility in the Aberdeen Area was identified in two EEO case files as the official alleged to have discriminated against employees.[19] The alleged misconduct occurred in 2007 and 2008, respectively. One EEO claim was dismissed due to procedural issues, while the second complaint was settled without a monetary award.

Increased Employee Grievances and Other Filings. IHS employees, like other federal employees, may file actions as Merit Systems Protection Board (MSPB) complaints, Unfair Labor Practice (ULP) complaints, or grievances, among other options. ULP complaints include interfering with or prohibiting union activities, failure to bargain in good faith, position description changes, and terminations. Employees may file grievances due to letters of warning, reprimands, suspensions, hostile work environments, harassment, and leave restrictions, among others.

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[16] Report of Investigation, Case No. IHSC-064-06, September 4, 2007; Report of Investigation, September 18, 2007; Report of Investigation, Case No. IHS-050-06; Report of Investigation, Case No. HHS-IHS-054-2006; Report of Investigation, Case No. IHS-028-05, August 17, 2005; and, Final Agency Intake Decision, Case No. HHS-IHS-0251-2007, July 30, 2007.

[17] Report of Investigation, Case No. IHS-069-05, April 7, 2006; Report of Investigation, Case No. HHS-IHS-1361-2008, June 8, 2009; and, Report of Investigation, Case No. IHS-0062-06.

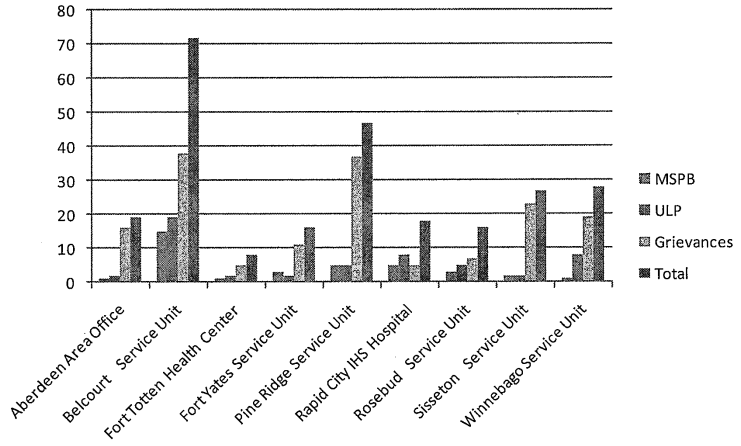
[18] Report of Investigation, Case No.HHS-IHS-0226-2008; Report of Investigation, Case No. HHS-IHS-0113-2007; and, Report of Investigation, Case No. HHS-IHS-0501-2007.

[19] Report of Investigation, Case No. HHS-IHS-1361-2008, June 8, 2009; and, Report of Investigation, Case No. HHS-IHS-0223-2008, August 26, 2008.

The MSPB is an independent, quasi-judicial agency in the executive branch that serves as the guardian of federal merit systems. The MSPB was established in 1978 and codified by the Civil Service Reform Act of 1978 (CSRA), Public Law No. 95-454. MSPB carries out its statutory responsibilities and authorities primarily by adjudicating individual employee appeals and by conducting merit systems studies, including hearing and deciding certain discrimination complaints, claims of whistle blowing reprisal, and negotiating and resolving ULPs.

Based upon the information IHS submitted the investigation revealed that of the facilities reviewed from January 2000 to September 2010, employees filed 354 work force grievances, ULPs and MSPBs at Aberdeen Area IHS facilities (including the Aberdeen Area Office). There were a total of 232 employee grievances, amounting to over 65 percent of all filings. The following graph is based on data received from IHS.

Aberdeen Area
Employee Work Grievances and Other Filings by Type and Facility:
January 2000 – September 2010



As illustrated above, in comparison to all other IHS service units, the Belcourt Service Unit had the greatest number of employee grievances, ULPs and MSPBs filed (72), accounting for 20 percent of all employee filings in the Area in the last ten years. The overwhelming amount of these filings were employee grievances (38), which included challenging a reprimand, detail, suspension or absence without leave, as well as reporting harassment. Pine Ridge Service Unit ranked second in employee grievances (39). Similar to Belcourt Service Unit, the majority of Pine Ridge Service Unit's filings were employee grievances.

The investigation also identified that while certain service units have experienced a higher rate of employee grievances, ULP, and MSPB filings than others, the overall Area has had a general decrease in these filings since 2004. In 2004 there were 48 filings; by 2008 it had declined to 18; and thus far in 2010 the number has held at 18.

Missing or Stolen Narcotics and Other Controlled Substances. The Chairman found that the frequency of missing or stolen narcotics and other controlled substances varied among IHS pharmacies. However, at certain facilities substantial levels of missing or stolen narcotics was a recurring issue, while a lack of consistent monthly audits of narcotics was a frequent issue at others.

Moreover, shortfalls in staffing and security deficiencies have contributed to greater amounts of missing or stolen narcotics at facilities, such as Quentin N. Burdick Memorial Hospital. Without consistent oversight, proper auditing, adequate staffing and sufficient security measures IHS will be at-risk of continued loss or theft of narcotics and other controlled substances.

There is a myriad regulations pertaining to controlled substances and how they should be handled, recorded, audited and reviewed by IHS pharmacies. There are also additional regulations provided for Schedule II drugs, such as Codeine, Morphine, Hyrdocodone, and Oxycodone.

Primarily, these regulations and guidelines are set forth by the Drug Enforcement Administration (DEA), HHS, Joint Commission, Centers for Medicare and Medicaid Services (CMS), internal policies of IHS and the state in which the pharmacy is located. For instance, to be a participating pharmacy, which enables a pharmacy to bill for services rendered to Medicare or Medicaid patients, there must be a current and accurate record of receipt and disposition of all scheduled drugs.[20] Furthermore, any discrepancy in the count of scheduled drugs should be reconciled promptly and abuses and/or losses of controlled substances must be reported.[21] Pharmacies must also have an adequate number of personnel to ensure quality pharmaceutical services.[22]

According to a 2010 internal IHS review of Aberdeen Area pharmacies an array of problems have contributed to challenges in managing and curtailing missing or stolen narcotics.[23] In addition, the IHS review indicates that the understaffing of pharmacists, though staffing has improved from 39 percent ideal staffing in 2006 to 61 percent in 2009, continues to be a contributing challenge.[24] IHS also determined in this report that increased prescription volume and medication therapy management, coupled with funding challenges, has resulted in insufficient accountability of controlled substances.

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[20] Centers for Medicare & Medicaid Services' Condition of Participation: Pharmaceutical Services, 42 CFR § 482.25 (a)(d).
[21] 42 CFR § 482.25 (b)(7).
[22] 42 C.F.R. § 482.25 (a)(2).
[23] IHS, Aberdeen Area Pharmacies, 2010 (no exact date provided in document).
[24] Ibid.

According to the same internal IHS 2010 of Aberdeen Area pharmacies, the Area experienced a 27 percent increase in prescription volume from 2006 to 2008.[25] The Chairman also recently became aware of one patient at Quentin N. Burdick Memorial Hospital that allegedly was prescribed on average 360 Oxycontin tablets per month in 2006. This information was submitted to the Federal Bureau of Investigation (FBI), which ultimately referred the matter to the DEA and later to HHS' OIG. The Chairman has requested additional information; however, at the time of releasing this report the information had not been made available.

The Aberdeen Area also continues to have deficiencies in consistent monthly auditing of its pharmacies. For instance, the hospitals at Rosebud Service Unit, Fort Yates Service Unit, Rapid City Service Unit, Belcourt Service Unit and Pine Ridge Service Unit provided inconsistent evidence that they conducted routine monthly audits. According to an IHS document titled, "Summary of Controlled Monthly Audits," in 2008 three service unit's hospitals, Belcourt, Fort Yates and Rapid City, in 2009, two service unit's hospitals, Rapid City and Winnebago, and in 2010, three service unit's hospitals, Rapid City, Belcourt and Fort Yates, failed to submit certain monthly audits.[26]

However, after reviewing the monthly audit documents submitted by IHS the Chairman found additional deficiencies that the Agency failed to identify. For instance, in 2009 Fort Yates also failed to submit monthly audits for three months: February, March and August. Also, two monthly audits encompassed four months, December 17, 2008 to February 13, 2009 and October 15, 2008 to December 17, 2008, respectively. Moreover, IHS did not detail that Rosebud Service Unit's hospital missed six months of monthly audits in 2009, and 2 months of monthly audits in 2008.

The following are examples of particular pharmacies that have experienced significant loss or theft of narcotics and other controlled substances.

- Belcourt Service Unit

The investigation revealed that Belcourt Service Unit's Quentin Burdick Memorial Hospital has had a troubling history of diverted narcotics and other controlled substances. Based on information received from the OIG and IHS, the facility has experienced substantial losses or thefts of Schedule II drugs since 2003.

According to a March 2003 Management Implication Report (MIR), the OIG found that the pharmacy was not in compliance with Title 21, section 1306.12 of the CFR, which requires a provider to write a new prescription for Schedule II drugs – not a refill.[27] The OIG identified that the pharmacy had routinely refilled Schedule II drugs without a new prescription. More troubling, the MIR states that when a senior level official was questioned about this, they

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[25] Ibid.
[26] IHS, "Summary of Controlled Substances," (two page summary of controlled substance monthly audits), no date provided.
[27] Office of Inspector General (OIG), Management Implication Report (MIR) No. 03-0010, March 12, 2003.

responded that they were "certain that Schedule II drugs *could* be refilled, and that [they] had 'seen it done all the time.'"[28]

The OIG expressed concern that the "very fact that the word 'refill' is written on a patient care component [a type of medical record used in the IHS medical records system] is good enough to fill the prescription for a Schedule II drug lends credence to the fact that the standards for obtaining the drugs aren't as strict in the IHS facility as they are in the private sector."[29] Further, the OIG noted that "one IHS provider admitted to testing a patient who routinely receives the Schedule II narcotic, and there was no trace of the drug in the patient's system. Yet, because of the ease at which the Schedule II narcotic is prescribed, the patient was able to continue receiving it."[30]

In a March 30, 2004 Memorandum and Order of the U.S. District Court of North Dakota Northwestern Division, the Court cited that "the apparent failure of IHS to control the dispensing of Schedule II narcotics from its hospital facility has created, and will continue to create, ongoing controversy and strife within the hospital and the community."[31] The court also noted that "it sincerely hopes that officials from the regional and national offices of IHS will investigate, address and correct this institutional problem. To do nothing… would be a tragedy."[32]

Based on documents the Chairman received from IHS, the pharmacy's inadequate management of controlled substances continued. In May 2006, an Aberdeen Area program review found that the pharmacy was not correctly handling narcotics. For instance, there was no evidence that the required random monthly audits of controlled substances were performed.

In 2010, the hospital reported missing or stolen narcotics on four separate occasions. On March 22, 2010, an internal email from a Quentin N. Burdick Memorial Hospital staff pharmacist indicated that another employee was caught stealing narcotics.[33] Nearly one month later on April 19th, an e-mail from a staff pharmacist indicated that for Hydrocodone the inventory in the electronic system was 2,424, yet the actual count was 1,925, resulting in a total shortage of 499 tablets.[34] On June 6th, a DEA form was completed indicating over 12,000 Alprazolam, Diazepam and Propoxyphen were reported stolen due to employee theft.[35] Finally, a July 1, 2010, document authored by an IHS pharmacy consultant indicated that a narcotics count conducted on June 21 showed over 48,000 tablets of Hydrocodone unaccounted for.[36]

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[28] Id. at 2.
[29] Id. at 3.
[30] Ibid.
[31] Case No. A4-02-133. at 17.
[32] Ibid.
[33] Email authored by the Staff Pharmacist addressed to the Chief Executive Officer of Quentin N. Burdick Memorial Hospital, March 22, 2010.
[34] Email authored by the Staff Pharmacist addressed to the Chief Executive Officer of Quentin Burdick Memorial Hospital, April 19, 2010.
[35] Quentin N. Burdick Memorial Hospital, "The Report of Theft or Loss of Controlled Substances," (Drug Enforcement Administration (DEA) Form 106), June 6, 2010.
[36] Schuchardt, Jon, Aberdeen Area Pharmacy Consultant, "Belcourt Diversion short synopsis," July 1, 2010. *See also* internal document titled "BE12BC~1.DOC."

On June 26, 2010, an Aberdeen Area review of the pharmacy found that the pharmacy had failed to maintain accountability of controlled substances and previous recommendations for the facility had never been implemented.[37] The report also indicated that the facility's pharmacy was out of compliance with CMS conditions of participation, placing its DEA license at risk.[38]

At the time of IHS' review of the pharmacy, the Chief Pharmacist and Staff Pharmacist positions were vacant. According to the same June 26th IHS report of the pharmacy, the Resource Requirements Methodology (RRM) indicates that the hospital "requires 11.5 pharmacists to adequately staff the facility."[39] Since January 2010 to June 2010, the pharmacy was staffed at between two to four pharmacists daily, resulting in "an unacceptable level of pharmacy staffing and a recipe for critical medication error, poor patient interactions, and once again, minimal oversight of controlled substances with potential for…diversions."[40]

- Rapid City IHS Hospital

The investigation identified that required monthly audit reporting of narcotics and controlled substances at Rapid City IHS Hospital were not consistently performed from 2008 to 2010. According to documents submitted by IHS, monthly audits were not performed for five months in 2008. IHS failed to submit monthly audits for three months of 2009. Finally, no monthly audit was performed in 2010 for the month of January.

In addition, based upon IHS documents the investigation also revealed various incidents of missing controlled substances. Specifically, the pharmacy issued a total of four official DEA reports of theft or missing controlled substances since 2008 that indicated various instances of missing narcotics.[41] The pharmacy submitted a report of theft or loss of controlled substances dated March 19, 2008, which indicates that 5,569 Hydrocodone tablets were missing due to employee pilferage.[42] On that same day, the pharmacy issued an amended report indicating the loss of 5,417 Hydrocodone tablets; 965 Darvocet tablets; and 187 Xanax tablets, totaling 6,569 missing controlled substances in one day.[43] The report identified employee theft as the reason for loss pills. In addition, there were two reports of theft or loss of controlled substances in March and April of 2010 detailing the loss of four tablets of Oxycodone.[44] One report indicates employee theft as the reason for missing narcotics.[45]

Based upon discussions with the OIG, the Chairman found that on November 25, 2008, a former employee for Rapid City IHS Hospital was sentenced to five years probation and was

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[37] Aberdeen Area IHS Pharmacy Consultant, "Belcourt Review of Narcotic Accountability and Diversion Issues," June 26, 2010.
[38] Id. at 7.
[39] Ibid.
[40] Ibid.
[41] Chief Pharmacy Service of Rapid City IHS Hospital, DEA Form 106, dates of issuance, March 16, 2010, April 2, 2010, and two were issued on March 19, 2008.
[42] Chief Pharmacy Service of Rapid City IHS Hospital, DEA Form 106, March, 19, 2008.
[43] Chief Pharmacy Service of Rapid City IHS Hospital, Amended DEA Form 106, March, 19, 2008.
[44] Chief Pharmacy Service of Rapid City IHS Hospital, DEA Form 106, dates of issuance, March 16, 2010 and April 2, 2010.
[45] Chief Pharmacy Service of Rapid City IHS Hospital, DEA Form 106, March 16, 2010.

required to pay restitution of $5,000 for committing health care fraud, a felony, and after admitting to OIG's special agents that he/she had stolen controlled substances from the hospital.

- Sisseton Service Unit

According to Aberdeen Area reviews from 2005 to 2007, Sisseton Service Unit's Woodrow Wilson Keeble Memorial Health Care Center's pharmacy showed improvements. However, in 2009 the OIG performed a review of the pharmacy and found significant discrepancies in narcotics accounting and unsecure dispensation of medications.[46]

On March 17, 2009, the facility's pharmacy filed two official reports indicating that employees stole 14,000 Hydrocodone and an additional 6,615 Hydrocodone tablets, respectively, totaling 20,615 missing Schedule II drugs.[47] According to a March 21, 2009 report issued by the Aberdeen Area Office, OIG conducted a site visit and found significant discrepancies and gaps in overall controls and oversight.[48] For instance, IHS' electronic Resource and Patient Management System (RPMS) reports indicated that the pharmacy had dispensed151,160 Hydrocodone tablets, yet 177,100 tablets were purchased. Moreover, the pharmacy failed to perform a perpetual inventory of schedule III controlled substances. During the OIG's site visit, two pharmacy technicians admitted that they had stolen Hydrocodone from the pharmacy. As a result, the Area Office provided a range of recommendations, most of which were security measures.[49]

In April 2009, the Aberdeen Area Office conducted a review of the pharmacy and found that while it had implemented several of the recommendations previously issued, 6,615 tablets of Hydrocodone were still unaccounted for.[50] On August 30, 2010, the Aberdeen Area Pharmacy Consultant performed a review of Sisseton's pharmacy and found that it had made progress in implementing many of the OIG's recommendations. While minor issues remained, such as the need to remove certain narcotics from the facility, the reviewer stated that it was "unlikely that diversion will be an issue for some time."[51]

Substantial Diverted Health Care Services. Generally, health care services are diverted, including service reductions, when an IHS facility determines that it will not accept patients for certain treatment or care, thereby diverting patients to another facility. However, a hospital cannot close its emergency department and is obligated under the Emergency Medical Treatment and Active Labor Act (EMTALA) to, at a minimum, complete a medical screening exam, provide stabilization and then, if necessary, transfer the patient. Diverted health care services are due to a range of issues, including a shortage of providers, inadequate reimbursement from public and private insurers, and lack of bed availability.

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[46] Aberdeen Area Office (no author), Trip Report, March 21, 2009.
[47] Chief Pharmacy Service of Sisseton-Wahpeton Oyate Health Care Center, DEA Form 106, two forms issued, March 17, 2009.
[48] Aberdeen Area Office (no author), Trip Report, March 21, 2009.
[49] Ibid.
[50] Aberdeen Area IHS Pharmacy Consultant, "Sisseton Service Unit Yearly Pharmacy Review and Physical Narcotic Audit: April 8-9, 2009," April 13, 2009.
[51] Aberdeen Area IHS Pharmacy Consultant, "Sisseton Service Unit Yearly Pharmacy Review and Physical Narcotic Audit: August 30, 2010," August 30, 2010.

The investigation revealed that, of the service units reviewed, a shortage of providers was the most cited reason for service diversions. Other reasons for service diversions included: no available inpatient beds, nonworking equipment, water outages, and high humidity.

According to IHS documents, only one hospital, Rosebud, produced a policy on diversion and three of seven hospitals in the Aberdeen Area (Ft. Yates, Eagle Butte, and Winnebago) have tracked data since 2003 on service diversions.[52] This indicates the Aberdeen Area Office or IHS' greater failure to effectively oversee local facilities' management of patient care.

During the hearing on September 28, 2010, the Chairman learned that IHS has made Rosebud's diversion policy applicable Area-wide.[53] However, the current policy lacks a clear definition of who exactly has the authority to place the health care facility on diversion status and does not set parameters on the length of diversions.

After reviewing the data submitted by IHS on health care service diversions, the investigation revealed inconsistencies in the data submitted demonstrating its unreliability. In addition, the Chairman learned that diversions not only detracts from providing patients with consistent care but can be extremely costly and deplete from CHS funding.

- Service Diversions Data Inaccuracies

IHS submitted data in early July 2010 on diverted/reduced services at facilities in the Aberdeen Area over the past ten years. The data showed that Quentin Burdick Memorial Hospital had experienced significant diversions over the past two years. Specifically, there were 53 days of service diversions in 2008, 306 days in 2009 and seven days in 2010.

However, IHS submitted additional information on September 16, 2010 that was inconsistent with the prior data. According to the latter submission, Quentin Burdick Memorial Hospital had experienced only 79 days of diversions/reductions in the past two years – not 313 as was originally reported. Thus, the information IHS later submitted was substantially disproportionate to its original submission.

The investigation also found inconsistencies with data submitted by IHS concerning service diversions at Rosebud and Sisseton Hospitals. Based on the data submitted to the Chairman on September 16, 2010, Rosebud Hospital had no diversions in 2003, 2004 and 2008.[54] However, according to documents submitted on July 28, 2010 specific to Rosebud hospital diverted services occurred nearly every year since 2000, such as 108 patients that were diverted in 2003. Furthermore, the September 16, 2010 data submitted by IHS does not indicate that diverted services occurred at Sisseton Hospital.[55] However, according to data submitted by the Agency on July 28, 2010 from 2000 to 2010, Sisseton Hospital repeatedly diverted x-ray services, dental

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[52] United States Senate Committee on Indian Affairs, Hearing entitled, "In Critical Condition: The Urgent Need to Reform the Indian Health Service's Aberdeen Area," Question presented to Ms. Charlene Red Thunder from Senator Tim Johnson of South Dakota at 20.
[53] Ibid.
[54] IHS, "Reduction in Services," submitted September 16, 2010.
[55] IHS, "Reduction in Services," submitted September 16, 2010.

and preoperative treatments.[56] Nevertheless, IHS failed to list any service diversions at Sisseton Hospital in its September 16th data submission.

- Lack of Service Diversion Policy

The Chairman also found no evidence that service units were provided with a policy that details who has authority to make decisions on diversions, when they may occur, and the length of the diversions as of August 2010. This has resulted in the inconsistent use and lack of oversight of diversions.

For example, the Aberdeen Area completed a program review of Belcourt Service Unit's Quentin Burdick Memorial Hospital's health care service diversions on November 7, 2008.[57] The review indicated a lack of oversight and inconsistent policies for when the hospital should divert patients. In addition, a senior level official at the hospital had little, if any, control over the decision to divert patients. Consequently, the decision to begin diverting adult patients was made by two other senior employees, but they never developed an explanation as to why they were diverting patients or a concrete strategy for how to get out of the diversion. Finally, according to this internal report there was no evidence of a proactive effort to identify the root causes of the problem or find alternative means to ensure admission of patients.

There also appears to be a 'business as usual' attitude when diversions occur at the hospital. In the same November 7, 2008 Aberdeen Area program review of the hospital it indicates that one of the employees that decided to diverted health care services stated that the facility had frequently diverted inpatient admissions in the past and it was "no big deal then so, why is everyone getting excited about it now?" This lack of concern expressed by this senior employee indicates poor leadership and an acceptance of service diversions, despite the burden placed on patients.

During the hearing on September 28, 2010, the Chairman learned that Rosebud Hospital's diversion policy was adopted Area-wide. The current policy does not provide guidance on the following: 1) who is the deciding official on diverting patient care; 2) whether diversions must have the final approval of the Area Office; and, 3) what parameters, if any, are recommended on the length of diversions.

- Service Diversions Impact CHS Funding

Service diversions not only impact the consistency and level of care provided to patients, it can also be extremely costly by detracting needed funding from CHS. Attached as "Exhibit D" in the Appendix is a chart specific to the cost of diversions at Quentin Burdick Memorial Hospital. This chart was developed from documents that IHS submitted to the Chairman. Based upon the information submitted by IHS the investigation revealed that a total of 666 patients

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[56] Sisseton Hospital, "Facility Operations: Diversion/Reduction in Health Care Services from 200[0] to 2008, as well as years 2009 and 2010," date of submission July 28, 2010.
[57] June Sabatinos, BSN, RN, MBA, and Mark Jackson, MD, Clinical Director, "Program Review at Quentin N. Burdick Memorial Health Care Facility," November 7, 2008.

were transferred from the hospital due to diverted services from October 2008 to June 2010. These diversions cost over $2.5 million in funding to CHS.

Mismanagement of Contract Health Service Funding. The CHS program funds health care services for Native Americans when they must go outside the Indian health care facility system. CHS supplements the direct health care provided at Indian health facilities.

The IHS and tribes contract with private providers when the Indian health program is unable to provide care, either because there is no Indian health facility or the existing Indian health facility is incapable of providing the service needed. CHS can include primary health care, routine and emergency ambulatory care, hospital stays, laboratory tests, pharmacy, and diagnostic imaging and screening services. Currently, the IHS and tribes contract with more than 2,000 private health care providers.

In order for CHS to pay for health care services, a patient must follow a specific approval process established by the IHS. There are essentially two tracks by which a patient seeks care through the CHS program: (1) a self-referral; or, (2) an approval from the Indian health program's CHS Review Committee, in conjunction with a clinician referral where an Indian health facility is present. Each tribe or Indian health program has a CHS Review Committee that is charged with reviewing each CHS case and must determine on a case-by-case basis whether the care should be covered.

Through the years, the Chairman has learned that CHS funding is generally rationed due to funding constraints. Many tribes have informed the Committee that Priority I cases that cover "life or limb" situations run out of needed funding by June of each year. Many tribal members have reported extreme numbers of denials and deferrals of CHS cases due to funding shortfalls.

IHS facilities are supposed to create monthly budgets for CHS funding and allocate funds on a priority basis so that the funds last through the end of each year. However, based upon data submitted by IHS Aberdeen Area facilities often end the year with a surplus of CHS funding. For instance, in FY2007 facilities had a total of $6.8 million in excess CHS funding, in FY2008 $2.4 million and in FY2009 $2.9 million.[58]

The investigation also discovered instances in which CHS funds were transferred (known as "non-recurring funds") to other programs and facilities. Notably, Aberdeen Area facilities have transferred $309,000 in CHS funds to tribal ambulatory programs, including a $100,000 transfer from the Fort Yates CHS program in FY2008, which ended the year with a deficit.[59] Also, in FY2008 the Sisseton Service Unit transferred $250,000 in CHS funds to a tribal program for oral health issues, which is likely not in compliance with CHS' priority system.[60] Funds were also transferred twice from the Sisseton Service Unit's CHS program: $2,500,000 as a loan to

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[58] Aberdeen Area Office (no author), "Contract Health Services Service Unit & Area Program Year End Balances," July 22, 2010.
[59] Aberdeen Area Office (no author), "Contract Health Services Recurring & Non-recurring Funding," September 10, 2010.
[60] Ibid.

Rosebud (to be repaid over the next four years) in FY2010 and $800,000 in FY2008 to Fort Yates.[61]

Finally, IHS recommended in its April 2010 review of the Aberdeen Area that increased routine communications with service unit CHS staff, training of its electronic reimbursement systems, and better management of the appeal process should be implemented. IHS has begun to fully implement these recommendations; however, it is unclear the extent to which it has assisted in alleviating many of the current challenges in management of the CHS program.

At-Risk: Facility Accreditation or Certification. The investigation identified multiple instances of IHS facilities receiving poor evaluations and being placed on notice for possible loss of accreditation. According to IHS' April 2010 review of the Aberdeen Area, five facilities were at risk of losing accreditation. IHS concluded in its April 2010 review that the "loss of accreditation would have devastating effects on these Service Unit budgets and severely restrict program operations." Described below, the Majority Staff identified a total of six facilities with accreditation problems and/or EMTALA violations.

Accreditation is the process through which hospitals and other health care facilities are evaluated on their quality of care, treatment and services provided, based on established standards of performance in the health care industry. CMS or a handful of organizations, called "deeming organizations," perform triennial surveys and inspections of IHS health care facilities and provide the accreditation or certifications that are recognized throughout the industry.

The most prominent of these groups is the Joint Commission, which has "deeming" authority from CMS, meaning that any hospital meeting the Joint Commission's conditions also satisfies the CMS conditions for reimbursement. The Joint Commission typically evaluates facilities once every three years. If a facility does not meet the necessary conditions for accreditation, the Joint Commission will place the facility on notice and typically require that improvements be made within 90 days or risk losing its accreditation.

Through the investigation the Chairman identified certain at-risk facilities given the information that IHS submitted. Specifically, the investigation revealed that IHS hospitals located at Pine Ridge Service Unit, Rosebud Service Unit, Belcourt Service Unit, Rapid City Service Unit, Fort Yates Service Unit, and Winnebago Service Unit had substantial accreditation and EMTALA issues. For instance, a CMS report from March 19, 2010, notes that Pine Ridge Hospital received a number of EMTALA complaints in 2009 and 2010, which centered on insufficient care in its Emergency Department. In addition, in November 2010, CMS reviewed Rapid City IHS Hospital's corrective action plans in response to a May 2005 EMTALA complaint (fifth revisit) and a September 2008 EMTALA complaint (second revisit). CMS determined that the Hospital's corrective action plans were unacceptable, requiring the facility to submit more responsive plans in order to avoid jeopardizing its accreditation.

The following are examples of accreditation or certifications problems at service units that were reviewed during the course of the Chairman's investigation.

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[61] Ibid.

- Rosebud Hospital

The Rosebud Hospital is one such facility where the investigation revealed a troubling record of repeat poor evaluations. From 2004 to 2009, the facility was routinely cited for being out of compliance with a number of CMS requirements. In a document titled, "Meet and Greet," it details that in May 2008 staff identified a number of serious concerns, including poor quality of care, questionable access to care, employee complaints not being resolved, bills not being paid on time, and a lack of professionalism in the clinic. According to a CMS August 2008 report, CMS conducted an unannounced site visit on August 27, 2008, and found that the facility had violated EMTALA, which requires that hospitals provide care to anyone presenting with an emergency condition regardless of ability to pay or legal status. The following day, CMS conducted a separate investigation of an additional complaint.

A CMS Recertification Survey Report dated July 2, 2009, detailed one troubling incident in October 2008 involving a pregnant patient at the Emergency Room (ER). The patient arrived at the ER with contractions every five minutes and was triaged as urgent. One and a half hours later, she was discharged from the ER. The patient proceeded to the outpatient department due to her continued contractions and was told to walk around and go to the bathroom for a urinalysis. Forty-one minutes after the patient was discharged from the ER, she delivered the baby in the outpatient clinic bathroom.

Further, a November 2009 Administrative Review describes how, on April 7, 2009, the White River Nursing Home filed a complaint with CMS after a patient who had been discharged to them from Rosebud Hospital showed evidence of nursing neglect. CMS determined that "conditions within Rosebud Hospital posed an immediate and serious threat to the health and safety of patients" in certain areas, and they placed the facility on "Immediate Jeopardy" status. The hospital submitted a Corrective Action Plan on April 10, 2009, and CMS lifted the jeopardy status.

On April 24, 2009, a letter from CMS to the hospital indicated that the facility was not in compliance with all conditions of participation (COP) for hospitals. CMS found that the facility was deficient in its governing body and nursing services. Specifically, the facility had ongoing issues with prevention of pressure ulcers and urinary catheter management, while the hospital's governing body had failed to provide proper oversight of nursing services to ensure these issues were addressed. As a result, the facility was once again placed in jeopardy status as conditions at the facility continued to pose a risk for patients.

During a recertification survey in June 2009, which was in response to the April 7, 2009, complaint, CMS concluded that the hospital was not in compliance with all of the Conditions of Participation for Hospitals, which are required for accreditation. The review identified serious problems with the quality of nursing care, an unqualified nursing supervisor, disengaged and inaccessible managers, disorganization, lack of basic supplies, and overall disrepair of the facility. Surveyors noted a series of troubling examples of poor patient care in the past year, including the woman giving birth in the bathroom of the outpatient clinic in October 2008; a patient being discharged with an IV catheter left in his/her arm; and, a 16 year-old patient being discharged 24 hours after delivering a baby by Cesarean section (also known as a C-section), a

surgical procedure normally utilized to deliver one or more babies. The hospital filed a formal Corrective Action Plan (CAP), which, according to a November 18, 2009, letter from CMS, was returned as "unacceptable." The facility submitted revised CAP on November 25, 2009.

The Chairman did not receive any accreditation documentation for the hospital beyond November 2009. As of November 2010, the Chairman received no evidence from IHS that the facility had taken measures to correct its jeopardy status or that CMS or IHS had performed any additional reviews.

- Fort Yates Service Unit

Fort Yates Service Unit's Standing Rock IHS Hospital has had substantial accreditation problems since 2007. In May 2007, a Mock Joint Commission survey of the hospital performed by Care Education Group, Inc. (CEG) identified a host of issues, including failure to verify staff credentials, providers treating patients with expired licenses, improper documentation and missing policies and procedures.

Two months later, the Joint Commission performed a survey of the hospital and found a number of areas of non-compliance and required the facility to submit an Evidence of Standards Compliance (ESC) within 45 days. According to the July 2007 Accreditation Survey, found, in part, that the hospital failed to consistently track provider licensure information, there was no process for reviewing medication orders after the pharmacy closed, and there were no policies on assessing the appropriateness of prescriptions.

Over a year later, in September 2009, CMS notified the hospital that it was found to be in compliance and had only minor deficiencies. However, a Mock Joint Commission survey conducted by CEG in November 2009 found a substantial list of problems, including expired medications and supplies (some more than six years old), rusted equipment, sterilization issues, and incomplete and improper patient care documentation. More troubling, a patient was transferred with no evidence that the physician approved the transfer and many providers had expired and/or unverified licenses.[62]

In February 2010, CMS performed a "substantial allegation survey" and found that the hospital was not in compliance with the Conditions of Participation for Hospitals due to unsafe water temperatures. According to a letter from CMS on February 18, 2010, surveyors found that "conditions within PHS Indian Health Services Hospital at Fort Yates posed an *immediate and serious threat* to the health and safety of patients" relating to the unsafe water temperatures.[63] The hospital immediately submitted a corrective action plan and the immediate jeopardy status was abated. Following the abatement, however, as the letter notes, "deficient practice continues to create a potential for harm" and CMS continued with the facility's scheduled termination of October 1, 2010. In an April 29, 2010, letter, the North Dakota Medicaid Director notified the

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[62] Slaba, Carol, Eric D. Joseph and Nancy E. Webster. "Mock Joint Commission Survey Report by Score and Department: Standing Rock Service Unit, Fort Yates, North Dakota," November 2009 at 6-7, 39.
[63] Chickering, Steven D. "Letter from Steven D. Chickering, CMS Western Consortium Survey & Certification Officer, to Carl Ducheneaux, Interim Chief Executive Officer, PHS Indian Hospital at Fort Yates," Feb. 18, 2010.

hospital that unless CMS rescinded its termination action, the state's Department of Human Services would also terminate its state Medicaid Provider Agreement on October 1, 2010.[64]

The Joint Commission conducted a survey of the hospital in July 2010 and identified a number of areas of non-compliance. Joint Commission found that the hospital had no process for ongoing professional practice evaluation, instances of lapsed provider privileges, no assessments of patient's mental, emotional and behavioral functioning, missing documentation of written plans of care for behavior health clinic patients, and insufficient documentation of patient consent for various procedures. The hospital was already on "immediate jeopardy" status stemming from the February allegation survey, but the projected termination date was extended by CMS from May to October 2010, and most recently to January 2011.

- Belcourt Service Unit

Belcourt Service Unit's Quentin N. Burdick Memorial Hospital has also had a history of accreditation issues. Joint Commission reports for the hospital in 2007 and 2010 and the hospital's laboratory in 2006, 2008 and 2010 required the facility to submit an ESC within 45 days from the date of the issued report describing progress made on correcting deficiencies and/or compliance issues. Failure to make sufficient progress may negatively impact accreditation.

A Joint Commission Survey Assistance Report was completed by CEG in 2007. This report includes reviews of specific areas of Quentin Burdick Hospital, which would be included in a Joint Commission accreditation review. The summary of findings and deficiencies lists over 80 for the hospital. The findings include, but are not limited to, safety concerns related to the lack of relevant policies for certain emergencies; incorrect procedures for removing hazardous waste; patient charts not containing correct information; and nursing staff for the emergency room have access to the entire pharmacy. The 2007 report also reveals ten significant deficiencies in licensure and credentials of providers, such as three providers with expired certifications and others in which the hospital failed to verify a provider's license.

In 2006, 2008 and 2010 Joint Commission's reports for the hospital's laboratory accreditation all required ESCs to be submitted within 45 days of the report. The reports demonstrate ongoing compliance issues. For example, the 2008 report lists such concerns as the laboratory failing to document which staff conducted tests and there were no documented comprehensive investigations and remedial actions taken for unacceptable lab results. The 2010 report indicated insufficient compliance in staff competence.

A Mock Survey of Quentin N. Burdick Memorial Hospital was conducted by CEG on February 22, 2010, through February 25, 2010, and found varying issues within the hospital. These findings included: improper storage and monitoring of medications and medical equipment; inadequate patient records in medical files; and, lack of proper training, reviewing, and tracking of employee qualifications in Human Resources. From July 7th through July 9th of 2010 the Joint Commission conducted an accreditation survey of the hospital and found 24

[64] Anderson, Maggie D. "Letter from Maggie D. Anderson, North Dakota Medicaid Director, to Carl Ducheneaux, Interim Chief Executive Officer, PHS Indian Hospital at Fort Yates." Apr. 29, 2010.

deficiencies requiring the submission of ESCs, including nine areas related to credentialing practitioners and privileges.

Expired Health Care Provider Licenses and Other Credentials. Generally, credentials are a health practitioner's documentation of education, clinical training, licensure, experience, current competence, and ethical behavior. Providers are also required to have particular credentials, such as cardiopulmonary resuscitation (CPR), Drug Enforcement Administration (DEA), Advanced Life Support (ACLS), and a Neonatal Resuscitation Program (NRP) license in order to practice various types of medicine, prescribe medicine and/or work in a health facility.

The main purpose of the credentialing and privileging process is to ensure that qualified and competent practitioners are granted medical staff membership and/or privileges. Active credentialing of providers is an established standard of conduct and is required by law.[65] According to the "IHS Medical Staff Credentialing and Privileging Guide," dated September 2005, the Agency requires at a "minimum primary source verification of the following: licensure, professional education, post graduate training and experience, current competence and ability to perform (health status)."[66]

While physicians and Physician Assistants are generally required to be credentialed and privileged, nurses and pharmacists are not required to be privileged.[67] However, their license should be verified initially and at each subsequent licensure renewal to ensure that it is unrestricted and in good standing.[68]

IHS is also required to retain all such records for at least ten years after the individual's termination of employment or association with IHS.[69] Credentialing is an essential element to gaining accreditation and certification of facilities. Also, if a provider's state license lapses the facility is required to reimburse Medicare, Medicaid or private insurers for services rendered to patients during that time.

Despite these requirements, the investigation revealed various instances of lapsed provider licenses, certifications, registrations, and privileges at Belcourt Service Unit, Fort Yates Service Unit, Rapid City IHS Hospital, and Winnebago Service Unit's hospitals. The following are examples of expired provider licenses and certifications problems at certain facilities reviewed.

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[65] *Darling v. Charleston Community Memorial Hospital*, 211 N.E. 2d 253 (Ill. Sup. Ct. 1965); *Thompson v. Nason Hospital*, 591 A. 2d 703, 707 (Penn. Sup. Ct. 1991); Privacy Act of 1974, as amended, 5 U.S.C. § 552a(e)(4). *See*, IHS Circular No. 95-16, Credentials and Privileges Review Process for the Medical Staff, December 8, 1995 and, IHS, "Indian Health Service Medical Staff Credentialing and Privileging Guide," September 2005.

[66] For instance, the Joint Commission requires that hospitals verify licensure, certification or registration with the primary source at the time of hire and upon expiration of the credentials. An outside authority, such as the medical school from which a medical degree was awarded, or the state licensing board that granted a license, will normally be asked to provide the evidence or attest to the validity of the provider's credentials, licensure or registration. IHS, "Indian Health Service Medical Staff Credentialing and Privileging Guide," September 2005 at 2.

[67] Id. at 7.

[68] Ibid.

[69] 71 F.R. § 34626

- Belcourt Service Unit

As detailed in the accreditation section of this report, a 2007 Mock Joint Commission Survey performed by CEG found licensure issues at Belcourt Service Unit's Quentin Burdick Memorial Hospital. Specifically, three of CEG's findings related to the hospital's failure to verify licenses and three other findings involved expired provider licenses, one in 2002 and two others in 2007. In addition, CEG determined that for two of the providers with expired licenses, both had expired CPR certifications and one had an expired certification of ACLS and NRP. Finally, CEG found that certain employees' skill sets were not adequate for the relevant health care field.

In a subsequent 2010 Mock Joint Commission Survey conducted by CEG in February of 2010, a "Human Resource File Review" was conducted involving a review of 28 employee files demonstrating the persistence of licensure and certification problems. For example, CEG found that ten employees did not have the proper license or registration, eight did not receive mandated background checks and 15 did not have verification of their education. Finally, a July 2010 Joint Commission accreditation report also found nine areas of deficiencies related to credentialing practitioners and privileges.

- Rapid City IHS Hospital

The investigation also identified significant licensing and credentialing lapses at Rapid City IHS Hospital. IHS submitted a June 2007 Mock Joint Commission Survey of Rapid City IHS Hospital conducted by CEG, which identified several providers that had expired licenses or certifications. For example, one physician had an expired medical license for over seven months.

In an accreditation survey conducted on August 9-10 of 2007, the Joint Commission identified additional issues involving the hospital's failure to verify licenses. For instance, a nurse's license was due for renewal on December 20, 2006. However, license verification was not performed until July 27, 2007 – nearly seven months later.

According to Agency documents dated between May 2008 through April 2009, licensure and certification problems at the hospital persisted. The following is a summary of the key issues identified:

  - Two medical doctors with expired state licenses;
  - Six doctors and family nurse practitioners with expired CPR certifications;
  - Eight family nurse practitioners and physicians with lapsed ACLS or Pediatric Advanced Life Support (PALS) certifications; and,
  - One family nurse practitioner with an expired DEA license.

- Winnebago Service Unit

A September 2009 Mock Joint Commission Survey conducted by CEG at Winnebago Service Unit's Hospital highlights significant licensure and credentialing problems. The surveyors reviewed 13 credential files and found the following:

- Failure to verify a Physician Assistant's education;
- Four providers' licenses had expired, (some over nine months ago, but the facility had not verified or checked for renewal);
- Three providers had no Child Care National Agency Check and Inquiries (CNACI), a background check required for those who provide care to persons under age 18. CNACIs include checking the individual for convictions of crimes involving children. For instance, one provider had worked at the facility since December 2005 and another had worked at the facility since July 2004, yet no CNACIs were performed; and,
- Three providers' ACLS certification had expired and three providers' CPR certification had expired.

In a subsequent accreditation survey conducted by the Joint Commission from August 3rd through August 6th of 2010, the hospital was awarded an insufficient compliance rating for failing to verify employee licensure/certification and exceeding two year privileging limitations. Specifically, the Joint Commission found that the hospital had no documentation of primary source licensure/certification verification for four employees, including two nurses. In addition, two physicians' re-appointments exceeded two years, including one physician whose privileges had lapsed for 22 days.

It is unclear whether these facilities took corrective action and refunded Medicare, Medicaid or private insurers for services rendered by unlicensed providers. However, the investigation revealed one instance in which a facility took corrective action to refund Medicare. An employee at Rapid City provided services to patients without a valid license from April 1, 2001, to October 2, 2003. The facility ultimately refunded over $63,000 to Medicare.

Disciplinary Actions Taken Against Provider Licenses. Health care providers are required by law to have an active license (from any state) in order to serve patients at IHS facilities. IHS is required to maintain records of provider licenses, including adverse actions for at least ten years after the individual's termination of employment or association with IHS.[70]

The Chairman requested that IHS submit information on all providers with licensure problems, including disciplinary actions, revocations and restrictions taken by state licensing boards over the past ten years. IHS submitted the name of two physicians detailing a total of four incidences, such as state licensure revocations, restrictions and voluntary surrender.

Based upon the information received from state licensing boards, the investigation revealed more instances of health care providers with reprimands, license suspensions, encumbrances, and revocations. Attached as "Exhibit E" in the Appendix is a description of some of the providers the Chairman discovered had disciplinary actions taken against their license, but were not identified by IHS in the data it submitted to the Committee.

The Agency's failure to submit information pertaining to provider licenses demonstrates a clear lack of adequate oversight and monitoring in this critical area. Without proper monitoring

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[70] 71 F.R. § 34626

and a guarantee that a health provider has a medical license in good standing, patient safety and care may be jeopardized and IHS could be exposed to litigation.

In addition to Exhibit E, the following are some of the individuals the Committee identified with licensing problems, all of whom worked for Belcourt Service Unit's Quentin N. Burdick Memorial Hospital at the time of the related disciplinary action.

- Nurse One – A state board of nursing found the nurse had diverted controlled substances for personal use, worked in an "impaired" condition and failed to abide by the Nursing Advocacy Program (monitors use of controlled substances) on numerous occasions from 1989 to 2003. For example, in 2000 the nurse was in such an impaired condition that during a C-Section procedure the nurse "could not properly place and hold retractors, and hold the patient's skin in place for staples."

- Nurse Two – A state board of nursing determined that the nurse had failed to notify or take action against an operating room supervising nurse who worked in an impaired condition in 1999 and 2000.

- Nurse Three – A state board of nursing found that the nurse had failed to supervise an unlicensed assistive person and falsified a patient's chart in 2002.

- Nurse Four – A state board of nursing determined that the nurse practiced without a state license for more than 30 days in 2004.

- Nurse Five – A state board of nursing found that the nurse slept in an empty patient room while on duty in 2005.

Employee Misconduct and Poor Performance. Based on documents received from IHS, individuals that contacted the Committee and HHS' Office of Inspector General (OIG), the Chairman found evidence of employee misconduct, yet the Area failed to take reasonable action or chose to transfer, detail and/or reassign the employee to another facility. Below are some of the more egregious examples.

- Winnebago Service Unit

An administrative review performed by the Aberdeen Area Office in November 2009 details issues involving a senior level management employee at Winnebago Hospital. IHS' Aberdeen Area reviewers found that:

  - According to interviews with members of the Governing Body and Supervisors, the senior employee reported to work two days a week (16 hours) on average and frequently arrives late.
  - The senior employee was absent without approval/authorization for 130 work hours in 2008 and 2009. In two particular instances the senior employee was supposed to be attending meetings, one with HHS and another with the Nebraska State Medicaid

Director. In each instance, the employee did not submit Government Travel Vouchers verifying travel.

- The senior employee misused government funding by using facility funds to purchase food for hospital employees on various occasions.
- The senior employee used a government vehicle for personal purposes.

Administrative reviewers ultimately found that that this senior employee did not "demonstrate the leadership and ethical skills necessary" and had difficulty with "interpersonal skills needed to influence people, avoid unwanted influence, develop cooperative relationships, establish and maintain networks, understand individuals, facilitate teamwork and resolve conflicts constructively at the Winnebago facility."[71] The reviewers concluded that appropriate disciplinary action should be taken against the employee.

The senior employee was placed on administrative leave for over two months in 2009 and three and a half months in 2010 due in large part to a pending investigation involving misuse of authority and mismanagement. Although, the Agency proposed the employee's removal such actions were ultimately mitigated to a 'last rights agreement' in which the employee agreed not to apply for another position within the Aberdeen Area for one year from the date of the execution of the agreement and agreed to voluntarily resign at the end of a 30 calendar day period, withdraw any informal and/or formal complaints or appeals to the Merit Systems Protection Board and any other venues.

According to IHS' website, the employee still works for IHS. The Chairman also received information indicating that this employee was previously reassigned from another Aberdeen Area facility in July 2004, prior to working at Winnebago.

- Fort Totten Health Center

In September 2006, the Spirit Lake Nation passed a resolution accusing a senior level management employee at Fort Totten Health Center of hostile work environment, retaliation against subordinates and noncompliance with IHS policy, i.e., "prohibited personnel practices." The tribe ultimately passed a resolution in October 2007 expelling the employee from the Spirit Lake reservation.

The OIG and IHS investigated these allegations at the request of Chairman Dorgan. IHS performed its review in March 2007, six months after Spirit Lake Nation passed two tribal resolutions regarding the employee. IHS' investigation found that the employee had 1) misused authority, 2) acted in an unprofessional manner, 3) created a hostile work environment, 4) engaged in sexual harassment, 5) misused government property, 6) had not abided by time and attendance policies, and 7) retaliated against subordinates, among other findings.

The OIG performed a criminal investigation and issued a report in September of 2008. Although the OIG did not find that criminal misconduct had occurred and the Department of Justice declined to prosecute the employee, the OIG identified that many of the alleged and

[71] IHS, Administrative Review: Winnebago Hospital, November 2009.

substantiated acts committed by the employee, and reviewed by IHS' investigation fall within prohibited personnel practices as defined by 5 U.S.C. § 2302(b), including:

- Nepotism;
- Reprisal for whistleblowing;
- Failure to take personnel actions against employees;
- Discrimination; and,
- Deceiving or willfully obstructing an individual from competing for employment.

IHS' reviewers recommended the immediate removal of the employee, in part due to the potential continued loss of money if more EEO complaints were filed and IHS lost. The OIG found that four of five EEO complaints originated prior to the employee's arrival at Fort Totten Health Center; however, all of them included issues specifically involving the employee. Mainly, complainants alleged that the employee had retaliated against them for the EEO complaints they had filed prior to the employee's arrival at the facility. The allegations in the EEO cases included the following, which have all been settled, costing IHS over $50,000 at the time of OIG's September 2008 report.

- Employee alleged discrimination based on race, national origin and reprisal.
- Employee alleged hostile work environment because of race, sex and national origin, and alleged reprisal occurred during the EEO process.
- Employee alleged discriminated based on national origin and reprisal. The employee also alleged that management created a hostile work environment in which the employee was ultimately detailed.
- Employee alleged subjection to a hostile work environment.
- Employee alleged discrimination based on disability and national origin.

Despite IHS' findings, the employee was ultimately suspended without pay for 14 days, from August 26 to September 8, 2007. The employee was eventually placed on direct reassignment to another service unit in the Aberdeen Area.

This individual remains employed at IHS. The Chairman learned that this employee was recently detailed to another facility in the Aberdeen Area.

- Belcourt Service Unit

As referenced in other sections of this report, Belcourt Service Unit's Quentin N. Burdick Memorial Hospital has an extensive history of mismanagement, resulting in diversion of narcotics/controlled substances, extensive diverted health care services and ample complaints filed by its employees.

There have been three OIG reports specifically regarding the hospital. First, a December 2002 report on retaliation for whistleblowing, mismanagement and harassment by a senior level management employee of the hospital. Second, two follow-up reports in June 2004 and March 2003 regarding extensive diverted narcotics (discussed in a prior section). The Chairman also received from IHS two internal reviews of the hospital dated November 2008 and June 2010.

The following are three examples of employee misconduct at the facility and the Agency's related corrective actions.

- Example 1: Employee A (Senior Level Management Employee)

The Committee found the following information based upon an OIG investigation:

In April of 2000 several billers discovered that large amounts of the Schedule II narcotics, Oxycodone, were being prescribed and dispensed at the hospital's pharmacy, Medicare Secondary Payor forms were back dated for billing purposes and there was no purpose of visit listed in patient records. Some individuals, for whom no purpose for the visit was listed, received refills for Oxycodone and were employees at the hospital. The matter had been reported to Employee A since 1999 but no corrective actions were taken.

In August 2000, another employee brought the drug diversion issues to the attention of the Aberdeen Area Office Personnel Director (AAOPD). In October 2000, the AAOPD filed a report with Employee A and indicated that the matter "needed to be investigated, and if true, pursue corrective action. This may include making contact with proper authorities." The Aberdeen Area Director, Deputy Director and Executive Officer were also copied on the review conducted by the AAOPD.

In February 23, 2001, Employee A instructed a subordinate to provide a written response to the issues in the AAOPD's review. Mistakenly, this letter was ultimately circulated, which identified many existing employees at the hospital. Ultimately, three senior level employees discovered that this subordinate employee had provided negative information about them.

Ultimately, Employee A failed to inform hospital staff of the following: 1) Employee A had ordered the subordinate employee to draft a written response to the AAOPD; 2) the document was meant to be confidential; and, 3) the subordinate employee was acting within policy to identify illegal activity taking place at the hospital and inform IHS management as set forth in 45 CFR § 73.735-1301 and HHS' General Administration Manual.

According to OIG's report, Employee A was upset that the subordinate employee also disclosed derogatory information about Employee A. Ultimately, Employee A failed to share the above information with staff and as retaliation for providing information regarding illegal activity at the hospital allowed several employees that were referenced in the subordinate employee's draft response to the AAOPD to file a Privacy Act complaint against the subordinate employee.

According to OIG's report, in April 2001 an IHS Aberdeen Area Privacy Act Investigator conducted a Privacy Act investigation. The OIG report indicates that IHS' findings were inaccurate and conclusions were not supported by facts. Based upon the erroneous information contained in IHS' investigative report, IHS management began consulting with IHS' Office of General Counsel (OGC) regarding prospective disciplinary actions against the subordinate employee originally ordered by Employee A to draft a response to the AAOPD. Ultimately, the OGC advised IHS to take no action until OIG had completed their investigation.

The December 2002 OIG report found that:

- Medicare Secondary Payor documents were backdated and altered by hospital billers, which was directly instructed by a senior level employee.
- Many records for Schedule II narcotics reflected no office visit and stated, "telephone call, med refill."
- Drug Enforcement Administration Diversion Agents confirmed that a high volume of Oxycodone was dispensed through the hospital's pharmacy.
- Certain hospital employees, in 1999, 2000 and 2001, pressured physicians to prescribe drugs to patients, friends and relatives. Other hospital employees solicited physicians in hallways at the facility to have their personal prescriptions for drugs refilled without an office visit.
- Employee A allowed the hiring of a dentist who had been terminated from the U.S. Public Health Service Commission Corps in January 2001, but had made a false statement on his official application indicating that he had never been fired from any job over the past five years. Employee A was aware of the termination and false statement, but permitted the hiring to take place.
- Employee A provided false and misleading information to the OIG.
- Employee A had made derogatory racial comments.
- Employee A retaliated against the employee that was ordered to provide a draft response to the AAOPD.

The OIG noted at page six of its December 2002 report that through the course of its two-year ongoing investigation, they had "documented a pattern of mismanagement, discrimination, and retaliation with a divisive management style resulting in civil suits, grievances, and unwarranted allegations of Privacy Act violations." The OIG further concluded that Employee A was "the driving force behind each problem" and recommended immediate termination.

Based upon documents received from IHS, the Committee found that despite OIGs recommendation to terminate Employee A, the individual was reassigned on March 24, 2002, within the Aberdeen Area. In March 2004, according to the memorandum and order issued by the U.S. District Court of North Dakota Northwestern Division, the court noted that Employee A was currently employed at another facility in the Aberdeen Area. Further, in 2008 the individual was detailed from that facility to another in the Aberdeen Area and received an outstanding or equivalent Performance Management Appraisal Program (PMAP) and was awarded 24 hours paid leave. The Majority Staff found that IHS did not submit information from 2000 to 2007 regarding the individual's PMAP assessment. Since IHS only submitted documents for individuals placed on administrative leave from 2005 to 2010, it is unclear whether this same person was placed on administrative leave at any point during OIGs or IHS' investigation. Ultimately, Employee A retired from the Agency in 2009.

- Example 2: Employees C, D and E (All Senior Level Employees)

Based on documents received from IHS, the Aberdeen Area performed a program review of the hospital in November 2008, which examined the diversion of adult inpatients allegedly due to inadequate provider staffing levels and lack of equipment and supplies (see "Substantial

Diverted or Reduced Health Care Services section" for additional information about diversion levels at Quentin N. Burdick Memorial Hospital).

IHS concluded that Employee C, a senior level nurse, had created an intimidating environment and his/her subordinates had "well founded fears of retaliation" for speaking out against any of Employee C's decisions or behaviors. As an example, the report notes that a state board of nursing expressed written concern to another senior level employee, Employee D, about the number of nurses reported to the board by Employee C. According to the report, it states that after this state licensing board conducted its investigation it found that the allegations submitted by Employee C were unfounded. Further, according to the report, the letter suggested that Employee C needed additional training and support.

IHS also found that, on at least one occasion, another employee, Employee E, a senior level physician, refused particular work schedules, despite the hospital having severe provider staff shortages. In addition, some contracted employees refused to work at the hospital because Employee E had treated five to six of them badly and would not return. As cited in the section titled "Substantial Diverted or Reduced Health Care Services," Employee E is the same individual that reacted to the lengthy diversion of services provided at the hospital nonchalantly without a sense of urgency to take appropriate action to correct the diversion crisis.

As a result of these findings, in part IHS recommended that:

1. The behaviors of Employee E and Employee C should be "dealt with" and cited that no matter "how experienced the next CEO is, he or she will not be successful because these two individuals have proven that they can effectively undermine the CEO and suffer no consequences."

2. "Eliminating the behaviors of these two employees is paramount to support the efforts of an experienced leader to help employees achieve some degree of insight and develop motivation for positive change that is once again patient focused."

The investigation revealed that ultimately Employee D resigned, while Employees C and E remain employed at the hospital. The Majority Staff also found that Employee E had previously been reassigned from another facility in the Aberdeen Area in February 2008. Employee C was also detailed within the service unit in February 2005. Despite IHS' clear concerns about Employee C in 2008, this employee's PMAP rating was fully successful or equivalent and was awarded a significant bonus.[72] In 2009, Employee C received a bonus of over 16 hours of paid leave. As detailed in the EEO section of this report, this employee was a primary subject of multiple EEO complaints filed against IHS.

- Example 3: Employee F (Senior Level Employee)

According to documents submitted by the OIG, a reassignment letter dated October 23, 2006, from the Deputy Director of the Aberdeen Area to Employee F, of Quentin Burdick Memorial

[72] Aberdeen Area Office (no author), "Performance Management Appraisal Program 2000-2009," Received from IHS August 24, 2010.

Hospital. The letter indicates that Employee F is reassigned from one facility in the Aberdeen Area to another located in the Area. At the time, Employee F was already on detail from one service unit in the Aberdeen Area to another.

The letter indicates that Employee F's reassignment was based upon an August 3, 2006, finding that the employee abused authority. Further, there was an adverse action taken against the employee. As a result, Employee F was placed on 30-day suspension. The letter cites that after Employee F was informed of a forthcoming detail, the employee reported for volunteer duty with the Army National Guard, thus giving the appearance of "purposely delaying" the pending official detail.

According to the information provided in the October 23, 2006 letter, Employee F's reassignment was "management's last effort to attempt to correct unwarranted and unacceptable workplace behaviors." The Deputy Director of the Aberdeen Area also warned Employee F that the next adverse action would result in a proposed removal from employment with IHS.

Employee F passed away this year. However, prior to the employee's death, the employee was placed on leave for alleged misconduct.

Hiring Excluded Employees or Those with Unsuitable Criminal Records. The investigation revealed several instances in which Aberdeen Area employees were hired by IHS despite being on the OIG's List of Excluded Individuals/Entities (LEIE). In addition, the Chairman identified one instance in which an employee with an embezzlement conviction was hired in a temporary position.

Under section 1128A of the Social Security Act, the OIG was given the authority to exclude certain individuals and other entities from participating in all federally funded health care programs. The basis for exclusion includes, convictions for program related fraud and patient abuse, licensing board disciplinary actions, and default on Health Education Assistance Loans. The OIG maintains the LEIE, which lists all excluded persons and entities.

The effect of OIG exclusion is that no Federal health care program payment may be made for any items or services furnished by the excluded individual or entity. In addition, any items and services furnished at the medical direction or prescription of an excluded physician or other authorized individual are not reimbursable from a third party insurer. This prohibition extends to payments for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Federal program beneficiaries.

Federal law permits the waiver of an exclusion where the exclusion would impose a hardship on program beneficiaries. Waivers are determined by the OIG on a case-by-case basis. Moreover, the reinstatement of excluded individuals and entities are not automatic. Generally, once an exclusion has ended, those wishing to again participate in Medicare, Medicaid and all other Federal health care programs must apply for reinstatement and receive authorized notice from the OIG that reinstatement has been granted.

In June 2008, the OIG issued a report indicating that IHS had two persons, one current employee and another former employee, that were employed at two Aberdeen Area facilities. At the time of issuing this report, it is uncertain whether these employees currently work for IHS. The following are the details concerning these two cases.

- Employee at Winnebago Hospital

An employee at the Winnebago Hospital was convicted of two felony counts of criminal conspiracy related to the delivery of Diazepam, a medication commonly used to treat anxiety and insomnia. In addition, the employee's license was revoked by the state licensing board from 1990 to 1993 for professional performance and competence issues.

On May 30, 1991 the OIG placed the employee on its LEIE. The employee applied for reinstatement in March 2008 and was removed from the list on April 23, 2008, at which time the employee was granted reinstatement. However, the OIG determined that the employee was hired by IHS in 2001, over seven years prior to reinstatement. Further, OIG's report notes that IHS had determined that the employee was suitable for employment at the time of hiring the employee in 2001.

- Employee at an Aberdeen Area Facility

The OIG determined in its June 2008 report that an employee was convicted in 2001 of one felony count of theft or embezzlement in connection with health care services. At the time of conviction, the employee worked for an Aberdeen Area facility and the IHS was listed as the victim in the case.

According to the same report, the OIG excluded the employee from participating in Federal health care programs until November 28, 2007. Despite the exclusion, IHS determined that the person was suitable for employment and was employed as an emergency hire twice in 2007.

The Chairman also identified another incident where a recently hired employee was not placed on OIG's exclusion list, but the employee's criminal record may have made them unsuitable for the job in which they were hired to perform. Specifically, a federal judge convicted the employee of embezzling money from a tribe and was sentenced to a year in federal prison. According to news reports, the individual had embezzled federal grant funding to support a gambling addiction. Despite the conviction, IHS determined that the employee was suitable for employment and hired them temporarily at an Aberdeen Area hospital. This employee ultimately worked in the business office in a temporary position that routinely exposed them to patient's private information.

The investigation revealed that the OIG may have never posted the convicted employee in its exclusion list given that their duties may not have been considered a necessary component of providing items and services to federal program beneficiaries, especially since the position was temporary. As such, it is unclear whether there is a federally operated list that IHS could have referred to in order to learn of this employee's conviction, absent disclosure from the employee or a criminal background check. It is also unclear what measures IHS took to evaluate the

employee's suitability for employment versus the risk posed to the illegal use of patient information.

Mismanagement of Third Party Billing. The Indian Health Care Improvement Act authorizes IHS to collect reimbursement for services provided at IHS facilities from third party insurers, such as Medicare, Medicaid, and private health insurers. Third party billing is an essential revenue generator for facilities and, in some cases, has enabled facilities to provide enhanced services to patients.

Based on data received from IHS most facilities suffer from backlogs in posting third party claims within the required time frame and have failed to collect on all claims billed. IHS' Aberdeen Area Administrative Review Report completed in April 2010 demonstrates the persistence of backlogs in coding and billing, which stalls the recoupment of third party payments. For instance, certain facilities failed to bill inpatient and outpatient claims within the required time frame of ten days and six days, respectively.

In a document submitted by IHS on September 22, 2010, the following service units had the lengthiest backlogged third party billing, where Medicare claims were not submitted until more than a month later: Belcourt Service Unit (65 days); Sisseton Service Unit (116 days); Rosebud Service Unit (38 days); and, Fort Yates Service Unit (32 days).

Other documents demonstrate a high number of uncollected bills after 120 days. According to an IHS report received on September 9, 2010, bills to third parties over 120 days past due should amount to no more than 20 percent of the outstanding claims due. That same report listed the following service units as having outstanding claims above IHS' acceptable levels: Belcourt Service Unit (39 percent), Rosebud Service Unit (30 percent) and Fort Yates Service Unit (42 percent). Finally, according to IHS' Aberdeen Area Administrative Review Report dated April 2010, the facilities are not transmitting bills over 180 days past due to the Program Support Center for collections, as required by IHS Debt Collection Policy. Below are examples of problems identified in third party billing.

- Fort Yates Service Unit

Internal monthly billing reports for fiscal years 2006 to 2010 indicate an extensive list of unpaid amounts, some as large as $317,000 in the month of May 2010. A 2010 e-mail indicates that the unit had collected over $3.8 million, exceeding their projected goal; however, the unit still has $278,286 yet to post. A January 2010 Corrective Action Plan from Health Information Management indicated that over 2,097 patient visits had not been billed nearly 30 days after the date of service. Further, according to the internal monthly billing reports, significant amounts in third party billing were unpaid: in FY2010 this amount totaled over $1.0 million.

- Winnebago Service Unit

According to a 2008 "Third Party Internal Controls Review," the Winnebago Service Unit did not submit third party claims in accordance with IHS requirements. Despite the requirement that outpatient claims must be submitted within six days from the date of service, claims lagged

for over 43 days for Medicare, 34 days for Medicaid and 53 days for private insurance. More troubling, inpatient claims were not submitted until 118 days for Medicare, 51 days for Medicaid and 77 days for private insurance, even though regulations require these claims be billed within ten days.

There were also backlogs in payments posted, despite a 72-hour requirement. According to the same 2008 report, Winnebago's posting staff did not post payments for Medicare until 15 days later, Medicaid 17 days later and six days later for private insurance. Unfortunately, the 2008 report was the only document submitted on Winnebago's third party internal controls. Therefore, the Chairman is unable to determine whether the above issues persisted in 2009 and 2010 or if these problems were present in years prior to 2008.

The Chairman received no documentation regarding billing backlogs from 2009. However, in a document submitted by IHS on September 22, 2010, the Winnebago facility had decreased its billing backlog to six days for Medicaid, seven days for Medicare, and five days for private insurers.

Based upon additional information by IHS the investigation identified $2.1 million in third party billing payment transfers from Winnebago Service Unit's hospital to other facilities in the Aberdeen Area over the past ten years. On September 11, 2006, the Winnebago Service Unit transferred $500,000 to Wagner Service Unit. Prior to transferring these funds, Wagner Service Unit had a combined deficit of $32,632 in mental health, Contract Health Service and facilities support programs. Eight days later, Winnebago Service Unit transferred $500,000 to Eagle Butte Service Unit, which had a deficit of $9,786 in Contract Health Service funds. In April 2007, Winnebago Service Unit transferred $100,000 to Eagle Butte Service Unit, which at the time had a combined deficit of $58,963 in its Contract Health Service program and equipment accounts. Finally, in April 2010, the Winnebago Service Unit transferred – for the third time – funds of $1 million to the Eagle Butte Service Unit.

To complete these transfers of funds, IHS uses an "H" form, which details the funds to be transferred and the facilities involved. The "H" forms are approved by the CEO of the facility, the Aberdeen Area Budget Officer, the Financial Management Officer, the Executive Office(r) and the Area Director. The tribes served by the IHS facilities, however, are not necessarily notified. The Chairman is aware of only one instance where the tribe was consulted and approved of the transfer of funds to another facility. Further, each transfer of funds did not consistently include the terms of repayment, such as accrued interest. Finally, it is unclear whether any of the above listed facilities have begun to repay Winnebago Service Unit's hospital for over $2.1 million in third party payment collections transfers.

- Belcourt Service Unit

The investigation found a history of improper and delayed billing and posting, which places the billing office in noncompliance with several requirements. An internal August 2006 report by the facility's Acting Compliance Officer indicates that Belcourt Service Unit's Quentin N. Burdick Hospital was compliant with two of 24 areas for billing, demonstrating gross

deficiencies in billing claims such as, almost 6,000 claims had not been billed within the six-day requirement for January through August 2006.

While some improvements were made in 2007, an internal IHS "Third Party Controls Review" found numerous areas of non-compliance in coding/data entry. For example, coding is required to be entered within four days of service. However, there was a backlog spanning two weeks or more and error reports were not being printed or reviewed. The reviewer found that errors included 247 records missing a primary provider and purpose of visit, 50 incomplete radiology visits, 115 incomplete lab visits, 146 incomplete pharmacy visits and 37 inpatient errors. The reviewer also found that the CEO was not reviewing third party billing.

A 2009 "Third Party Controls Review" indicates continued issues with billing and posting not being conducted within the proper timeline creating a situation where the business office is out of compliance. It is unclear whether a review was performed in 2010 since the 2009 report appears to switch between the years of 2009 and 2010.

According to IHS documents submitted to the Chairman in September 2010, hospital last reported backlog of its Medicare billing indicated a 65 day backlog as of June 23, 2010. The hospital had a 37-day backlog in its private insurance billing as of August 2, 2010. Further, the hospital's most updated record of Medicaid billing was on September 14, 2010, and it indicated a six-day backlog. According to IHS the hospital is currently utilizing a contractor to assist with its billing activity.

Staff Vacancies. A significant challenge to providing consistent and quality health care to AI/ANs is ensuring adequate staffing of IHS-run facilities. Improving the retention and recruitment of skilled personnel, particularly physicians, nurses and other health care professionals, would mean increased patient's access to health care services. The Indian Health Care Improvement Act (P.L.-94-437), requires one individual be assigned in each Area office for recruitment activities.

The Chairman requested that IHS submit information on staff vacancies for Clinical Director (CD) and Chief Executive Officer (CEO) at each facility in the Aberdeen Area over the last five years. The Committee found lengthy vacancies for all of these positions and several employees placed in "acting" positions.

The investigation revealed that as of September 2010 in the Aberdeen Area many of the most senior level positions, CD and CEO, had either been vacant for an extended period or were filled by individuals in an acting capacity. At the Belcourt, Fort Yates, Winnebago, and Sisseton Service Units three of four CEO positions and two of four CD positions were vacant as of September 2010. Further, since 2007 Belcourt Service Unit's Quentin N. Burdick Memorial Hospital has had at least six different CEOs in charge of the facility. At other facilities such as, the CEO position of Fort Yates Service Unit, has suffered from lengthy vacancy periods amounting to as much as a year and a half. According to documents, received by IHS, hiring individuals to fill permanent CEO or CD positions has taken as long as 34 months to fill. As of November 2010, IHS had made progress in filling vacant CD and CEO positions; however, preventative measures should be taken to ensure lengthy vacancies do not reoccur.

According to a report titled, "The Indian Health Service: Status and Recommendations for Physician, Nurse and Other Healthcare Professional Recruitment and Retention," the Agency's overall vacancy rates for January 2010 are 21 percent for physicians, 17 percent for dentists, 16 percent of nurses, and 11 percent for pharmacists.[73] The investigation identified that filling provider positions in the Aberdeen Area has continued to be a challenge, which directly impacts patient care. In addition, the IHS does not monitor or track the vacancy rates for mental health professionals, such as psychologists, psychiatrists or clinical social workers. The following are examples of provider vacancies and its impact on access to health care services.

- Belcourt Service Unit

In early 2008 there were nine vacant physician positions, three vacant pharmacist positions and six vacant dentist positions at Belcourt Service Unit's Quentin N. Burdick Memorial Hospital. In addition, during this same time IHS had lapsed contracts with providers (i.e., locum tenens). Further, in 2009 four health care provider positions were vacant.

The combination of vacancies in health care providers and the facility's inability to secure temporary providers, led to diversions in health care services. As noted in the previous section titled, "Substantial Diverted Health Care Services," from October 2008 to June 2010 a shortage of providers was the primary cited reason for placing the hospital on diversion status and resulted in 388 days of diverted health care services.

- Fort Yates Service Unit

Over the last five years, the Standing Rock Sioux Tribe has experienced multiple tragic spikes in suicides among the Native American youth residing on or near the Reservation. The shortage of mental health care providers has resulted in limited access to mental or behavioral health services for the youth on the Reservation. If fully staffed, the IHS Fort Yates Service Unit, which serves the tribal community, would have only two mental health provider positions, a Mental Health Director and Staff Psychologist.

In the first half of 2009 the Standing Rock Sioux Tribe's health officials reported that 50 Native American youth attempted suicide. This year tribal health officials reported that another 50 suicides were attempted and 10 suicides were completed. Often both mental health provider positions at the Fort Yates Service Unit were vacant during periods of increased suicides. In fact, at the onset of the most recent spike in suicide attempts, in August 2010, the Mental Health Director position had been vacant for over a year and the staff psychologist position for several months. Furthermore, the investigation identified that the Mental Health Director position which was vacated in August 2009, was not posted or advertised until May 2010, nine months after the position was originally vacated.

On August 24th the Chairman sent a letter to the Director of IHS, Dr. Roubideaux, regarding the spike in suicides and lack of mental health professionals on the Standing Rock Reservation.

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[73] Author Unknown, Report to the Director of Indian Health Service, "The Indian Health Service: Status and Recommendations for Physician, Nurse and Other Healthcare Professional Recruitment and Retention. Report to the I.H.S. Director," 2010 at 12.

On September 17th the Chairman received a response letter from Dr. Roubideaux stating that both mental health provider positions at Fort Yates Service Unit had been posted and the Mental Health Director position was filled on September 7, 2010. The investigation revealed that although the position was filled, it was later vacated. As of November 2010 the Mental Health Director position remains vacant, having not been permanently filled since August 2009.

Use of Locum Tenens. Contract providers (also termed locum tenens) are generally utilized by IHS to fill staff vacancies, to provide for specialty care or to enhance the current services available at a health care facility. The Chairman requested IHS to submit information concerning the use of locum tenens, particularly the number of contract providers serving in the Aberdeen Area and the cost of these contracts from 2000 to 2010. While IHS was not able to provide information on the exact number of providers, the Chairman did receive information relating to its cost from FY2008 to FY2010.

The investigation revealed that the use of locum tenens cost the Aberdeen Area over $17.2 million over the last three fiscal years. The cost of locum tenens has decreased this year, totaling $4.4 million, in comparison to FY2009, totaling over $9.3 million. However, when the Committee compared the FY2008 cost of locum tenens to this year, we found an increase of over $1 million.

The Chairman also found that while nearly every service unit experienced a decrease in the cost of locum tenens from FY2009 to FY2010, Sisseton Service Unit and Kyle Health Center locum tenen expenditures increased. Specifically, the cost of locum tenens at Sisseton Service Unit increased from $946,000 in FY2009 to $1.4 million in FY2010. Kyle Health Center's locum tenens in FY2009 was over $21,000; however, by FY2010 costs increased to nearly $300,000.

Agency Directives Inhibit Employee Communications with Congress. During the course of the investigation, numerous employees of the IHS expressed fears of reprimand, retribution, and concerns about communicating with congressional staff due to emails and actions taken by the Director of IHS and local supervisory employees.

The Chairman received copies of an IHS-wide e-mail dated April 26, 2010 from Dr. Yvette Roubideaux, Director of IHS, discouraging IHS employees from communicating with Congress, tribal governments, other agencies and groups without permission from either their direct supervisor or staff at the headquarters office located in Rockville, MD. The e-mail indicates that IHS employees should "always get approval before talking in your official capacity with Congress, the Department [of Health and Human Services (HHS)], or the media." It further notes that at "all times" employees are "speaking for IHS." Numerous IHS employees were concerned that this could be interpreted to mean that at "all times" employees are speaking in their official capacity and, therefore, at no time are they permitted to speak with Congress or other groups without prior approval.

Finally, the e-mail states that employees should "avoid making statements about the direction of the organization or recommendations on policy matters" unless they have "approval to do so and it is consistent" with what is being said up the chain-of-command." However, many IHS

employees felt that they were forbidden from making statements about their own observances or experience within IHS, which may be vastly different from those "up the chain-of-command."

Additionally, the Chairman obtained an e-mail dated July 30, 2009 stating that "all communications to and from HHS" must go through the Chief Financial Officer and that "all communications with Congress" must go through Michael Mahsetky, Legislative Director, at the IHS headquarters office. Further, employees are prohibited from having conversations about IHS matters without clearance from Mr. Mahsetky.

This policy was reinforced by a senior level employee in the Fort Yates Service Unit in an e-mail forwarded by a third party who was previously under disciplinary action in part for communicating with Congress and the tribe, among other issues.

The impact of these emails on employee morale and their willingness to communicate with Congress was seen in several instances. For example, during a site visit to Quentin Burdick Memorial Hospital, an employee informed Committee staff that they could not speak with the them because there was a "gag order." Further, after the Committee staff left the facility, certain employees were told by a supervising employee that they must provide all information that they shared with the Committee staff to the Agency. Finally, the Laborers International Union of North America has reported to the Committee staff that since the investigation was initiated one employee was told by their supervisor that they were not allowed to communicate with Congress.

Although the Chief of Staff to the Secretary of HHS directly informed the Chairman of the Committee that IHS and other departmental employees are allowed to communicate with Congress, many IHS employees felt differently based on the above emails and actions by local supervisors. Federal law safeguards the "right of employees, individually or collectively, to petition Congress or a Member of Congress, or to furnish information" to a Committee.[74] Congress has also expressly provided that no funds appropriated in any act of Congress may be spent to pay the salary of one who prohibits or prevents an employee of an executive agency from providing information to Congress, when such information concerns relevant official matters. Congress has also enacted provisions that provide that no funds may be spent to enforce any agency nondisclosure policy, or nondisclosure agreement with an officer or employee, without expressly providing an exemption for information provided to the Congress.

Although investigations into federal agencies are uncomfortable, and clearly supervisors worry that employees may communicate messages to Congress that are inconsistent with the current political agenda, communication is essential to the oversight responsibility of the Committee and should not be hampered in any manner.

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[74] 5 U.S.C. § 7211.

INITIATIVES TO ADDRESS INDIAN HEALTH SERVICE'S ABERDEEN AREA DEFICIENCIES

Indian Health Service's Initiatives in the Aberdeen Area. Under the guidance of the Director, Dr. Roubideaux, the IHS is working to review each IHS Area, including each Area Office. The Aberdeen Area was the second Area to be reviewed. In addition, IHS has taken additional actions to resolve other outstanding issues identified in the Chairman's investigation. The following paragraphs detail key actions taken by IHS to date.

Ensure that IHS does not hire or contract with excluded felons, and conducts background checks as a condition of hiring. The Chairman's investigation found that IHS had hired individuals placed on the LEIE.

IHS has stated that they are now conducting background checks for all pending new hires. Furthermore, anyone who hires someone on the OIG exclusion list will be held accountable with appropriate disciplinary action. Although IHS plans to perform a background check on all current employees, IHS has not provided the Chairman with a concrete plan on how to address current employees who have a criminal record that may make them unsuitable for particular job responsibilities.

Limit use of administrative leave. The Chairman's investigation found that administrative leave has been utilized excessively and for lengthy periods of time as a tool to address problem employees. Formerly, the decision to place employees on administrative leave was performed at the local facility.

IHS now plans to require written approval by the Director of the IHS Area Office for each administrative leave request. In addition, IHS' goal is to closely monitor the status and length of time that employees are placed on administrative leave due to a pending investigation. Further, IHS has often placed the same employees on long periods of administrative leave due to lengthy internal investigations. As a result of the Chairman's findings, IHS is in the process of reviewing the use of administrative leave and, if necessary, will take action to ensure it is used appropriately on a case-by-case basis.

Improve security in IHS pharmacies. The Chairman's investigation revealed that several facilities in the Aberdeen Area that had a recurring history of missing and stolen narcotics and inadequate pharmaceutical audits. Specifically, the Chairman's findings indicated that numerous facilities in the Aberdeen Area were not following the IHS policy of performing monthly audits.

As a result of these findings, IHS is performing a review of all relevant pharmacy policies, monitoring processes and systems. However, to date IHS has not articulated a plan on how it will enforce its current auditing requirements. In addition, in the Aberdeen Area the IHS plans to establish specific rooms to store controlled substances in each facility's pharmacy and install cameras and dual security systems to prevent theft. Yet, it is unclear when these security measures will be implemented. Further, IHS' corrective actions does not include initiatives to address staff shortages, despite IHS' 2010 report on Aberdeen Area pharmacies that determined that vacancies continue to be a challenge and contribute to greater management challenges.

Ensure health care providers have current licenses/credentialing. The Chairman's investigation identified that IHS failed to ensure all health care providers in the Aberdeen Area have an active health care provider license. The investigation identified multiple instances where nurses received reprimands for misconduct by state licensing boards where IHS was unaware of the majority of these actions. Through the investigation the Chairman also learned that IHS is required to reimburse Medicare, Medicaid and private insurers for services delivered by providers with an expired, suspended or revoked license. The Majority Staff only identified one instance in which IHS reimbursed the third party for services rendered by a provider with a lapsed medical license. Finally, the investigation revealed that according to reports issued by the OIG, IHS failed to routinely query or report information into the National Practitioner Data Bank (NPDB), despite the mandate that all agencies submit information on disciplinary actions against physicians, dentists, and other health care practitioners.

Dr. Roubideaux has directed all Area Directors and Chief Medical Officers to review how each Area monitors health care providers' licenses. Ultimately, IHS plans to develop a process to ensure that providers with expired licenses are not allowed to practice in IHS facilities until their status is corrected. IHS also plans to ensure that all providers are queried on the NPDB and OIG's exclusion list prior to their hiring. Thus far, Dr. Roubideaux has required the use of a checklist for managers to ensure all requirements are met in clearing applicants against the OIG Exclusion List, and that fingerprints are cleared and licenses have been validated before an applicant reports for duty.

However, IHS has not presented the Chairman with a comprehensive plan for corrective action or time frame for ensuring that employees are up-to-date on provider qualifications, training/education and licensing. Moreover, IHS has failed to demonstrate an action plan for reimbursement to Medicare, Medicaid and private insurers for services rendered by providers with revoked or expired licensure.

Although the IHS' policy is to check all current practitioners against the NPDB, such efforts may be futile since IHS has failed to ensure all IHS facilities are reporting to the database. Further, given that state licensing boards provided the Majority Staff with substantial information regarding license revocations, suspensions and reprimands that IHS was not aware of, the Chairman is concerned that performing NPDB checks alone is inadequate.

Improve business practices in the Contract Health Services Program. The Chairman's investigation identified several funding transfers (termed "non-recurring funds") from the Contract Health Services (CHS) program to 638 tribal programs. The Chairman is uncertain whether this practice violates the authority and regulations of the CHS program.

Despite this concern, IHS maintains the funding transfers are allowed under the regulations and does not plan to take corrective actions. IHS plans to discuss, with an ongoing tribal CHS workgroup, issues related to transferring CHS funds to tribal programs. However, its corrective action plans does not include performing an evaluation of whether CHS funding transfers are within the framework of the law.

Addressing Certification/Accreditation Problems at Five Facilities. The investigation found that six facilities in the Aberdeen Area have recurring accreditation/certification problems, which could jeopardize patient safety and quality of care.

IHS reports having begun meetings with CMS to address accreditation/certification problems. Nevertheless, IHS has not demonstrated to the Chairman a clear plan of how to address recurring accreditation/certification problems at its facilities. IHS' health care facilities are accredited by entities other than CMS. Therefore, IHS may consider holding similar meetings with other accrediting/certifying entities, such as the Joint Commission.

Department of Health and Human Service's Initiatives to Improve Performance in the Aberdeen Area. Under the leadership of Secretary Kathleen Sebelius, HHS has begun a "program integrity initiative," an agency-wide improvement plan. This initiative will include a risk assessment of HHS's agencies, including IHS, which it will then utilize to establish a plan to address issues and support successes within each HHS agency. The Council on Program Integrity is comprised of the heads of each agency in the Department and staff from the Office of the Assistant Secretary for Financial Resources.

The Council on Program Integrity will work with IHS to perform a risk assessment, as well as to examine all Government Accountability Office, OIG, tribal and Committee on Indian Affairs' concerns and reports. The Council on Program Integrity's goal is to work with IHS to identify the Agency's greatest risks and then establish a permanent integrity initiative at IHS to ensure that the Agency successfully fulfills its mission. HHS officially began the review of IHS on August 9th. Thus far, the Council on Program Integrity review is focusing on the Aberdeen Area, including human resources, finance policies and procedures.

APPENDIX

Exhibit A: Testimony of Dr. Roubideaux

Testimony of Dr. Yvette Roubideaux, Director of Indian Health Service, submitted in preparation for a Senate Committee on Indian Affairs hearing originally scheduled on December 8th, which was ultimately canceled.

Mr. Chairman and Members of the Committee:

Good Morning. I am Dr. Yvette Roubideaux, Director of the Indian Health Service (IHS). I am pleased to have the opportunity to testify on the Senate Committee on Indian Affairs' ongoing review of the Aberdeen Area's programs and operations. And, I am honored to have served the IHS during your tenure as Chairman of this Committee. Your leadership and concerns have had a direct impact on the manner in which IHS goes about conducting the business of delivering health care to Indian people; and, I am personally grateful for the direction you have provided toward improving health outcomes of American Indians.

As I noted in my testimony before this Committee in September, I am a member of the Rosebud Sioux Tribe of South Dakota. I have a long history with the Indian Health Service Aberdeen Area. I am aware of the longstanding challenges facing the Area, including insufficient accountability with respect to performance and financial management, and the difficulties of providing care in rural, remote, and impoverished communities with existing resources. We are determined to make

meaningful progress toward addressing these issues by utilizing existing resources.

In September, I testified that the Area's management problems are not solely attributable to limited resources, but it does play a role. We can manage our human and financial resources more capably, and that is what I am committed to doing.

In fact, my priorities for our agency during my time as Director are focused on changing and improving the entire IHS system in numerous ways. Our patients, our staff, and our Tribes are all in agreement that we need to reform the IHS. I know the members of this Committee are committed to the same goal, and your investigation has been helpful in identifying additional problems and providing valuable input as we continue to work to bring needed and lasting change to the agency. As you know all too well, a quick fix won't work here – and that's why we're focused on the fundamental changes necessary for long-term success.

In addition, I continue to work to advance my priority goals for IHS in the Aberdeen Area which has helped to address many of the specific concerns raised by this Committee. I will report on these goals and then discuss both

updates to the Aberdeen Area review since September and reviews for all 12 of the Areas.

Priorities for IHS reform

In September, I testified about the four agency priorities that will guide fundamental reform in IHS and the work of the agency in the coming years. Specific to my priority to reform the IHS and immediately following this Committee's September hearing, I implemented several actions to make improvements. I issued a clear and specific agency-wide directive to address the concern about individuals on the Office of Inspector General Exclusion List being hired in the Aberdeen Area. I made it clear to all IHS staff that hiring employees on the OIG General Exclusion List is unacceptable. All management and appropriate Human Resource staff were instructed to check each potential hire against the OIG Exclusion List before they are hired, as a part of the initial routine background clearance for all employees, and document that the Exclusion List was checked.

In addition, supervisors must also certify they have conducted reference checks, and ensure the OIG Exclusion list was checked in each case before making a selection or hiring. If any individuals are hired that appear on the OIG Exclusion List, the hiring supervisor will be held accountable. I

can testify today that no Aberdeen Area employee or contractor working in the Area, which totals 2,114 individuals, is on the OIG Exclusion List. Since the hearing, we checked all 15,700 IHS employees against the OIG Exclusion List and we currently have no employees on the list.

In addition, all new hires and contractors will now undergo fingerprint checks before they report for duty, and funds are committed to upgrade software for finger printing for all 13 IHS sites in the Aberdeen Area. All new Area contracts will include pre-clearance security requirements before contractors are hired to work in our facilities.

While these actions cover the agency's own hiring process, we also issued a new policy on October 29 to ensure these same background clearance requirements apply to our contractors. New contracts awarded after October 29, 2010,must have a contract term of "security pre-clearance" for any employees referred to IHS through the contract. The contractor will be responsible for appropriate security clearance of the contract employee they are providing to the Indian Health Service, before the employee arrives on-site. Some contracts currently have this requirement. However, if the pre-clearance requirement is not currently a term in a particular contract, then the individuals who are sent to IHS through these contracts

should be treated the same as employees who were hired or already on board prior to October 29. Those employees, if they will be assigned to IHS for an extended period of time, will be cleared after they begin working, as they would have been prior to the October 29 policy change. Existing contractors will be notified of this policy change.

The Committee has also previously expressed concern regarding drug diversion and pharmacy security. I am pleased to report we are strengthening pharmacy security in the Aberdeen Area. The Area Director, Ms. Red Thunder, is making funding available to purchase camera/security systems for all IHS locations. She will ensure that security measures are strengthened, including monthly monitoring of inventories of controlled substances; implementation of caged controlled substance work areas; and limited access to pharmacy work areas that include a swipe card and combination keypad lock by authorized personnel only. Seven IHS sites are renovating pharmacy areas to heighten security measures. The number of pharmacists will be increased to ensure sufficient monitoring of controlled substances. I have also directed all IHS Area Directors to review security in their pharmacies and implement security measures if not already in place. During the September hearing before this Committee, we discussed the problem of provider's practicing on expired or restricted licenses. On an Agency-wide basis, we are reforming our hiring process to address this

issue. In the Aberdeen Area, the Director is requiring additional steps in the hiring process to ensure healthcare providers have current licenses. She has instructed the Human Resources office to change the application process so that only qualified applicants who submit a copy of their current license will be cleared for referral on a selection certification, and all selecting officials are required to validate applicant licenses before selection is made. A checklist is now available for managers to ensure all requirements are met in clearing applicants against the OIG Exclusion List, and that fingerprints are cleared and licenses have been validated before an applicant reports for duty.

The issue of prolonged use of administrative leave was also previously raised by the Committee. The Aberdeen Area Director has issued a directive outlining the administrative leave policy and requiring strict adherence to the policy. All administrative leave over eight hours must be approved by the Area Director. All leave approving officials are required to examine employee timecards each pay period to ensure compliance. I have instructed all IHS Area Directors to review their use of administrative leave and take similar actions to correct any problems they find.

The Aberdeen Area Director has implemented other actions to increase oversight and accountability of Area management and staff. Ethics and Integrity training is required as part of orientation for all new staff and is also available to all staff. Since July, at least 133 employees have completed the training. The Area Director has required monthly conference calls with Chief Executive Officers to ensure the Agency priorities are communicated to staff and to provide a forum for discussing ways of improving processes/systems and accountability. She has responded to all requests from the HHS's Program Integrity Task Force and submitted all required documents on a timely basis.

In addition to the actions listed above, the Aberdeen Area has continued to implement the recommendations made from the Area Management Review completed in April 2010. Since September, the Area Director directed all Chief Executive Officers at 12 IHS sites to provide education on the Contract Health Services guidelines and regulations to the general public, Tribal leaders, patients, and vendors, and to provide annual training for all 21 IHS and Tribal Contract Health Services programs. The training includes a provider education manual outlining the paths for navigating the IHS and CHS programs.

The Area Director implemented a comprehensive agency orientation program for all new employees, which includes a weekly video conference for all new hires and current staff.

The Area Director closed out FY 2010 budget deficit-free and FY 2010 third-party collections surpassed FY 2009 collections by $34 million.

The Area Director requires all meetings with Tribal leadership and service unit governing body meeting agendas be structured to reflect the Agency priorities.

The Area Director has required annual reviews of service unit functions and requires corrective action plans be posted on a shared internal website for monitoring compliance with all service unit plans.

The Area Director requested and has signed a formal agreement with the IHS Headquarters Equal Employment Opportunity (EEO) program to provide oversight for the Aberdeen Area EEO functions, including the development of a training plan for all supervisors, managers, and counselors. The training will include Basic EEO, Alternative Dispute

Resolution, and NoFear Act. She has required all 12 IHS sites to identify counselors to attend the training. The Area Director has begun holding quarterly meetings between Service Unit executive leadership and Area Office staff to address budgets, human resources, and facility accreditation issues. CEO's are required to review productivity reports on various services in order to monitor productivity and service delivery and ensure appropriate action is taken when areas of deficiency are identified through performance indicators, such as the Government Performance Results Act measures. The Area Director has filled all but one of the Area Chief Executive Officer positions at 12 IHS sites, and interviews are being scheduled in consultation with tribes to fill the remaining CEO vacancy. All, but two of the Clinical Director positions at IHS sites are filled and the Area is actively recruiting to fill these positions. Of course, Area Director, Ms. Red Thunder and her leadership team have not always been perfect. Nevertheless, she has done a commendable job of making meaningful progress in addressing management issues, at times, under extremely challenging conditions – in an Area known for having particularly serious problems. That's one of the reasons why Ron His Horse is Thunder stated during the last hearing that tribes consider Ms. Red Thunder the best Aberdeen Area Director they have ever had.

IHS Reform for all 12 Areas

I originally began this work last year, by initiating a series of administrative reviews of all 12 IHS Areas to examine key administrative functions in order to identify best practices and areas for improvement. As a result of concerns expressed by the Committee that some of the issues identified in the Aberdeen Area may be occurring in other Areas, we-intensified our activities to review other Areas and develop a structure for more regular oversight of the management of all 12 IHS Areas. The reviews were designed to obtain an initial assessment of the administrative issues in all the IHS Areas, and included some, but not all, of the issues raised by the Committee's investigation. However, in response to the Committee's concerns, I have instructed senior leadership to do the following:

a. Incorporate all the concerns raised by the Committee's investigation into the Area reviews;

b. Accelerate the reviews so that all 12 Area reviews are completed within a two-year time period;

c. Implement recommendations of the Aberdeen Area Program Integrity Task Force; and,

d. Develop a timetable for reviewing all IHS-operated facilities with a focus on identifying and reviewing the highest risk facilities first.

In response to the Committee's announcement of its investigation into problems in the Aberdeen Area, the HHS Council on Program Integrity established the Aberdeen Area Program Integrity Task Force. The Task Force is reviewing IHS policies and standards, as well as the problems identified by the Committee to ensure that: (1) proper policies and procedures are in place in the Aberdeen Area; and (2) those policies and procedures result in corrective actions that prevent problems and improve service in the Aberdeen Area. We will use the Task Force's recommendations, which will be completed by early spring, to help formulate the reviews in all 12 Areas. While these reviews are conducted over a two year period with available resources, I plan to implement corrective actions at the time problems are identified and will not wait until the end of the two year period to correct problems. I am committed to working to correct any problems as soon as they are identified and I have already begun to address issues raised in the last hearing. We will have the ability to incorporate into reviews an oversight function to make sure actions I have directed Area Directors to take have been implemented. I am also incorporating specific measurable performance indicators that must be met by all agency senior leadership, including Area Directors and CEOs, that will demonstrate whether improvements have actually been made. I will hold senior leadership and Area Directors accountable for failure to implement these corrective actions.

I want to assure the Committee that the Administration supports my efforts to change and improve the way the IHS does business, and the way its employees provide health care.

The IHS is committed to cooperating fully with the Chairman's investigation. My staff and I have worked to be as responsive as possible to the Committee's requests for documents within the stated timeframes, and to answer follow-up questions and requests for clarification expeditiously. Providing complete and timely agency responses to all the Committee's information requests is and will continue to be a top priority of mine through the completion of the Committee's review of the Aberdeen Area operations.

Mr. Chairman, this concludes my statement. Thank you again for your long-standing commitment to improve Indian health, both in the Aberdeen Area and throughout IHS, and for the opportunity to testify today on the Aberdeen Area Indian Health Service programs.

I will be happy to answer any questions you may have.

Exhibit B: Testimony of Laborers' International Union of North America

Statement for the Record submitted in preparation for a Senate Committee on Indian Affairs hearing originally scheduled on December 8th, which was ultimately canceled.

On behalf of the Indian Health Service National Council of the Laborers' International Union of North America (LIUNA), the union thanks the Committee for holding this hearing on the widespread mismanagement nationwide at the Indian Health Service (I.H.S.).

LIUNA proudly represents approximately 500,000 workers in the United States and Canada. While primarily in the construction industry, the union also represents 65,000 workers in federal, healthcare, and public employment. LIUNA has represented federal employees at the Indian Health Service since 1977. We represent 9,600 employees at I.H.S. nationwide – over 90% of all bargaining-unit eligible workers at the Agency. The I.H.S. has one of the highest densities of union membership of any government agency. LIUNA represents all job classifications at I.H.S., from surgeons to housekeepers to public health educators. The vast majority of workers LIUNA represents at I.H.S. are Native American. The employees LIUNA represents are very dedicated to I.H.S.'s mission as part of their jobs and because of the important role the agency plays in providing health care to them and their families as enrolled tribal members.

Earlier this year, LIUNA submitted a statement to this Committee regarding mismanagement in the Aberdeen Area of I.H.S. Today, we appreciate the opportunity to comment on themes of mismanagement nationwide at the Agency, and to provide some recommendations for needed reform.

The Union shares Director Roubideaux's goals for I.H.S., which include: improving recruitment and retention; improving health care quality and access through increased accountability and customer service; ensuring transparency, fairness, accountability, and inclusivity. However, pervasive problems with communications, the Agency's systemic lack of understanding and respect for federal labor law, including their collective bargaining obligation, have hampered the Union's ability to work with I.H.S. to improve the Agency.

Pervasive Mismanagement at I.H.S. Harms Workers and Patients

As the exclusive representative of over 9,000 employees nationwide at I.H.S., the Union has extensive experience with management problems at the Agency. These problems primarily fall into two categories – financial and supervisory mismanagement.

Financial Mismanagement

I.H.S. continues to be under-funded. However, an increase in the Agency's budget alone will not solve the financial mismanagement at I.H.S. Instead, Congress, HHS, and I.H.S. must all work to ensure proper financial accountability.

First, many I.H.S. Service Unit Directors and Area Directors do not properly budget for their facility's needs. In 2009 alone, shortfalls in facility operating budgets led to threats of reduction in services (or actual diversions of services) in Belcourt, North Dakota; Kayenta, Arizona; Rosebud, South Dakota; and Phoenix, Arizona. These diversions or threats of reductions in services harm workplace morale and also can compromise patient health and safety. Another key budgeting issue is decentralization across I.H.S. regions. While Areas and facilities must have some leeway in determining their specific needs, the current decentralized system results in little accountability or oversight at Agency headquarters. In addition to diversions or reductions in services, this lack of accountability and oversight leads to the following: harms in the Agency's ability to fill vacant positions in a timely manner, resulting in understaffing; widely divergent performance awards for employees getting the same rating in different Areas; and different levels of the use of contract health services, wasting federal funds.

Second, I.H.S. excessively uses contract health care workers. Nurses at I.H.S. are typically paid between $25-$35/hour. However, contract nurses filling vacant positions cost the Agency $60-$70/hour. Taking into account the vacancy rate for nurses, the cost to I.H.S. to hire these contract workers is estimated to be tens of millions of dollars. Physician positions are also often contracted out, at an even higher pay rate. Contract employees cannot be in the Union's bargaining unit, so those workers lack key workplace rights. Reports from facilities show that contract nurses are less well-trained and less familiar with and sensitive to the unique needs of I.H.S. and its Native population than the federal employees who work there.

Third, several GAO reports have detailed mismanagement of property at I.H.S. Despite the GAO's findings, several senior I.H.S. officials responsible for this mismanagement still work at I.H.S. The failure to take action against the responsible managers is demoralizing to the employees.

Supervisory Mismanagement

Employees at I.H.S. are consistently ranked in the top 10% of the federal workforce in the annual "Best Places to Work" Survey. However, I.H.S. managers are consistently ranked in the worst 10%. Managers at I.H.S. are either poorly trained, unqualified, or both. There is no mandatory training in human relations or labor relations for supervisors. Managers typically either do not understand, or fail to respect, federal labor law. The primary types of these legal violations are: changes in working conditions without union notification; denials of proper leave requests by employees; abuse and harassment of employees; overtime/Fair Labor Standards Act violations; and health and safety violations.

Some of the most egregious examples of how supervisory mismanagement harms I.H.S. employees and patients include:

- Employees being forced to work in facilities without running water (Wamblee, SD), electricity (Eagle Butte, SD), or a functioning sewer system (Wamblee, SD).
- Chronic understaffing - especially of nurses.
- Managers ignore reports from employees of patient safety concerns, including possible EMTALA violations.

- Chronic over-use of term and temporary employees, which violates merit system principles.
- Managers violating nepotism rules and improperly hiring family members.
- CEOs/Area Directors detailing poor-performing supervisors to other I.H.S. facilities instead of disciplining/removing them.
- Managers putting employees on long-term administrative leave during disciplinary investigations, violating the employee's due process rights.
- Managers threatening employees for cooperating with CMS investigators.
- Denying workers properly requested leave, including:
    - Leave to be with a child on military leave from Afghanistan (Phoenix, AZ)
    - Leave when a worker was trapped at home during a severe ice and snow storm (Gallup, NM)
    - Leave when a worker collapsed due to a diabetic condition when her electricity went out during a blizzard (Eagle Butte, SD)
    - Leave when the worker provides a note from his/her physician (multiple facilities)
    - Leave to care for a sick child (the supervisor told the employee she should have a family member care for her child instead of her, a violation of FMLA) (Shiprock, NM)
    - Leave for a veteran suffering from PTSD (Ft. Defiance, AZ)
    - Leave for the death of a parent (Northern Navajo Medical Center; also widespread)

This year alone, the Union has filed hundreds of unfair labor practices and grievances over managers' failure to adhere to federal labor law and the union's collective bargaining agreements – however, these filings fail to deter management misconduct. Dr. Roubideaux must set a tone at the top that this type of violation will not be tolerated.

I.H.S. Must Partner with the Union and Employees to Reform and Revitalize the Agency

In order to carry out necessary reforms at the Agency, Dr. Roubideaux and other senior leaders at I.H.S. must partner with the Union and its workforce.

Improved Communications

The Union supports Dr. Roubideaux's goals to reform and revitalize I.H.S. However, in order to partner on these efforts, I.H.S. needs to improve its communication practices with the Union and the workers we represent.

In the past year, Dr. Roubideaux has sent out a number of memos regarding working conditions to the I.H.S. workforce. However, the Union was never provided copies of these memos, in violation of federal labor law. The topics of these memos are on important topics ranging from ethics to hiring practices to reviewing and changing performance management practices to customer service. The Union has requested that it receive these notices when the employees receive them.

Under President Obama's Executive Order 13522, I.H.S. has an obligation to give the Union "pre-decisional involvement in all workplace matters to the greatest extent practicable..." This can and should include the issues included in Dr. Roubideaux's memos. The Union and its employees have invaluable insight from the point of view of the front-line worker, as well as Agency-wide problems and

possible solutions. Management cannot continue to operate in a bubble; it must listen to the voice of the worker in order to bring about real reform at the Agency.

Implementation of the New National Collective Bargaining Agreement
On October 15, 2010, after more than five years of negotiations, the new LIUNA-I.H.S. national collective bargaining agreement (NCBA) covering over 9,600 of the Agency's employees went into effect. The NCBA puts all workers represented by LIUNA under one contract; previously, both management and labor had to deal with over 30 contracts. This new NCBA will bring about a more efficient process for both parties. The NCBA includes a host of issues that will help the workforce and management work more effectively together, including: union presence on health and safety committees; workplace flexibility, including flexiplace and compressed and alternative work schedules; and union participation in new employee orientation. These joint ventures will help to increase productivity, promote efficiency, and improve morale at the Agency.

Implementation of the Labor-Management Relations Council
President Obama issued Executive Order 13522 on December 9, 2009. This Order implements labor-management partnerships at federal agencies, and also requires pre-decisional involvement of unions in all workplace matters to the fullest extent without regard to whether those issues are subjects of bargaining. In short, the Order's goal is to ensure greater involvement by unions in the federal agency decision-making process for issues affecting federal employees. In addition, the new LIUNA-I.H.S. NCBA also includes a provision to establish such a partnership (known as the Labor Management Relations Council, LMRC). The IHS LMRC must be implemented by January 15, 2011. LIUNA looks forward to partnering with I.H.S. on a host of issues, including two in particular:

- Implementation of the Indian Health Care Improvement Act provisions in the Affordable Care Act - The IHCIA and other ACA provisions will affect I.H.S. employees. These provisions include: maintaining consistent funding for the IHS core health care facilities; providing for the release of significant capital improvement funds to build and maintain health care facilities; increasing recruitment and scholarship programs for Indian health professionals; and a host of other programs affecting Native patients at the Agency, such as diabetes, home health, and mental and substance abuse programs.

- Expanded Supervisor Training in Labor and Human Relations - Most I.H.S. supervisors receive little or no training in labor and human relations. The more supervisor training in these areas, the more supervisors will know the law and the NCBA. Training should lead therefore to fewer grievances, unfair labor practices, and discrimination cases. Fewer filings save the Agency a great deal of time and funds, and will improve employee morale.

Conclusion and Recommendations

LIUNA appreciates the work that this Committee has done to investigate and try to reform serious management problems throughout I.H.S. The Union and the workers it represents should be seen as a

resource willing to work with Congress and I.H.S. to remedy these problems. Ultimately, the patients that we serve will benefit. To this end, we recommend the following:

1. **Involve the union and the workforce in plans to reform I.H.S.** This would not only allow for the agency to hear from the rank and file workers on the ground, but also would increase I.H.S. employees' confidence in Dr. Roubideaux's leadership and ability to improve morale. Set a tone from the top that the union is a partner in reform at the agency. This should be done by implementing provisions in President's Obama's Executive Order (13522) and the LIUNA-I.H.S. NCBA to form a Labor-Management Relations Committee.
2. **Determine best practices for management at I.H.S.** and work with the union and agency employees to implement those practices throughout the Aberdeen Area and nationwide. These should include:
   - Reporting of patient complaints
   - Preventing health and safety violations
   - Establishing a Labor-Management review body to examine and implement best practices that improve patient care, customer service and public relations.
3. **Hold poor managers accountable**. Discontinue the practice of detailing poor performing managers from one facility to another. Discontinue the practice of placing poor performing managers on overly long administrative leave.
4. **Include budgeting, financial planning, and accounting as part of the reform process to avoid diversion of services**. These should include:
   - Prevention of diversions and reductions in services
   - Re-centralization of key budget functions at Agency headquarters
5. **Determine baseline metrics for labor-management reform**. Conduct an inventory of the numbers and types of grievances, unfair labor practices, EEO complaints, and MSPB disciplinary cases and work with the union to determine the cause of these problems and how to eliminate them.
6. **Review why I.H.S. employees are consistently ranked in the top 10% of federal employees while I.H.S. management is ranked in the bottom 10% of agencies**.
7. **Commit to recruitment and retention of federal workers at the agency** (rather than reliance on contract workers) to save costs, improve morale, and ensure consistency of care. Ensure that all managers receive training on labor-management issues, including performance management systems and the collective bargaining agreement with the union.

The implementation of this collaborative process brings the front-line caregivers into the reform process with the inevitable result of achieving the joint labor-management mission of improving patient care.

EXHIBIT C: BELCOURT DIVERSIONS

History and Cost of Diversions in Health Care Services (2006-2010)				
Dates:	**Type of Diversion:**	**Length of Diversion:**	**Number of Patients could have been served at IHS (if no diversion)**	**Cost to CHS**
10/11/2008 to 11/5/2008	Due to the shortage of providers, **no adult patient admissions** with diversion to Trinity Hospital, Minot, ND, with approved CHS referrals. Pediatric patient admissions were still available. OB-GYN patient admissions were available.	**26 days**	**47 (62 total patients transferred)**	$235,000
12/4/2008 to 9/1/2009	Due to the shortage of providers, **no adult patient admissions** with diversion to Trinity Hospital, Minot, ND, with approved CHS referrals. Pediatric patient admissions were still available. OB-GYN patient admissions were available.	**271 days**	**375 (501 total patients transferred)**	$1,900,000
9/1/2009 to 11/1/2009	Due to shortage of 4 Hospitalists providers to cover all shifts, **full adult in-patient services were not available**, with partial diversion to Trinity Hospital, Minot ND with approved CHS referrals. Pediatric patient admissions were still available. OB-GYN patient admissions were available. Diversion was reduced, and then was eliminated with hiring of the 4 providers.	**62 days**	**75 (99 total patients transferred)**	$375,000
12/21/2008 to 1/2/2009	Due to the shortage of providers, **no Pediatric patient admissions** with diversion to Trinity Hospital, Minot, ND, with approved CHS referrals. Adult patient admissions were still available. OB-GYN patient admissions were available.	**14 days**	0 **(1 patient transferred but could not have been served at IHS)**	0
3/29/2009 to 4/5/2009	Due to the shortage of providers, **no Pediatric patient admissions** with diversion to Trinity Hospital, Minot, ND, with approved CHS referrals. Adult patient admissions were still available. OB-GYN patient admissions were available.	**8 days**	**2 (3 total patients transferred)**	$10,000
5/30/2010 to 6/6/2010	Due to loss of provider (placed on Administrative Leave), the **extended hours Convenience Clinic was not in operation.** Contracted providers are now in place acquired to fill in for this service.	**7 days**	0	0
			Total number of transferred patients: 666	**Total Cost to CHS: $2,520,000**
			Total number of transferred as a result of the lack of providers: 499	

Note: CHS Patients and Cost Estimates are based on IHS documentation ($5,000 per patient).

EXHIBIT D:

EMPLOYEES PLACED ON LENGTHY ADMINISTRATIVE LEAVE HOURS

- Senior Employee in Aberdeen Area Office
  - 2007: 1 week
  - 2008: 2 ½ months
  - Reason for Leave: Pending Investigation for Allegations of Misconduct

- Employee in Lower Brule
  - 2008: Over 2 Months
  - 2009: Nearly 5 months
  - Reason for Leave: Pending Investigation for Inability to Perform Job Duties

- Employee in Pine Ridge Service Unit
  - 2007: Nearly 4 months
  - Reason for Leave: Pending Investigation for Failure to Report to Duty

- Senior Employee in Sisseton Service Unit
  - 2009: Over 8 Months
  - Reason for Leave: Pending Investigation for Allegations of Sexual Harassment and Hostile Work Environment

- Senior Employee in Winnebago Service Unit
  - 2009: Over 2 Months
  - Reason for Leave: Pending Investigation for Allegations of Misuse of Authority and Mismanagement

- Employee at Belcourt Service Unit
  - 2006: Over 3 ½ months
  - 2007: Nearly 9 months
  - Reason for Leave: Pending Investigation or Settlement Agreement involving Destroyed Medical Records

- Employee at Belcourt Service Unit
  - 2006: Nearly 2 weeks
  - 2009: Over 5 ½ months
  - Reason for Leave: Pending Investigation for Allegations of Misconduct

- Employee at Belcourt Service Unit
  - 2010: Nearly 1 Month
  - Reason for Leave: Pending Disciplinary Action for Conduct Unbecoming, Inappropriate Statements and Failing to Follow Instructions

- Employee at Belcourt Service Unit
  - 2010: Nearly 2 Months
  - Reason for Leave: Pending Investigation and BIA Criminal Investigation for Inappropriate Touching of Patient

- Employee at Fort Yates
  - 2006: Nearly 2 Months
  - Reason for Leave: Pending Disciplinary Action for Domestic Abuse and Disorderly Conduct

- Employee at Fort Thompson
  - 2010: Over 1 Month
  - Reason for Leave: Pending Disciplinary Action for Failure to Follow Supervisor Instructions

- Employee at Pine Ridge
  - 2006: Nearly 3 Weeks
  - 2007: Over 1 ½ Months
  - Reason for Leave: Pending Investigation for Diversion of Drugs

EXHIBIT E:
PROVIDERS WITH STATE LICENSE SUSPENSION, REVOCATION, TERMINATION, REPRIMAND AND OTHER ACTIONS

The following is a sample of the information the Chairman received from a state board of nursing concerning IHS providers that worked or are currently working in the Aberdeen Area.

Nurse 1

Employed at two Aberdeen Area facilities during the course of actions taken by the licensing board.

Board Actions and Timeline:

- September 2009: Letter of Reprimand and Remediation for allegations of patient neglect while working at an Aberdeen Area hospital; licensee had to undergo courses/training.
- October 2009: Nursing Board received a complaint from a senior level employee at an Aberdeen Area hospital about patient neglect by the licensee; Board stated that the licensee had also given false testimony during an informal meeting with the Board
- January 2010: Board investigators conducted an informal meeting with the licensee at the Board's office to discuss the hospital's complaint. At the meeting, the nurse indicated reassignment by the IHS to outpatient care because of concerns that were raised concerning Nurse 1's patient care." According to documents submitted by the Board, the OIG was advised of Nurse 1's practice issues and the licensee was ultimately removed from federal service effective Dec. 10, 2009.
- March 2010: Nurse 1's license was suspended.
- April 2010: Nurse 1 voluntarily surrendered nursing license.

Current Employment Status: No longer employed in federal service.

Nurse 2

Employed at an Aberdeen Area facility at the time of the board's actions.

Board Actions and Timeline:

- July 2007: Licensee contacted the Board of Nursing and admitted to diverting Vicodin for personal use for a period of seven months; licensee was referred to the chemical dependency program; licensee also provided an affidavit/statement to OIG admitting this diversion.
- September 2007: Arrest warrant was issued for licensee, who was to be charged with felony health care fraud and possession of a controlled substance.
- October 2007: Board suspended Nurse 2's license indefinitely and licensee voluntarily surrendered license.
- January 2008: Board reinstated Nurse 2's license after licensee requested reinstatement for successful completion of dependency program.

Currently employed by IHS.

Nurse 3

Employed at an Aberdeen Area facility at time of board's action.

Board Actions and Timeline:

- August 2009: License placed on one-year probation for patient care issues (non-adherence to standards of practice, issues of documentation, inappropriate assessments and treatments, and lack of patient education); licensee ordered to undergo courses/training.

Currently employed by IHS.

Nurse 4

Employed at an Aberdeen Area facility at time of board's actions.

Board Actions and Timeline:

- July 2003: Licensee was referred to the chemical dependency program by IHS and signed a contract to participate after admitting suffering a relapse in dependency.
- November 2003: Licensee was discharged from the program for failure to comply.
- January 2004: Board suspended Nurse 4's license after hearing; licensee failed to appear.

Nurse 5

Board Actions and Timeline:

- February 2000: Licensee voluntarily surrendered his license.
- November 2003: Board reinstated Nurse 5's license with the condition that the nurse participates in the chemical dependency program; licensee had admitted to diverting narcotics from his employer for his own use.
- May 2005: Licensee was discharged from chemical dependency program.
- June 2005: Board summarily suspended Nurse 5's license after contacting the nurse about a complaint and requested that the nurse meet with the Board at an informal meeting; licensee expressed indecision about continuing with the chemical dependency program as well as the return to nursing and did not appear at the meeting.
- September 2005: Board suspended the nurse's license indefinitely.

Currently employed by IHS.

Nurse 6

Board Actions and Timeline:

- July 2004: Board issued Letter of Reprimand for unprofessional conduct, based on allegations received from coworkers.

Currently employed by IHS.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BYRON L. DORGAN TO GERALD ROY

Question 1. Office of Inspector General (OIG) investigations of the Indian Health Service (IHS) have resulted in numerous criminal convictions relating to employee misconduct. For instance, the OIG investigated the former CEO of Fort Totten Health Center in 2008 and the former Service Unit Director of Quentin Burdick Memorial Hospital.

Did the OIG determine that the IHS responded appropriately and addressed the findings of these investigations?

Answer. Although the OIG cannot address the appropriateness of IHS's response to the OIG's employee misconduct investigations regarding the former Service Unit Director of Quentin N. Burdick Memorial Hospital in 2001 and the former CEO of Fort Totten Health Center in 2008, we can speak to how IHS addressed the findings of these investigations.

- IHS transferred the former Service Unit Director of Quentin N. Burdick Memorial Hospital out of his position at the facility.

- IHS issued the former CEO of Fort Totten Health Center a 14-day suspension and she was subsequently transferred out of the facility.
- The OIG is not aware of additional sanctions or employee discipline implemented by IHS to the former Service Unit Director of Quentin N. Burdick Memorial Hospital and the former CEO of Fort Totten Health Center regarding these investigations.

The results of the OIG investigations involving the former CEO of Fort Totten Health Center and the former Service Unit Director of Quentin N. Burdick Memorial Hospital were turned over to the United States Attorney's Office in the District of North Dakota for review. Both investigations involving these individuals were declined for criminal prosecution.

Question 1a. Do you have recommendations for how the IHS could better address these employee conduct and accountability issues?

Answer. OIG has not examined IHS's personnel policies and procedures to an extent that would permit it to provide general recommendations. OIG last examined this issue in 2000, when the Office of Evaluation and Inspections issued a report on IHS's Equal Employment Opportunity (EEO) Complaint Process. The report is available at *http://oig.hhs.gov/oei/reports/oei-05-99-00290.pdf.* The study found that many IHS employees were confused about Indian preference laws, commissioned corps EEO rules, and employee EEO rights under tribal contracting. OIG found that inconsistencies in IHS's EEO system resulted in unequal treatment of complaints and the EEO program lacked direction, which potentially weakened its effectiveness. Additionally, OIG found that employee distrust of EEO was widespread throughout IHS and undermined effectiveness of the EEO process.

From 2005 through 2010, OIG's Office of Investigations conducted fraud awareness presentations to IHS officials, including 13 in the Aberdeen area, for the purpose of describing and discussing internal investigative procedures. These presentations consisted of an OIG overview, and discussion of specific OI functions, including drug diversion, employee misconduct issues, reporting requirements, and reporting processes. OIG is happy to brief the Committee if you are interested in additional information about these presentations.

Question 2. The Committee is aware of the fact that the OIG has investigated several instances of employees stealing narcotics at Belcourt Service Unit and Rapid City IHS Hospital. In addition, there has been a troubling history of diverted narcotics and controlled substances at Quentin N. Burdick Memorial Hospital since 2003. The Inspector General conducted an investigation of the facility's pharmacy in 2003 and issued a Management Implication Report.

Please provide a brief description of your findings at the Belcourt and Rapid City service units. Do you have recommendations for how the IHS could prevent the theft of narcotics in the future?

Answer. During the course of our investigations, we discovered that the IHS pharmacies at both the Belcourt Service Unit and Rapid City IHS Hospital lacked effective security controls to prevent and detect drug diversion by employees, contractors, and others. The lack of security controls and poor internal oversight of the pharmacies and their staff allowed drug diversion to go undetected for long periods of time. The OIG recommended the following measures be implemented at these facilities in order to minimize drug diversion:

- A perpetual inventory of all Class II-V (CII) medications stocked in each pharmacy should be completed and maintained. The logging in and out of inventory should also be completed and documented with two pharmacy staff members.
- Security cameras should be installed in each pharmacy to record the CII storage area(s) and any other locations that store controlled substances. The areas of video observation should include automated medication dispensing robots, the pharmacy filling area, and the primary areas of dispensing medications to the patients. All entrance and exits to the pharmacies should also be monitored by security cameras.
- Access into each pharmacy should be restricted to pharmacy staff and IHS employees with a need to enter the pharmacy area.

Question 2a. Can you describe what the Inspector General found in its investigation of Quentin N. Burdick Memorial Hospital?

Answer. During the course of our investigation at the Quentin N. Burdick Memorial Hospital, we discovered that the facility's pharmacy lacked effective security controls to prevent and detect drug diversion by employees, contractors, and others. The lack of security controls and poor internal oversight of the pharmacy allowed drug diversion to go undetected for long periods of time. The facility's pharmacy

lacked effective video surveillance, proper inventory controls, two-party witnessing of controlled substance stocking, and comprehensive security controls to prevent and detect drug diversion.

Question 2b. Has this facility been referred to Inspector General any additional times since 2003?

Answer. Yes, the Office of Investigations received complaints regarding the Quentin N. Burdick Memorial Hospital in 2004, 2007, and 2010. Each complaint and subsequent investigation related to lost or stolen medications at the facility's pharmacy. The 2010 criminal investigation remains open and we would be happy to brief the Committee on our findings once this matter is resolved and our investigation at this facility is closed.

Question 3. The Committee also identified a history of missing or stolen narcotics at Sisseton Hospital. On March 17, 2009, the Inspector General received two reports of missing or stolen narcotics from the hospital and the Inspector General conducted a site visit in response.

Please provide the Committee with the findings of this investigation?

Question 3a. Do you have any indication that your findings from 2009 have been addressed?

Answer. The OIG was notified of missing or stolen narcotics from the Sisseton Hospital in March 2009. Agents with OIG's Office of Investigations immediately initiated a criminal investigation at the Sisseton Hospital Pharmacy and that investigation remains open. We would be happy to brief the Committee on our findings once this matter is resolved and our investigation at this facility is closed.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN BARRASSO TO GERALD ROY

Question 1. Your written testimony notes several investigations that have occurred over the course of 10 years, including a 2008 investigation regarding drug diversion. One of your investigation found that the IHS pharmacy in Rapid City lacked *basic* security controls, such as security cameras, to prevent drug diversion.

Has the Inspector General conducted any follow up reviews to determine whether IHS has adopted drug diversion prevention measures?

Answer. The Office of Investigations completed a follow up review in 2010 of the Rapid City Sioux San Indian Hospital Pharmacy regarding security measures that were added, modified, or are in the planning stages since the 2008 investigation. The following security enhancements are now in place or have been scheduled for installation at this facility:

- Pharmacy door access has been changed to have security enhanced keys and a cipher lock with the combination of the lock changed every 90 days.
- Pharmacists are the only staff members that have physical keys for the pharmacy.
- Pharmaceutical orders and product intake are now separate duties and forms are completed to ensure that the ordering staff does not check-in the order when received.
- Bars have been installed on the exterior windows of the pharmacy to prevent unlawful entry.
- Pyxis machine for the CII inventory was updated with user passwords now being changed every 90 days.
- More staff was added to handle incoming orders and patients to prevent medications from being stored unsecured or forgotten.
- Security cameras are budgeted through the Aberdeen Area Office for installation in FY 2011.

Question 1a. What support do you need to achieve the goals for improving the Aberdeen Area?

Answer. The OIG utilizes and prioritizes its investigative resources in the Aberdeen area based on the nature of the referrals that are received. Our investigators pursue those criminal cases that warrant investigation after a review of the particular issue or complaint. We will continue to closely analyze any complaints that we receive and accept or reject such complaints based on standardized criteria.

'without a proactive effort to identify the root causes of the problem o-
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Question 1. In November 2008, after lengthy periods of diversions in health care services, the Aberdeen Area Office conducted a review of Quentin N. Memorial Hospital. The reviewer concluded that two individuals—including the Director of Nursing and Clinical Director–had made the decision to divert services "without a proactive effort to identify the root causes of the problem or find alternative means to ensure admission of patients."

The reviewer also noted that the Clinical Director stated that the facility had frequently diverted inpatient admissions in the past and it was "no big deal then so, why is everyone getting excited about it now?"

*Question 1a.*Considering that Quentin N. Burdick Memorial Hospital diverted services for over 388 days, what is your reaction to the quote above?

Question 1b. Did this Clinical Director face any disciplinary action for allowing these lengthy diversions without a long-term plan to address the understaffing?

Question 1c. Please describe how the decision to go on a diversion is made at an IHS facility.

Question 1d. Does the Aberdeen Area Office notify the respective Indian tribe prior to initiating a diversion?

Question 1e. What do you see as the long-term solution to prevent diversions in health care services at facilities in the Aberdeen Area?

Question 2. The Committee found that the Director of Nursing at Quentin N. Burdick Memorial Hospital has been the subject of three Equal Employment Opportunity (EEO) complaints—two of which were fully adjudicated. One found substantial evidence of discrimination costing the Agency over $148,000. A second was resolved just this year and found the Director of Nursing had failed to take action to prevent subordinates from harassing another employee.

Can you explain how the IHS addressed this issue and whether any disciplinary action has been taken against the Director of Nursing?

Question 3. As Chairman of the Committee, I wrote to the Agency with serious concerns about the vacancies in the mental health department on the Standing Rock Sioux Reservation. During a spike in youth suicides (100 suicide attempts and 16 completions in 2009 and 2010), the Mental Health Director position at the Standing Rock IHS facility was not posted for 10 months after it became vacant and continues to be unfilled today.

What obstacles is the agency facing in filling the vacancies in the IHS Aberdeen Area?

Question 3a. Why does it take so long to post a vacancy? Do you have recommendations for how to shorten the timeframe?

Question 3b. What happens to funding for these positions when they are left vacant? Were the funds for the Mental Health Director position spent on some other program or at a different facility?

Question 4. The Committee found that the use of locum tenens cost the Aberdeen Area over $17.2 million over the last 3 fiscal years.

What actions have you taken to address staffing issues in the Aberdeen Area, including excessive use of contract nurses and doctors, and "Acting" managers?

Question 5. The Aberdeen Area has had an increasing number of EEO complaints over the past 10 years. We have heard that IHS policy states that there should be two EEO Counselors per facility, but there are currently only 13 for the entire Aberdeen Area. We are aware that the Aberdeen Area is in the process of training and hiring more EEO counselors.

What are the biggest barriers to ensuring that there are two EEO Counselors at each IHS facility?

Question 6. In one EEO case, an administrative judge described an IHS facility as a workplace where employees threaten the use of EEO complaints against one another. In addition the judge stated that supervisors often either side with one employee or simply ignore divisive situations altogether.

How big of a problem are retaliatory complaints and what is done to deter or punish employees who wrongly accuse others?

Question 6a. Do you think the prospect of retaliatory complaints deters people from becoming EEO counselors for their facilities?

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* Response to written questions was not available at the time this hearing went to press.

Question 7. The Aberdeen Area Administrative Review, completed in April 2010, states that five service units were identified as being in jeopardy of losing their CMS accreditation.

What are the five service units at risk?

Question 7a. When a facility is in danger of losing its accreditation, how quickly are you notified?

Question 7b. What is your role, as Director of the Area, in ensuring that the facility takes the necessary actions to avoid losing its accreditation?

Question 7c. What steps have you taken to address the deficiencies at these service units?

Question 8. Both the Fort Yates and Quentin Burdick Hospitals have had a history of accreditation issues.

What steps are you taking to ensure that these hospitals submit an acceptable Corrective Action Plan and retain their CMS accreditation?

Question 9. The Committee found that Rosebud Hospital has had three EMTALA violations between 2005 and 2010. One particularly troubling violation involved a pregnant woman who presented to the hospital in October 2008 nearing delivery and was then discharged shortly thereafter. According to the IHS report:

> A "[p]atient presented with contractions every 5 minutes and bloody show. [The] patient was discharged from [the] ER at 7:15 still with contractions and [was] not stable. [The patient] delivered in the . . . bathroom at approximately 7:50."

In an Administrative Review of the hospital in July 2009, CMS addressed an allegation of negligent care by nursing staff and ultimately placed the facility on "Immediate Jeopardy" status. The hospital submitted a Corrective Action Plan, which was returned in November 2009 as "unacceptable."

Please explain the current status of the facility. Is it CMS-accredited?

Question 9a. What has been done to address these serious concerns involving patient care?

Question 10. In October 2007, just after the beginning of the 2008 fiscal year, Fort Yates transferred $100,000 of CHS funds to an ambulance program. Later in that same fiscal year, Fort Yates then borrowed CHS funds from Sisseton to pay CHS bills.

Why did this transfer occur so early in the fiscal year?

Question 10a. What kind of oversight does the Area Office have for these types of transfers?

Question 11. There is a troubling history of repeated narcotics losses and/or diversions at Rapid City Sioux San Hospital. A statement submitted for the record by the Laborers International Union of North America (LIUNA) said this:

> "At Rapid City, South Dakota . . . [we] received reports that a CWT employee was distributing marijuana and methamphetamine at work. The Aberdeen Area Human Resources Office told the Union they were too busy with the Senate investigation to deal with these issues."

What measures have you taken to address this serious concern?

Question 12. There also appears to be a pattern of narcotics losses and/or diversions at Quentin Burdick and Sisseton Hospitals in recent years. These problems may exist at other facilities as well—the Committee did not even receive documentation on the pharmacy at Fort Yates Hospital, for example.

Please describe what the Area Office is doing to address the lost and missing narcotics. In addition, explain how the Area will enforce the IHS policy to conduct monthly audits of pharmaceuticals.

Question 13. The Committee received documentation of lapsed provider licenses and certifications at Belcourt, Fort Yates, Rapid City and Winnebago Service Units. At Belcourt, for example, the most recent Mock Joint Commission Survey found that 10 of 20—half—of all employee files reviewed did not have the proper license or registration. At Rapid City Hospital, one physician was practicing with an expired medical license for over seven months, and a Physician Assistant was practicing without a valid license for over two years.

What is the process at each local facility for monitoring provider licenses and ensuring that these licenses are current?

Question 13a. Who is responsible for this monitoring?

Question 13b. How often are the licenses verified?

Question 13c. Do local facilities communicate with the licensing state boards to ensure that provider licenses are current?

Question 13d. How is it possible that a provider could have practiced for over two years without a valid license?

Question 13e. Were providers who practiced without a valid license put on notice or disciplined in any way for failing to maintain current credentials?

Question 13f. What corrective actions have you taken to address this pattern of poor oversight of provider licenses?

Question 14. The Committee found that Rapid City Hospital refunded $63,000 to Medicare for services provided by the Physician Assistant who for over two years did not have a valid license.

Are there other instances where an IHS facility, in the Aberdeen Area, refunded a third party insurer because the services were rendered by a provider without an active license?

Question 15. The Aberdeen Area Internal Review found significant backlogs in billing Medicare, Medicaid and private insurers. The internal review states that these backlogs result in reduced cash flow to fund service unit operations. The Committee is aware that contractors have been hired to help the facilities catch up with their billing, and that many of the service units are already up-to-date.

What steps have been taken to prevent these backlogs from occurring again?

WRITTEN QUESTION SUBMITTED BY HON. TIM JOHNSON TO CHARLENE RED THUNDER *

Question. What support do you need to achieve the goals for improving the Aberdeen Area?

WRITTEN QUESTIONS SUBMITTED BY HON. BYRON L. DORGAN TO YVETTE ROUBIDEAUX, M.D., M.P.H. *

Question 1. A nurse at Quentin Burdick Hospital was found to have stolen drugs from the pharmacy for her own personal use and also worked in an impaired state on several occasions from 1989 to 2003. The North Dakota Board of Nursing found that the employee was in such an impaired condition that during a C-section procedure in 2000 the nurse "could not properly place and hold retractors, and hold the patient's skin in place for staples."

Can you please explain why this employee was not terminated? The Committee was told that the nurse was ultimately placed on a "desk job" so that she could reach her 20 years of service and reap the benefits of a full retirement.

Question 2. During the hearing, the former Chief Executive Officer (CEO) of Fort Totten Health Center was discussed as an egregious example of employee misconduct. In this instance, the Spirit Lake Tribe passed several resolutions—first asking for an investigation and finally—expelling the CEO. IHS performed an investigation six months after the Tribe passed the first resolution. IHS found 7 key areas of misconduct, including creation of a hostile work environment, misuse of property and sexual harassment. According to documents the Committee found—IHS reviewers recommended the CEO's termination.

Please explain why the former CEO was given a 14 day suspension rather than terminated?

Question 2a. According to Inspector General's investigative report, it found that the CEO had been the subject of 5 EEO complaints—4 of which were filed during the employee's previous place of work. These cases were settled and cost the Agency over $50,000. What efforts are in place to ensure the Agency oversees and addresses employees that are repeatedly the subject of EEOs?

Question 3. An Aberdeen Area administrative review in November 2009 found that the CEO of Winnebago Hospital (1) was absent without approval for 130 work hours in 2008 and 2009; (2) misused government funding by using these dollars to purchase food for hospital employees on various occasions; and (3) used a government vehicle for personal purposes.

Administrative reviewers ultimately found that that the CEO did not "demonstrate the leadership and ethical skills necessary" and that appropriate disciplinary action should be taken against the CEO. The Committee understands that the

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* Response to written questions was not available at the time this hearing went to press.

IHS' removal action was mitigated after the CEO agreed not to apply for another position in the Aberdeen Area for one year.

Please explain how the CEO was held accountable for misconduct and potentially criminal behavior.

Question 3a. Why did the Agency digress from its initial termination action, despite the reviewer's recommendations?

Question 4. The Quentin Burdick Memorial Hospital diverted inpatient services for more than 45 percent of the time between 2008 and 2010. When an IHS facility diverts patients there are numerous negative consequences, such as requiring the use of already underfunded Contract Health Service dollars and the burden of travel time and cost on Native American patients. In this case, patients had to travel at least 100 miles to the next hospital—Trinity Hospital in Minot.

Trinity Hospital reportedly has $10 million in unpaid bills from serving Belcourt IHS patients during the almost 400 days of diversions. Can you confirm this?

Question 4a. Is it common for local hospitals to be burdened by unpaid bills after diversions?

Question 4b. Can you provide inform the Committee of which non-IHS facilities are owed money in the Aberdeen Area due to the non-IHS facilities providing patient care to IHS-eligible patients?

Question 4c. Does the IHS have an Area-wide policy on when it is appropriate for a facility to divert patients?

Question 5. The Committee found instances of lapsed provider licenses, certifications and privileges at the Belcourt Service Unit, Fort Yates Service Unit, Rapid City IHS Hospital, and Winnebago Service Unit. For instance, in a 2009 Winnebago Hospital's Joint Commission Mock Survey, 4 providers had expired licenses—some for over 9 months. Provider licensure is critical to the safety of patients and the credibility of a facility.

Were you aware that providers had been practicing for as long as two years without valid licenses?

If yes, how did you allow providers to continue practicing months after their license had expired?

Question 6. IHS is required to maintain records of provider licenses, including adverse actions for at least 10 years after the individual's termination of employment or association with the Agency. The IHS only submitted only 5 instances of Aberdeen Area providers with a disciplinary action by a State Board. However, the Committee contacted SD, ND, IA and NE nursing boards and found 14 Aberdeen Area nurses with license suspensions or revocations due to misconduct committed during their employment with the Agency.

Does the Agency have any system in place to ensure providers are not treating patients with a revoked or suspended license?

Question 6a. How is a report of a provider's license suspension communicated from the Area Office to Headquarters?

Question 7. The Aberdeen Area Administrative Review, completed in April 2010, states that five service units were identified as being in jeopardy of losing their CMS accreditation.

Five of 12 service units—nearly half of all major facilities in the Aberdeen Area—are at risk for losing their CMS accreditation. Is this unique to the Aberdeen Area?

Question 7a. How many other service units in the IHS system are at risk for losing their accreditation?

Question 7b. How important is it for facilities to retain their CMS accreditation? How would that affect the hospital's operation and patient care?

Question 7c. How does Headquarters work with the Area Directors to ensure that local facilities get the support they need in order to avoid losing their accreditation?

Question 8. The Aberdeen Area facilities have been below average in all aspects of its third party billing operations, facing backlogs in submitting bills to Medicare, Medicaid and private insurers. For example, the Committee found that a high percentage of bills remain uncollected beyond 120 day and accounts were also not turned over to the Department's Program Support Center (PSC) for debt collection after 180 days, in accordance with IHS policy.

What role does IHS headquarters play in the third party collection process?

Question 8a. Is there any oversight of the various Areas or service units?

Question 8b. Have there been changes to the IHS policies since the Aberdeen Area internal review revealed problems with all aspects of the third party billing process?

Question 9. As you know, CHS is often labeled as chronically underfunded and the budget requests often focus on large increases for the CHS program. However, the Committee has become aware of transfers of Aberdeen Area Contract Health Service (CHS) funding between CHS programs at different IHS facilities as well as to non-CHS programs. For example, in 2008 the IHS facility in Sisseton transferred $250,000 to an oral health care program. There have been several instances over the past five years of transfers to tribal ambulatory programs and also an instance of CHS funds being transferred to an oral health program.

If these facilities are running out of CHS money every year, why are CHS funds being transferred to other programs?

Question 9a. In your opinion, is it within the authorization of CHS to utilize these funds for purposes other than paying directly for health services rendered outside the Indian health system?

Question 9b. Is the practice of transferring CHS funds specific to the Aberdeen Area or is this done throughout the Indian health system?

Question 13. There is a troubling history of missing or stolen narcotics at Quentin Burdick, Rapid City and Sisseton Hospitals, among others.

What steps have you taken to address these issues?

Question 14. During the investigation, the Committee encountered instances where it appeared union stewards had been retaliated against. For instance, one union steward experienced alleged harassment by management at Rapid City IHS hospital, resulting in her denial of leave for her own surgery, denial of leave for her mother's funeral and harassment for reporting that her supervisor had come to work drunk on several occasions.

How has the Agency engaged the union to ensure a better working relationship and to prevent retaliation against union stewards?

WRITTEN QUESTIONS SUBMITTED BY HON. TIM JOHNSON TO YVETTE ROUBIDEAUX, M.D., M.P.H. *

Question 1. How and when will IHS implement the OIG's recommendations for controlled medications?

Question 2. Does IHS have a plan for providing greater support services to staff to better job performance and prevent misconduct and poor performance?

Question 3. While the program is severely underfunded, it is critical to properly manage Contract Health Service (CHS) funds. How will IHS ensure that these monies are managed better in the future?

Question 4. What discretion is given to Area offices to move funds around between accounts? What funds were moved in FY 2010 and why?

Question 5. Do you consult the National Combined Council of Chief Executive Officers? It is my understanding that they were contacted about the issues and problems encountered at the Service Units. Would you consider consulting that group for solutions for reform?

WRITTEN QUESTIONS SUBMITTED BY HON. JOHN BARRASSO TO YVETTE ROUBIDEAUX, M.D., M.P.H. *

Question 1. Your written testimony indicates you are working to streamline the hiring process to bring more qualified health professionals on board more quickly. Bringing quality care to tribal members is an important priority. However, the IHS must also ensure that these providers are duly licensed and have no suspensions or other disciplinary action against them.

In 2008, the Office of Inspector General found that IHS did not have certain safeguards in place to determine whether employees or contractors were on the OIG List of Excluded Individuals and Entities. What safeguards, policies, and procedures are in place to ensure that the professionals, employees, and contractors are all appropriately qualified to work in IHS facilities?

Question 2. Employee accountability and oversight appeared to be two major weaknesses that the Office of Inspector General has identified in past investigations of IHS. The Office of Inspector General's testimony mentions one case where an IHS employee altered government medical records of patients for personal gain. What specific oversight, verification, and accountability measures are in place to prevent this type of incidence from occurring again?

* Response to written questions was not available at the time this hearing went to press.

Question 3. I understand that the Department has begun a program, directed by an "integrity council," to assess the IHS financial integrity and quality of care. Can you describe the process that will be employed for this initiative and when it will be conducted?

WRITTEN QUESTIONS SUBMITTED BY HON. JOHN MCCAIN TO YVETTE ROUBIDEAUX, M.D., M.P.H.*

Question 1. On July 22, 2010, I wrote a letter to IHS Director Roubideaux with questions concerning the Service's responsibilities under the IHS Healthcare Facilities Construction Priority System. I've heard from my constituents of the Gila River Indian Community that IHS is not meeting its contractual obligations for the South East Ambulatory Care Center. Please let me know when I can expect a response from IHS concerning my two-month old letter.

Question 2. The Gila River Indian Community has complained to me about several administrative delays at IHS that are jeopardizing the SEACC project. For example, the approval of the Program of Record didn't occur until 7 months after the deadline set forth in the contract. Furthermore, transfer of Design Funds didn't occur until 8 months after contract deadline. What is the cause of these lapses?

Question 3. Local newspapers in Arizona recently reported that the Service's Fort Yuma Service Unit, which provides medical care for the Cocopah Indian Tribe and the Quechan Indian Tribe, may have exposed approximately 111 tribal members to HIV, hepatitis B and C and other infections because of a failure to property sterilize medical equipment.

Has the IHS identified specific at-risk tribal members and have those members been notified? What recourse do tribal members have with IHS if they're diagnosed with one of these potential infectious diseases?

Question 3a. Please explain why there was a failure to properly sterilize the unit's medical equipment. When were IHS officials made aware of this incident? When were the two tribes officially notified? When will IHS complete its investigation of this incident?

Question 3b. What steps is IHS taking to ensure this doesn't happen again at Yuma?

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