PRESIDENTIAL TASK FORCE ON PROTECTING NATIVE AMERICAN CHILDREN IN THE INDIAN HEALTH SERVICE SYSTEM

REPORT

JULY 23, 2020

Table of Contents

Executive Summary

On March 26, 2019, President Donald J. Trump formed a Presidential Task Force on Protecting Native American Children in the Indian Health Service System ("Task Force") to investigate the institutional and systemic breakdown that failed to prevent and stop after detection a predatory pediatrician working at the Indian Health Service (IHS) from sexually assaulting children. President Trump broadly charged the Task Force with identifying means to better protect Native American children and improve IHS's ability to provide quality healthcare to the more than 2.6 million Native Americans served by IHS. The Task Force carried out its mission as directed by President Trump and in accordance with his commitment to fixing broken, bureaucratic institutions. During its investigation, the Task Force found fundamental and longstanding deficiencies at IHS that included:

- *Employees not understanding child abuse reporting obligations;*
- *Inadequate training of employees regarding child sexual abuse reporting;*
- *Confusing policies, procedures, and jurisdictional issues when reporting suspected child abuse;*
- *Systemic issues of low-morale, lack of leadership, and inability to recruit and retain enough qualified healthcare professionals; and*
- *Deficiencies in verifying and credentialing processes.*

Although the concluding recommendations primarily seek to address the findings above, they also provide guidance to correct some of the overarching issues at IHS that will assist the agency to improve as a whole, especially under the leadership of recently confirmed Rear Admiral Michael Weahkee. It should be noted that while this report highlights some failures at IHS, the vast majority of employees encountered by the Task Force were dedicated public servants who worked tirelessly to fulfill the agency's mission. The Task Force is appreciative of their commitment to Native American communities and their continued efforts to improve the safety of children who receive care.

Task Force Overview

Background & Members

President Trump charged the Task Force to investigate institutional failures at IHS and make recommendations for improvements that would better protect Native American children who use the system. IHS is an operating division of the Department of Health and Human Services (HHS) that provides comprehensive clinical and public health services to over 2.6 million Native Americans through a network of hospitals and clinics across 37 states. Systemic and institutional breakdowns at IHS, combined with individual failings by certain employees, allowed a United States Public Health Service (USPHS) Commissioned Corps officer, who worked as a pediatrician, to sexually assault children for decades. The predatory pediatrician is no longer employed by the agency and was successfully prosecuted by two United States Attorneys' Offices in separate jury trials. President Trump found the longstanding systemic and institutional failures that enabled child abuse at IHS unconscionable and inconsistent with the agency's mission to "raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level."[1]

The Task Force, co-chaired by Joseph Grogan, Assistant to the President for Domestic Policy, and the Honorable Trent Shores, United States Attorney for the Northern District of Oklahoma and citizen of the Choctaw Nation, was comprised of civil servants from varying United States Government agencies who have extensive experience working with Native Americans in Indian country for most of their professional careers. In addition to the co-chairs, the members of the Task Force are:

- Bo Leach, SE Region Agent in Charge, Bureau of Indian Affairs, Office of Justice Services, Branch of Criminal Investigations;
- Stephanie Knapp, MSW, LCSW, Child/Adolescent Forensic Interviewer, Federal Bureau of Investigation's Office for Victims Assistance, Child Victim Services Unit;

[1] [https://www.ihs.gov/aboutIHS]

- Shannon Bears Cozzoni, Tribal Liaison and Assistant United States Attorney, United States Attorney's Office for the Northern District of Oklahoma;
- Caitlin A. Hall, MD, FAAP, Clinical Director/Pediatrician, Dzilth-na-o-dith-hle Health Center, Indian Health Service; and
- Farnoosh Faezi-Marian, Program Examiner, Office of Management and Budget.

The Task Force also drew on the expertise of other Federal employees and sought input from a diverse group of tribal leaders and Native American citizens.

The Process

To develop its findings and recommendations, the Task Force traveled throughout Indian country over a four month period, including visits to Oklahoma, New Mexico, Montana, and South Dakota. During those visits, the Task Force interviewed Native American citizens, tribal leaders, healthcare professionals, government and law enforcement officials, sexual assault experts, and tribal school administrators, and teachers. The Task Force engaged in discussions pertaining to processes and protocols for handling child abuse reporting as well as recruitment of doctors, nurses, and other medical staff. To appreciate the diverse views and wide spectrum of experience that were incorporated into the Task Force's conclusions, some of the notable participants who contributed to this process are addressed below.

At the initial meeting in Oklahoma, the Task Force discussed its mission, expectations, and goals, and then interviewed persons familiar with the IHS system on matters including, but not limited to, child abuse reporting requirements, training, licensing and credentialing, background checks, and recruitment and retention. Persons interviewed included:

- Former Muscogee (Creek) Nation Principal Chief James Floyd;
- Dr. Mark Butterbrodt, a former pediatrician at Pine Ridge Hospital, and
- Inspector Curt Muller, HHS Office of Inspector General.

For the second site visit, the Task Force visited the Navajo Nation's Dzilth-Na-O-Dith-Hle Tribal School and Dzilth-Na-O-Dith-Hle IHS Health Center, facilities primarily providing care to Navajo citizens. Specifically, the Task Force met with:

- Health officials and tribal leaders at the IHS facility;
- Dzilth-Na-O-Dith-Hle Tribal School officials, including teachers and administrators;
- Navajo officials, including Navajo Nation Council Delegate Amber Kanazbah Crotty;
- All Pueblo Council of Governors and their designees at the Indian Pueblo Cultural Center;
- Governor Paul Torres of Isleta Pueblo and Governor Michael Chavarria of Santa Clara Pueblo, Chairman and Vice Chairman of the All Pueblo Council of Governors; and
- The Honorable John Anderson, U.S. Attorney for the District of New Mexico, and Supervisory Assistant U.S. Attorney Kyle Nayback.

During these discussions, tribal representatives presented information to the Task Force about institutional challenges within the IHS system that have impacted the safety of Native American children and issues related to the quality of healthcare, funding, staffing, and high turnover rates. The Task Force engaged with tribal leaders during roundtable discussions and received written comments.

For the third site visit, the Task Force convened in Montana to discuss similar issues and met with the following individuals:

- Tim Davis, Tribal Chairman of the Blackfeet Nation;
- Medical Staff at the Blackfeet Community Hospital;
- The Honorable Kurt Alme, U.S. Attorney for the District of Montana and Vice Chair of the Attorney General's Native American Issue Subcommittee; and
- Law enforcement officials, prosecutors, child welfare, victim service providers, and healthcare officials who focused on crimes against Native American children.

In July 2019, the Task Force met with healthcare professionals at the Avera Behavioral Health Center in Sioux Falls, South Dakota to discuss whether telehealth could provide services essential to combating child abuse. Other topics addressed were emergency services, specialist consultations, and patient care for children, as well as whether Avera would provide cultural education and related training for its providers. The Task Force also traveled to Rapid City and the

Pine Ridge Sioux Reservation where they visited the Pine Ridge Indian Health Service Hospital and met with IHS employees, as well as law enforcement officials. At a final meeting, the Task Force met in Washington, D.C., to interview senior officials from HHS, IHS, and the USPHS Commissioned Corps, as well as other persons who had independently contacted the Task Force and requested to provide information.

Based on the totality of information collected, the Task Force developed the following findings and recommended policies, protocols, and best practices to protect Native American children, prevent abuse, and effectuate a timely reporting of and response to future allegations of suspected child abuse.

Task Force Findings

I. Many IHS employees do not fully understand their responsibility to report child sexual abuse.

There are two primary, applicable Federal statutes that require reporting of child abuse at IHS facilities. Title 18, United States Code, Section 1169 criminalizes the failure of certain individuals, such as doctors and nurses, to report child abuse that occurs in Indian country when the person "knows, or has reasonable suspicion that a child was abused in Indian country, or actions are being taken, or are going to be taken, that would reasonably be expected to result in abuse of a child in Indian country." In addition, Title 34, United States Code, Section 20341 provides for criminal penalties for certain statutory defined "covered professionals" who fail to report suspected child abuse learned of while in their official capacity on Federal land or in a federally operated facility. The complexity of these laws and their legal nuances appeared to contribute to the confusion as to individual reporting responsibilities.

Specifically, IHS employees' understanding of child abuse reporting obligations did not align with Federal laws. In arriving at the conclusion that IHS staff were generally unaware of their mandatory reporting obligations, the Task Force met with a diverse array of IHS employees throughout the twelve IHS service areas. The employees interviewed included management, administrative personnel, doctors, nurses, social workers, and security. Although many IHS employees knew they had "some sort" of duty to report, they were unaware of what they were to report, when they were to report, to whom they were to report, or how to report. Moreover, when employees did attempt to explain reporting processes, their responses were inconsistent across IHS facilities and within a single facility. Given the interplay among state, Federal, and tribal jurisdictions, employees and patients expressed significant confusion as to which law enforcement or child welfare agency, if any, should be informed of suspected child abuse. Indeed, multiple persons claimed that they contacted tribal and state authorities to report child abuse, but were told by both that they had no jurisdiction.

In addition, the various child welfare and law enforcement entities varied tremendously in their processing of child abuse reports, and often did not coordinate with one another to ensure reports of child abuse had been investigated or otherwise addressed. Likewise, if the reported child abuse allegations involved manipulative behavior (*i.e.*, grooming activity) which did not arguably rise to the criminal elements of abuse, then law enforcement and child welfare services were also unresponsive and closed out any investigation or inquiry into the matter. Child welfare services and law enforcement entities' failure to respond often contributed to the confusion as to where child abuse should be reported and deterred others from ever attempting to report.

The Task Force also found that IHS employees were reluctant to report suspected child abuse unless they were "absolutely certain" abuse had occurred. This often resulted in individual

employees or supervisors investigating matters on their own before reporting the suspected child abuse to law enforcement or child services, if ever. Such investigations by untrained persons jeopardized criminal investigations and prosecutions, and potentially placed Native American children at additional risk. Although the vast majority of IHS employees indicated that they would report child abuse suspicions to a supervisor, many said they would only do so after taking some steps or measures to confirm their suspicions were true. When they did report such allegations to a supervisor, the IHS employees erroneously believed such reports satisfied their reporting obligations under Federal law. Employees also expressed concern about creating personnel and relational issues with allegations that were not first fully vetted.

II. IHS does not have a uniform process for reporting child abuse.

The Task Force found that there was no consistent or uniform process to receive, catalog, or otherwise record suspected abuse reports within IHS. This correlated with a gap in employees' understanding regarding how to report suspected child abuse.

Title 34, United States Code, Section 20341(f) requires a standard child abuse reporting form within IHS. However, each IHS facility that was visited by the Task Force used a different form to report suspected child abuse. Additionally, each facility's form captured different information and varied in length and size. IHS employees and others indicated that the sheer length and appearance of the reporting form dissuaded them from attempting to complete it. Alternatively, some reporting forms failed to include basic questions that would elicit critical information needed by law enforcement or child protective services to respond. This lack of uniformity resulted in substantially inconsistent and incomplete data collection during the reporting phase and had a negative impact on the initial investigative responses and processes.

Further, despite an IHS policy mandating that supervisors report and document all incidents of inappropriate sexual contact, the Task Force noted a lack of any organized repository or cataloguing of reporting forms. The Task Force could not identify an operational, reliable system or means of cross-referencing reports of suspected child abuse involving the same victim or abuser when reported at different times, different locations, or to different law enforcement or child welfare agencies. Without information of compounded allegations, the likelihood of identifying an abuser significantly decreases. The lack of a centralized reporting and information collection process by IHS may have contributed to employees suspected of child abuse being able to avoid scrutiny and transfer from facility to facility.

III. IHS issued the "Protecting Children from Sexual Abuse by Health Care Providers", but its system-wide implementation remains deficient.

During the visits to IHS facilities, the Task Force found that IHS employees were unfamiliar with IHS policies generally and specifically with regard to the "Protecting Children from Sexual Abuse by Health Care Providers" Policy (hereinafter the "IHS Child Sexual Abuse Policy"), including the mandatory reporting requirement. Notwithstanding this new policy, IHS did not establish a uniform standard for responding to allegations of child sexual abuse. As stated in IHS Policy (3-20.01), the varying obligations and reporting responsibilities are assigned to the following individuals and groups:

A) Director, Office of Human Resources and Directors, Servicing Regional Human Resource Offices
B) Deputy Director for Field Operations, IHS
C) Area Director (AD)
D) Chief Executive Officer (CEO)
E) Supervisors
F) Healthcare Provider
G) All IHS Staff

The IHS Sexual Abuse Policy requires Clinic CEOs to establish local policy and procedures, seemingly allowing for differing reporting procedures for IHS employees. If different Clinic CEOs create varying policies, then there may be variations in the national implementation of the IHS Child Sexual Abuse Policy. Furthermore, the new policy misplaced primary responsibility at the level of Clinic CEOs.

Additionally, the IHS Child Sexual Abuse Policy revealed considerable gaps that need to be addressed. Under "Staff Rights" (3-20.4), current IHS Policy states that accused employees should be provided with independent, confidential support and counseling services during the investigation. However, these services are not generally available under current employee assistance programs. Another concern of the Task Force was that IHS's policy did not provide sufficient clarity about the transfer of employees or contractors suspected of child sexual assault between IHS Hospitals and Service Units. IHS Policy (3-20.1E(3)) requires IHS facilities to post information on how IHS staff members, patients, parents, and others may report sexually inappropriate behavior related to an examination, a provider's actions, or a provider's statement to the facility's administration, IHS Hotline, the HHS Office of Inspector General (OIG), and to the appropriate law enforcement and/or child protective services agency. The Task Force observed almost no such postings at IHS facilities.

IV. Inconsistencies exist between IHS Child Sexual Abuse policy and Federal law.

The IHS Child Sexual Abuse Policy should reflect Federal law to avoid reporting issues. For instance, current IHS policy confusingly differentiates "child sexual assault" from "child abuse" when describing the mandatory reporting requirements, duties, and responsibilities of their various management positions. In contrast, Federal law establishes mandatory reporting

requirements for all suspected child abuse regardless of whether the abuse rises to the level of assault.

In addition, the IHS Maternal and Child Health Policy (3.13.8 (3a2)) states that "in all cases requiring treatment beyond emergency first aid, a patient's consent to treatment should be obtained before treatment is provided according to the requirements of State Laws." The policy further states in the case of a minor child, consent to examination for treatment and evidence of sexual assault is governed by the law of the state where the IHS facility is located. But this oversimplifies what may be a difficult question between Federal jurisdiction and tribal jurisdiction within the same state. Many IHS facilities are located in Indian country or are Federal enclaves, which may be removed from state jurisdiction.

The IHS Child Sexual Abuse Policy fails to account for a situation in which the suspected offender is also the legally designated person to give consent. Title 25, United States Code, Section 3206 provides, "absent parental consent and upon belief that a child has been abused in Indian country, a law enforcement officer or child welfare worker can consent to x-rays, photographs, medical examinations, and psychological examinations." This IHS policy does not appear to recognize such an exception.

However, during the course of the drafting of this report, the Task Force became aware of other IHS policies that may have some relevance to child sexual abuse reporting. The fact that reporting duties are spread across multiple internal policies, including but not limited to, a Maternal and Child Health Policy, an IHS Child Maltreatment policy, an IHS Child Sexual Abuse Policy, and a sexual assault policy for adults, may contribute to the confusion or lack of clarity as to individual reporting responsibilities and institutional responsibilities pertaining to such reporting.

The IHS sexual abuse policy also indicates that if a minor is competent under State law to sign a consent to treatment but refuses treatment, a parent cannot supersede the competent minor's refusal. By failing to define "competent minor," and instead incorporating state definitions that may not exist, the IHS policy may be difficult to apply. Various states have passed legislation identifying "mature minors." However, the "mature minor" definitions vary. Many states have no legislative provisions allowing a minor to refuse medical treatment, and the Task Force found no Federal legislation that supports the right of a minor child to refuse medical treatment, much less deny a parent or guardian's right to supersede a minor's refusal for treatment following an alleged sexual assault.

V. Indian country law enforcement, and child welfare entities lack the requisite organization and training to adequately respond to reports of child abuse.

Several IHS employees voiced concerns to the Task Force about the ability of law enforcement and child welfare agencies to respond adequately or in a timely fashion to investigate child abuse allegations. Communities in rural areas raised serious concerns about the proximity of law enforcement because of the vast physical areas being covered. In some instances, the closest law enforcement entity in proximity to the IHS facility was not the law enforcement agency with primary jurisdiction for criminal investigations within the facility, causing delayed responses and further confusion. For example, the Federal Bureau of Investigation (FBI) maintains primary jurisdiction in child abuse cases occurring in many Indian country locations, but the agents lived and worked several hours away. Moreover, FBI special agents are not "first responders" similar to local or tribal police officers. FBI special agents are investigators. Therefore, most IHS facilities

reported directly to tribal police or the Bureau of Indian Affairs, Office of Justice Services ("BIA-OJS"), regardless of whether they had primary investigative jurisdiction.

The Task Force heard that in some instances, the suspected child abuse report was not communicated further to the FBI for follow-up investigation. While Federal law requires that a suspicion of child abuse be reported to either local law enforcement or child welfare, the Task Force found that the responses were wholly separate and uncoordinated. A lack of coordination among entities designated to receive child abuse reports did not accomplish the mandatory reporting law's goal of protecting children and identifying abusers.

Additionally, some IHS facilities had no regular security presence on site within their facility. This not only impacted the perception of safety of patients and staff within a facility but also reporting capabilities as no law enforcement officer was present to receive an immediate report.

VI. IHS faces significant challenges recruiting and retaining healthcare professionals.

IHS remains on the Government Accountability Office's High-Risk List for inadequate oversight due, in part, to challenges in recruiting and retaining permanent quality leadership and healthcare professionals. IHS, like other predominately rural healthcare providers, faces chronic staffing shortages. The system-wide staff vacancy rate is approximately 30 percent and may be even higher for skilled providers like nurses and physician assistants. Longstanding vacancies have had an adverse effect on patient access, quality of care, and employee morale. High turnover rates also adversely impact doctor-patient relationships as families do not know who their family doctor will be on any given trip to the clinic.

The law requires preference be applied to certain groups in the context of Federal employment decisions. Indian preference is intended to encourage qualified Native American persons to seek employment with the Federal government. Relatedly, veterans' preference places veterans in a favorable competitive position for employment in recognition of their selfless service and sacrifice. There are very good reasons to maintain these preferences, and the Task Force does not recommend that those preferences be eliminated altogether, but rather a review of their application be conducted. In practice, however, the application of Indian and veterans' preferences impact the hiring process when Indian or veteran applicants are only minimally qualified. Current practice is to apply preference to the initial list of applicants for a vacant position without consideration to qualifications or suitability for the position. The human resources office then reviews only the "preference candidates" for qualifications. The human resources office sends only the Indian and veterans' preference applicants to the hiring official. If the applicant is minimally qualified, but determined to be unsuitable for the position or Federal employment, the hiring official still may not consider non-Indian candidates and must go through a lengthy process to justify rejecting a veteran candidate before they may review other non-preference candidates. As a result, other qualified candidates may move on to other opportunities. The Task Force heard of instances when the same minimally qualified individual applied for multiple positions across IHS, thus slowing the hiring process at multiple facilities.

Facilities located in or near urban areas also experience challenges with recruitment, in part, due to competition for staff with other public sector agencies and private sector organizations.

The Task Force found that housing is a primary consideration for health professionals interested in working for IHS. Notably, IHS and tribal facilities are located in predominately rural locations on or near reservations where there are limited options for housing. Some staff travel

more than three hours roundtrip to go to work, and facilities may be forced to reduce services or close if inclement weather limits travel.

Healthcare providers are also increasingly concerned about how they will pay off their student loans. The IHS loan repayment program is an effective tool to attract and retain talent. In 2018, a total of 1,325 health professionals received loan repayments; however, 844 eligible health professionals did not receive funding, and a majority moved on to other opportunities outside of IHS. The Task Force was advised by some IHS healthcare professionals that the IHS-funded scholarship and loan repayment awards increased the overall tax bracket for participants and created a financial disincentive for those otherwise willing to work for IHS.

VII. Morale is low among IHS employees and Native Americans served by IHS.

IHS employees take great pride in their mission. However, many employees indicated that they lacked confidence in the ability of their managers and supervisors. The Task Force found that the majority of IHS employees had little faith in the abilities of their leadership; IHS employees did not believe they had sufficient resources to do their job; IHS employees do not believe steps are taken to deal with poor performers; and IHS employees did not feel there was good communication among different work units.

The Task Force found that lack of permanent and consistent leadership at IHS, which has plagued the organization for years, contributed to low morale. The vacancies in management positions span across the agency and historically included the IHS Director. IHS had not had a permanent, Senate-confirmed Director for five years and had cycled through acting Directors until the Senate confirmed RADM Weahkee as the Director in April 2020. Vacancies in positions of leadership and upper management have undoubtedly contributed to the culture of apathy in decision-making, resulting in a lack of consistent messaging and confidence in management's

ability. Without a sufficient management structure and training, IHS is unable to hold employees accountable for poor ethical decisions, bad judgment, and other actions that violated policy.

The Task Force noted that IHS employees consistently compared themselves to Department of Veterans Affairs (VA) employees. There was a perceived disparity in how employees of the VA were treated compared to employees of IHS. IHS employees believed VA employees received better benefits and higher pay, comparatively, for similar work.

Many civilian IHS employees perceived differences in how they are treated compared to USPHS Commissioned Corps officers. The military-style uniforms worn by Commissioned Corps officers contribute in part to the perception of inequality, including among patients who did not appreciate the use of military uniforms in reservation clinics. The Task Force heard concerns expressed from patients and IHS employees that the use of rank and uniforms could be exploited by a predatory pedophile to facilitate his or her crime of child abuse. Further, managers at IHS expressed frustrations with conducting annual performance appraisals of USPHS Commissioned Corps officers. Managers do not uniformly have access to officer billets, which describe the duties, responsibilities, and qualifications necessary to perform a specific assignment, and are essential to evaluating an officer's performance. Some managers told the Task Force that they felt pressured to provide a positive appraisal of an officer because the USPHS Commissioned Corps uses the agency appraisals to inform promotion decisions. Although officers are employed and evaluated annually by IHS, promotion decisions are made at Commissioned Corps Headquarters, which the Task Force found could displace incentives for performance.

VIII. IHS credentialing, privileging, and hiring processes lack consistency, thereby increasing the risk of persons suspected of child abuse gaining access to an IHS facility or transfer to a new IHS facility.

Credentialing is the process of obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a healthcare organization. It ensures that individuals who are providing care are qualified to do so. Privileging is the process of authorizing a specific scope of practice for patient care based on an individual's credentials and performance. Credentialing processes are driven by Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (482.22), The Joint Commission Standards (MS.06.01.03), state statutes for licensed facilities, Medical Staff Bylaws, and Governing Body policies.[2] These processes also serve to ensure an applicant's work history and criminal history do not include allegations or convictions of child abuse.

The Task Force talked to credentialing staff at several different IHS locations and discovered inconsistencies. Following standard practice, each location had a credentialing office that collected the above information on each applicant and used primary source verification where applicable. A credentialing committee then reviewed the information and made recommendations to a Governing Body, which then made the final recommendation whether to approve an application for appointment to the medical staff. The Task Force found that some hiring committees prioritized filling vacant positions over a thorough background and credentialing check. Specifically, the Task Force was advised that hiring committees filled vacant positions with professionals who had questionable backgrounds, citing a need-based priority over quality.

The Task Force found that some service units used staffing software with online applications while others used paper applications. The Task Force also found other personnel and

[2]The following is a list of the recommended criteria to be used in assessing an applicant's suitability: (1) proof of identity, (2) education and training, (3) military service, (4) professional licensure, (5) DEA registration, (6) board certification, (7) affiliation and work history, (8) criminal background disclosure, (9) sanctions disclosure, (10) health status, (11) National Practitioner Data Bank query, and (12) professional references.

hiring problems across IHS service units, including lack of communication and shared information among facilities. This failure to effectively communicate through a uniform system increased the risk that a healthcare employee with a questionable work history or background could transfer among facilities.

IX. Institutional failures in communication among facilities, regional offices, and headquarters resulted in policies not being effectively implemented and a lack of accountability.

IHS Headquarters did not have adequate tools to oversee Area Office operations, which has led to inconsistent oversight of Federal facilities. In 2019, IHS established the Office of Quality at IHS Headquarters to develop and monitor quality assurance; patient safety and clinical risk management; enterprise risk management and internal controls; and to lead innovation and improve the IHS system.

Further, communication between IHS headquarters and Area Office operations was substantially lacking. Area Office management indicated that one reason why IHS policy may differentiate from facility to facility is the lack of clear communication, if any, from headquarters. During the course of interviews, Area Office staff indicated they had sought guidance from IHS headquarters but received no response or a "non-answer" response. Many IHS employees, including local area supervisors/managers, believed IHS headquarters preferred not to make decisions because of possible consequences for making such decisions and to avoid accountability.

X. IHS does not adequately utilize telemedicine to address staffing inadequacies, as appropriate, nor to provide care to child abuse victims.

Telemedicine is a healthcare delivery service that extends care to locations where it was previously unavailable due to funding or provider shortages. The healthcare services that can be provided through telemedicine include care of child sexual abuse victims' mental health and

medical needs. The specialty clinical services provided through telemedicine are not available to many IHS medical facilities, including many of the most remote sites with the greatest need. One current telemedicine delivery model is a specialty service contract structured such that each service facility pays for individual consults as needed. This structure limits the number of IHS facilities that utilize telemedicine due to lack of financial resources. Many IHS healthcare facilities are further limited from utilizing telemedicine by lack of appropriate facility infrastructure and inadequate staff training. Telemedicine could assuage IHS staffing shortages by providing access to a quality medical professional the local service unit had been unable to recruit. Moreover, telemedicine would relieve at least some pressure from a hiring/credentialing committee to fill a vacancy with "any person" as opposed to a quality person.

As telemedicine becomes more standard in medical practice, its level of utilization in IHS medical facilities could contribute to difficulties with provider recruitment and retention. The Task Force found that this could cause "ripple effects" at individual facilities which are seemingly willing to accept a lower standard of care, and have shown an inability to hire the highest quality doctors, nurses, and other healthcare providers. Further, increased utilization of telemedicine services may increase reports of child sexual abuse by IHS employees who maintained concerns that their reporting of such abuse would result in a provider leaving the facility and therefore leaving the community without access to care.

Task Force Recommendations

For IHS to achieve its stated goal of raising "the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level," [3] the Task Force recommends ten urgent policy, process, and culture changes. The recommendations are not presented as one-

[3] https://www.ihs.gov/aboutIHS/

to-one solutions to the findings presented in the sections above but rather as collective guidance to providing greater protection for Native American children in IHS. The first eight recommendations directly respond to the charge of providing greater protection for Native American children in the IHS system. Two recommendations respond to systemic issues in IHS that, when addressed, would result in far-reaching improvements in care delivery, including greater protection for children. Finally, guidance is provided for the appropriate oversight of the timeline and implementation of these recommendations.

I. Require annual, in-person, standardized training of IHS employees conducted by instructors with law enforcement and/or child welfare experience.

The Task Force recommends IHS establish mandatory training for its employees and contractors pertaining to Federal child abuse reporting requirements and the consequences for failing to report. The mandatory training should be conducted by persons with law enforcement and child welfare experience, preferably members of a local Multi-Disciplinary Team ("MDT"). The Task Force recommends that the training also be conducted in coordination with IHS and human resources personnel. The presenter should not be an IHS employee. The inclusion of non-IHS trainers will impress upon employees and contractors the seriousness of their reporting requirement obligations under applicable law and policy.

The Task Force further recommends the following as presenters of the training: Assistant United States Attorneys and/or U.S. Attorney's Office Tribal Liaisons, Tribal Prosecutors, BIA special agents, FBI special agents, HHS OIG agents, or tribal law enforcement. These individuals are often members of an MDT. It is also the recommendation of the Task Force that the training has a standardized curriculum that includes information pertaining to grooming, manipulative behaviors, and other indicators or signs of abuse, which again should be presented by law

enforcement, child welfare, advocates, or social workers. The training should also emphasize civil liability protections under Federal law when a reporter is acting in good faith.

The mandatory reporting training can and should be adjusted for regional needs of Area Offices. For example, training may include jurisdictional issues in Indian country to include introduction of the law enforcement entity that may respond in that location and who must report. In some situations (i.e., the failure to report crimes that occur under state jurisdiction), the state law and/or the Federal laws regarding reporting may apply. Currently, nineteen states require any person with reasonable suspicion of child abuse to report to law enforcement.

II. Make reporting of child abuse easier and more streamlined by creating and publicizing a centralized child abuse hotline.

The Task Force recommends IHS establish, publicize, and monitor a hotline dedicated solely to reporting of suspected child abuse. Notably, this hotline should be separate and apart from the "fraud, waste, and abuse" hotline. The child abuse reporting hotline should be staffed by individuals trained to receive, document, and respond to or relay child abuse reports in a timely manner. Additionally, the Task Force recommends IHS establish a website or other virtual reporting system to receive reports of suspected child abuse. Federal law requires the Attorney General to designate an agency to receive and investigate child abuse reports. 34 U.S.C. § 20341.

The Task Force recommends that, upon the establishment of the HHS/IHS child abuse hotline and reporting website, the Attorney General designate the Federal Bureau of Investigation (FBI) or, by written agreement, the HHS Office of Inspector General as the primary agency to receive and investigate such reports, or disseminate for investigation by another law enforcement agency as appropriate. HHS OIG should collaborate with local and tribal law enforcement, as needed, to timely respond to and investigate child abuse allegations at IHS facilities. HHS OIG is

already tasked with handling investigations for internal IHS matters and can catalog abuse reports, determine the appropriate law enforcement agency based on location of abuse and parties involved, and then transfer the information to that agency. In instances where local HHS OIG are adequately trained in child abuse investigations, then they may choose to assist in those investigations.

Measures should also be taken to alleviate jurisdictional confusion, such as amending the Indian Health Care Improvement Act to authorize IHS to establish concurrent Federal and state criminal jurisdiction, as appropriate, at IHS facilities located on Federal enclaves. Moreover, law enforcement staffing and resources in Indian country should be increased so that they, at least, match that of similarly situated rural areas. IHS should be required to provide a trained security officer at every facility. Given the lack of proximity of law enforcement in many rural areas, the granting of concurrent jurisdiction at Federal enclaves could serve as a needed force multiplier to improve public safety at IHS facilities. Moreover, a regular law enforcement presence at and in an IHS facility could serve to both deter crime, including child abuse, and facilitate better reporting as a trained officer could receive abuse allegation reports on site.

III. The Director should establish policies and procedures pertaining to allegations of child sexual abuse.

The Trump Administration nominee for IHS Director was confirmed by the U.S. Senate on April 21, 2020. Prior to this confirmation, the IHS did not have a Senate Confirmed Director for five years. A Director will improve oversight and promote consistent application of IHS policies across the 12 Area Offices, including child abuse reporting policies. The Director should implement uniform policy and procedures pertaining to allegations of child sexual abuse. The policy and procedures should include:

(a) Guidelines for mandatory reporting to the appropriate child protection services ***and*** law enforcement authorities (including HHS OIG).

(b) Creation of a single national child abuse hotline for reporting suspected child abuse.
(c) Implementation of a single standardized reporting format used for documenting all incidents of suspected child abuse.
(d) Implementation of a standardized annual in-person training/certification for all IHS employees and contractors.
(e) Implementation of a "Zero Tolerance" policy regarding failure to report child abuse by IHS personnel. Such policy should clearly establish that if it is administratively determined, after reasonable due process, by a preponderance of the evidence that an employee or contractor failed to properly report child abuse, then disciplinary action up to termination for the first offense will result.
(f) IHS Area Governing Boards response to reports of suspected child sexual abuse by IHS employees and contractors.
(g) Establishment of uniform process for administrative actions following an allegation of child abuse against an IHS employee or contractor to include:
    - Suspension of IHS credentials during criminal or administrative investigation; and
    - Preclusion of transfers between IHS Hospitals and Service Units during criminal or administrative investigation.
(h) Designation of every IHS employee, contractor, and volunteer as a mandatory reporter of suspected child abuse.
(i) Requirement that every IHS employee, contractor, and volunteer receive written notice, and certify receipt, of their designation as a mandatory reporter of child abuse.
(j) Mandatory posting and publication of means and methods to report suspected child abuse at IHS facilities.

IV. Withhold retiree pay and benefits for civil service employees and USPHS Commissioned Corps officers convicted of sexual exploitation crimes against children.

The Task Force recommends amending Title 5 to withhold or revoke annuity and retiree pay for retired civil service employees convicted of sexual exploitation crimes against children. Currently, annuity and retiree pay may only be withheld for specific high crimes of treason, aiding the enemy, perjury, and subordination of perjury. Expanding IHS authority to sexual exploitation crimes against children would allow the Federal government to address the pay of retirees who commit certain egregious crimes like child sexual assault during the commission of their Federal duties, on Federal property, or while otherwise using their Federal position. HHS should also have the authority to involuntarily recall a USPHS Commissioned Corps officer from retirement to

change the characterization of the officer's service from Honorable to Other than Honorable and withhold retiree pay for sexual exploitation crimes against children.

V. Designate all Federal employees, contractors, and volunteers at Federal facilities, including IHS, as mandatory reporters for reasonable suspicion of child abuse.

The Task Force recommends legislative change to create one law – and repealing existing duplicate or inconsistent laws – to require all employees, contractors, and volunteers of a Federal agency or facility and all employees, contractors, elected and appointed officials, and volunteers of a Tribe to report any suspected child abuse. It is the recommendation of the Task Force that there be legislative changes to require simultaneous reporting to both law enforcement and child welfare agencies to close the gap in reporting suspicions of child abuse.

VI. IHS should explore the viability and benefits of expanded use of telemedicine.

IHS should pursue agreements for telemedicine and improved broadband capability utilizing telemedicine more aggressively, including for mental health and adolescent psychiatry, social worker involvement, and adolescent medicine. IHS should explore telemedicine's potential use with suspected cases of child sexual abuse with regards to Sexual Abuse Nurse Examiner (SANE) exams, support of law enforcement involved in these cases, and periodic training for all IHS staff related to the issue of child abuse.

VII. Bolster recruitment and retention of quality of healthcare professionals.

The Task Force recommends parity across Federal healthcare systems, including alignment of position classification and qualification standards and use of all United States Code Title 38 authorities available to the Veterans Health Administration. The U.S. Office of Personnel Management (OPM) has authorized IHS, through HHS, to use the Title 38 provisions pertaining to pay rates and systems, premium pay, classification, and hours of work. Thus, the Task Force

recommends that IHS develop pay tables for additional positions and fund more eligible employees under Title 38 instead of the comparable authority under Title 5, subject to the availability of appropriations. Despite delegation of the aforementioned authorities, a legislative change is required to provide IHS discretionary use of all Title 38 personnel authorities, which would allow IHS to offer candidates better scheduling options and paid time off. For example, IHS is only able to offer four or six hours of annual leave accrual per pay period to new hires but could provide eight hours under Title 38. In addition to these benefits, Title 38 would allow IHS to institute a two-year probationary period for new staff and have jurisdiction over appeals for adverse actions involving professional conduct or competence pertaining to direct patient care. These authorities would enable IHS to more effectively address misconduct administratively, separate from, and in addition to, a criminal investigation.

The Task Force recommends that IHS construct additional staff quarters where housing options are limited and provide housing subsidies for staff that are able to secure housing and prefer to live off-site, subject to the availability of appropriations.

The Task Force found that the IHS loan repayment program is an effective tool to attract and retain talent. IHS could support additional qualified health professionals if provided parity with the National Health Service Corps (NHSC), specifically regarding tax treatment and service obligation requirements. To address the disparate tax treatment of IHS-funded scholarship and loan repayment awards, the Task Force recommends that the IHS Loan Repayment Program and the IHS Health Professions Scholarships be excluded from Federal taxable income under Title 25 of the Internal Revenue Code to allow the funds to be directed to additional loan repayment and scholarship awards. These programs also have a corresponding service obligation, which can act as a deterrent for providers interested in working in private practice part-time, including specialists.

The Task Force recommends that loan repayment and scholarship recipients be allowed to fulfill their service obligation on a part-time basis. The ability to provide scholarship and loan repayment awards for half-time clinical service would make these recruitment and retention tools more flexible and provide incentives for an additional pool of providers that otherwise may not consider working at IHS. The recommendation would also allow providers who are interested in management positions to devote half of their time to clinical duties and spend the other half pursing leadership opportunities.

The Task Force recommends an independent review of how Indian and veterans' preference are applied during the hiring process. Further, the Task Force recommends that IHS, in consultation with OPM, launch a pilot to apply preference only after candidates are assessed by a subject matter expert for technical competence for the position to which they are applying. The Task Force is not recommending abolishing these preferences.

Leaders who are trained, supported, and have earned the authority to make decisions would benefit IHS. A leadership training program for employees who aspire to management would build confidence, provide a professional growth opportunity, and create a successive plan for IHS agency management. Well trained and qualified management would stabilize the chain of command for IHS, which is critical to increasing morale.

Finally, the Task Force recognizes that employee morale and pride in mission are highly important factors for recruitment and retention of quality staff. Therefore, the Task Force recommends that the Director of IHS be elevated to Assistant Secretary of Indian Health within HHS. This predominately symbolic change could increase agency morale and would provide parity with the Department of the Interior, which has an Assistant Secretary for Indian Affairs. The Task Force notes that Tribes have advocated for this change for years.

VIII. Develop and implement a uniform credentialing and privileging policy.

The Task Force recommends that the IHS write a Credentialing and Privileging policy that standardizes the process for all IHS facilities. It is recommended that the structure include a centralized verification office (CVO) at the area office. In addition, the IHS should standardize the credentialing and privileging process in the Medical Staff Bylaws.

IX. The Secretary of HHS should commission an independent review of USPHS Commissioned Corps management practices within 180 days of this report.

The Task Force recommends an independent review of USPHS Commissioned Corps personnel management practices, including annual performance assessments, promotions, and discipline of Commissioned Corps officers. The Task Force additionally recommends that the Commissioned Corps Headquarters mandate the consistent and timely sharing of officer billets to allow agency supervisors to properly conduct annual assessments, and review and reconsider the practice of wearing Commission Corps uniforms at IHS facilities on or near reservations.

X. Recommend that the President task the Secretary of HHS with following up on the Task Force's recommendations, including legislative or other actions, every ninety days until implemented.