



PEACE CORPS

Office of Inspector General



Regional Medical Officer Taoufik Baddou, Senior Evaluator Erin Balch, Senior Evaluator Susan Gasper, and Peace Corps Medical Officer Amel Kane discuss the post's medical evacuation plan.

Final Program Evaluation Report

OIG Follow-Up Evaluation of Issues Identified in the 2010
Peace Corps/Morocco Assessment of Medical Care

IG-16-01-E
March 2016



PEACE CORPS Office of Inspector General

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Background

In 2009, the Office of Inspector General conducted an independent inquiry into the facts and circumstances related to the illness and death of a Peace Corps Volunteer in Morocco. As part of its inquiry, OIG reviewed the organization and care provided to Peace Corps Volunteers in Morocco. The scope of our inquiry included accountability and reporting lines, quality assurance procedures, funding and staffing levels, and professional skill levels and qualifications.

The Peace Corps has affirmed that Volunteers' health, safety, and security are the agency's top priorities. This follow-up evaluation seeks to understand to what extent actions taken in response to OIG's 10 recommendations from the 2010 report have led to improvements in clinical oversight, transfer of care, scope of practice management, quality improvement processes, sentinel event reporting, and staffing.

Objectives

We used the following researchable questions to guide our work:

- How does Peace Corps provide oversight to overseas health units?
- Is the agency meeting its standards for quality assurance?
- Is the agency meeting its standard for sentinel event reporting?
- Is the agency able to provide posts with qualified Peace Corps Medical Officers (PCMOs)? If not, what are the barriers to hiring?
- Has the agency developed a scope of practice policy? How does it oversee the scope of practice to ensure sufficient clinical oversight?
- Are Peace Corps posts adequately prepared to respond to medical emergencies?

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What We Found

Since 2010, the Peace Corps Office of Health Service (OHS) has enhanced its oversight of health units and its quality improvement program, expanded the Regional Medical Officer (RMO) model, enforced its clinical escalation policy, strengthened its chart review process, implemented a sentinel event program, developed a scope of practice policy, and launched a new electronic medical records system.

However, aspects of the Volunteer health care program needed improvement. Our review found four deficiencies in the Peace Corps' sentinel event review process: too many events were being reviewed, members of the sentinel review committee had conflicts of interest with the cases, the root cause analyses were not comprehensive, and the reviews did not result in systemic change. In addition, although staff felt prepared to respond to medical emergencies, we found gaps in medical emergency preparedness, including incomplete medical evacuation plans and non-compliance with the requirement to perform periodic medical emergency preparedness drills. Further, we assessed that country directors were unaware of all of their oversight responsibilities regarding health unit operations because relevant agency guidance was spread across multiple policies and technical guidelines.

Finally, we found that PCMOs' dissatisfaction with workload, compensation and professional development opportunities had undermined the agency's ability to retain them as staff. Unwanted turnover among PCMOs was associated with high cost and increased risk for the agency.

What We Recommend

This evaluation makes 23 recommendations to address aspects of the Volunteer health care program. The recommendations address a range of issues including the role of the RMO, agency-wide indicators of the quality of medical and mental health services, the sentinel event reporting process, medical emergency preparedness, assessments of local medical providers, guidance concerning the division of responsibilities for health unit oversight, training and use of back-up medical providers, resources and administrative support for health units, and factors that cause unwanted PCMO turnover.

EXECUTIVE SUMMARY

BACKGROUND

In 2009, the Office of Inspector General (OIG) conducted an independent inquiry into the facts and circumstances related to the illness and death of a Peace Corps Volunteer in Morocco. As part of its inquiry OIG reviewed the organization and provision of care to Peace Corps Volunteers in Morocco, including accountability and reporting lines, quality assurance procedures, funding and staffing levels, and professional skill levels and qualifications. In this follow-up evaluation we sought to understand to what extent actions taken in response to OIG's 10 recommendations from the 2010 report have led to improvements in clinical oversight, transfer of care, scope of practice management, quality improvement processes, sentinel event reporting¹, and staffing.

RESULTS IN BRIEF

The agency has affirmed that Volunteers' "health, safety, and security are the Peace Corps' top priorities." Since 2010, the Peace Corps Office of Health Service (OHS) has improved its oversight of health units and its quality improvement program. Specifically, OHS has expanded the Regional Medical Officer (RMO) model², enforced its clinical escalation policy³, strengthened its chart review process, implemented a sentinel event program, and developed a scope of practice policy. Most recently, in the summer of 2015, OHS launched a new electronic medical records system.

However, our evaluation found that aspects of the agency's Volunteer health care program needed improvement. For instance, the agency's sentinel event reporting process had not had the intended effect of identifying and addressing root causes of negative outcomes. Root cause analyses were not comprehensive, members of the sentinel event review committee often had conflicts of interest with the cases being reviewed, and OHS was selecting too many cases for root cause analysis which impaired the effectiveness of the process.

While staff believed that they were well prepared to respond to medical emergencies, we found gaps in medical emergency preparedness practices, including incomplete medical evacuation plans. Peace Corps medical officers (PCMOs) were not assessing local medical facilities frequently enough, nor were staff carrying out medical emergency preparedness drills as required by policy. Without having assessed medical facilities throughout the country, posts were less prepared to respond to a medical emergency and could lose valuable time figuring out where to send Volunteers in the event of an emergency. Lacking complete and comprehensive medevac plans, health unit staff at some posts may not be aware of all of the requirements in case of a

¹ Peace Corps defines a sentinel event as "an unexpected occurrence involving death, serious physical or psychological injury, or a significant risk thereof in a Peace Corps Volunteer or a Returned Peace Corps Volunteer whose event was related to their Peace Corps service.

² Regional Medical Officers are regionally-based OHS staff who manage regional medevacs and provide clinical consults to Peace Corps medical officers in their regions.

³ Peace Corps' clinical escalation policy, outlined in TG 212, requires PCMOs to immediately inform OHS (and RMOs by extension) of any Volunteer who has a significant illness.

medevac. And by not regularly conducting medical emergency drills, posts may not be prepared to respond efficiently and appropriately to an actual emergency. In addition, we found that overseas health units that had experienced PCMO turnover and staffing gaps were not consistently transferring information to each other on Volunteer care, increasing the risk to Volunteer health and safety.

Oversight of health unit operations was shared between OHS and country directors (CDs), but CDs were not always aware of their oversight responsibilities, and relevant agency guidance was spread across multiple policies and technical guidelines. When country directors are unaware of all of their oversight responsibilities, the agency cannot ensure that critical tasks, such as emergency medevac plans and local facility/provider assessments, have been completed. Furthermore, the RMOs did not have clearly defined responsibilities related to PCMO supervision, including conducting performance reviews of PCMOs in their sub regions. As a result, the intended benefit of employing RMOs to enhance the agency's oversight capability had not been fully realized.

In addition, the agency had not provided sufficient resources and support to ensure that the full range of PCMO and RMO job responsibilities could be fulfilled effectively and efficiently. Finally, we found that PCMO morale had been negatively impacted by perceived low compensation, lack of professional development opportunities, high workload, and unsatisfactory collaboration and communication between overseas health units and administrative units.

RECOMMENDATIONS

In total our report contains 23 recommendations, which, if implemented, should strengthen the agency's ability to provide Volunteers with quality medical care.

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BACKGROUND OF FOLLOW-UP EVALUATION

This report addresses whether recommendations OIG made in its [Peace Corps/Morocco Assessment of Medical Care \(February 2010\)](#) have had the intended effects. OIG produced that report after former Peace Corps Director Aaron Williams requested that OIG conduct an independent inquiry into the facts and circumstances related to the illness and death of a Peace Corps Volunteer in Morocco. As part of its inquiry OIG reviewed the organization and provision of health care to Peace Corps Volunteers in Morocco, including accountability and reporting lines, quality assurance procedures, funding and staffing levels, and professional skill levels and qualifications. OIG provided the agency with two reports based on its work in Morocco. One internal report addressed the facts and circumstances relating specifically to the death of the Volunteer and the provided health care. The other report contained OIG's findings and recommendations specific to the health care program in Peace Corps/Morocco as well as findings and recommendations intended to address systemic challenges in the agency's health care program worldwide.

Because it is important for the reader of this report to understand the main findings and recommendations in that February 2010 report, we have provided key paragraphs from the executive summary.

Excerpts from the Executive Summary of Peace Corps/Morocco Assessment of Medical Care (February 2010)⁴

The OIG . . . identified possible contributing factors including PC/Morocco medical unit's sizeable workload, questionable organization of case management and dissemination of duties, and the lack of an effective mechanism to ensure that a PCMO is practicing within his or her scope of practice.

Because of the way in which the Peace Corps is organized, much is left to the professional judgment of the PCMO to support Volunteer medical needs. It is the medical officer's decision to determine whether: (1) a Volunteer can be effectively assisted over the phone at his or her site; (2) should be evaluated or treated by a local provider; (3) must be seen in person by a PCMO to be evaluated or treated; or (4) must be medically-evacuated. This requires that Peace Corps hires medical officers who not only are professionally competent and can determine when a Volunteer is in trouble, but also understand the resources available in country in relation to Volunteers' sites.

We determined that there was minimal clinical oversight of PCMOs in Morocco and that the way in which the Office of Medical Services (OMS) measured and monitored the quality of health care provided to Volunteers was insufficient. The standard assessments currently conducted by the OMS did not, and would not, identify the issues raised with [the Volunteer's] medical care. The current assessments do not identify communication failures, ineffective teamwork and collaboration, or ensure that a practitioner is practicing within his or her scope of practice. There is no direct observation of clinical skills or measurement of clinical outcomes in typical reviews.

⁴ The excerpt was edited to protect the identity of the Volunteer.

The 2010 Peace Corps/Morocco Assessment of Medical Care report included 10 recommendations intended to: improve the agency's ability to provide clinical oversight of its overseas health units; ensure overall quality and accountability; establish a scope of practice policy for PCMOs with different training and clinical credentials and oversee adherence to the policy; and institute a sentinel event reporting policy. These recommendations will be referenced throughout this report. For more information on the current status of those 10 recommendations from the 2010 report, please see Appendix D.

On April 10, 2015, the OIG announced its intent to conduct a follow-up evaluation of the Peace Corps/Morocco Assessment of Medical Care. We used the following researchable questions to guide our work:

- How does Peace Corps provide oversight to overseas health units?
- Is the agency meeting its standards for quality assurance?
- Is the agency meeting its standard for sentinel event reporting?
- Is the agency able to provide posts with qualified PCMOs? If not, what are the barriers to hiring?
- Has the agency developed a scope of practice policy? How does it oversee the scope of practice to ensure sufficient clinical oversight?
- Are Peace Corps posts adequately prepared to respond to medical emergencies?

The evaluation team conducted the fieldwork and analysis for this evaluation from April 2015 to October 2015. This research included interviewing headquarters staff; traveling to nine posts to conduct interviews and a medical emergency tabletop exercise; and conducting a survey of all PCMOs as well as a survey of all Volunteers at the nine posts we visited.

OVERVIEW OF VOLUNTEER HEALTH CARE

Since Peace Corps' inception in 1961, Volunteer health care has been a top priority for the agency. The Peace Corps Act requires that Volunteers receive health care during their service, which includes "all appropriate examinations, preventive, curative, and restorative health and medical care."

As part of the Peace Corps Volunteer health program, the agency has in-country health units (hereafter referred to as "the health unit") that provide all necessary and appropriate medical care to Volunteers and trainees throughout their service. The health units are responsible for implementing the agency's Volunteer health program at posts. According to the agency's technical guidelines the core functions of the in-country Volunteer health program are to:

- Support Volunteers in assuming responsibility for their own health,
- Promote the health of Volunteers and prevent disease,
- Provide health services to Volunteers overseas in as safe, efficient, and as timely a manner as possible within the particular host-country environment, and

- Provide medical evacuation (medevac) to Volunteers who require medical care beyond the care available in-country.

POST HEALTH UNITS

Each overseas office of Peace Corps has a health unit staffed by at least one Peace Corps medical officer (PCMO) who serves as the primary medical clinician for Volunteers. PCMOs are responsible for assessing, diagnosing, providing clinical care, and documenting Volunteers' physical and mental health conditions. PCMOs also establish and maintain an in-country network of health care providers who provide additional health care services to Volunteers, if necessary. Furthermore, PCMOs manage the health unit, provide health education and training for Volunteers and trainees in the country, and participate in OHS's quality improvement processes.

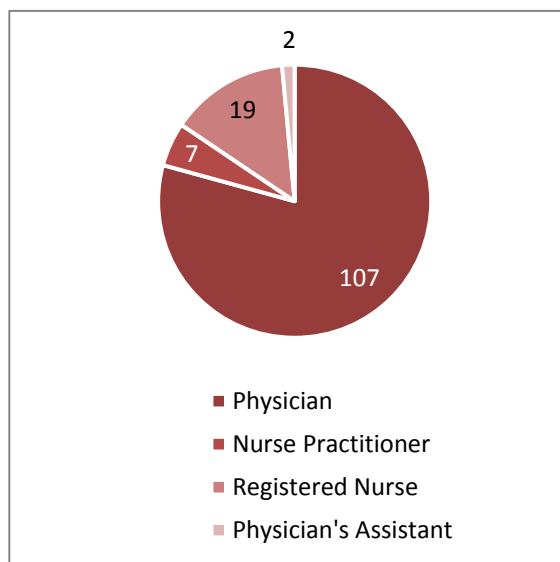


Figure 1. PCMOs by Medical Credentials. Total=135.
Source: PCMO roster as of August 30, 2015.

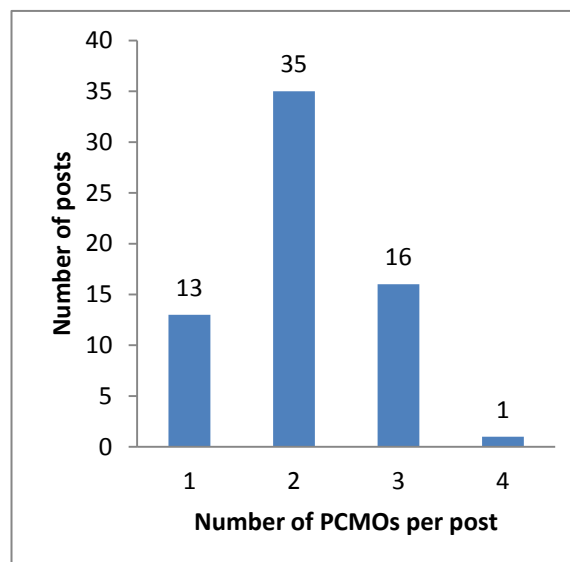


Figure 2. Number of PCMOs at posts.
Source: PCMO roster as of August 30, 2015.

A PCMO may be a trained physician, nurse practitioner, registered nurse, or physician's assistant. Figure 1 outlines the professional qualifications of the 135 PCMOs at the time of fieldwork. Figure 2 shows how many posts have between one and four PCMOs.

In addition to PCMOs, Peace Corps also staffs post health units with medical assistants (MAs) and/or medical secretaries. Medical assistants and secretaries provide management and administrative support to the health unit. Their responsibilities can include medical supply inventory, assisting with pre-service training materials, and other duties. In addition, medical assistants can accompany Volunteers to consultations with local providers and sterilize some medical equipment. As of August 2015, there were 33 medical assistants and 35 medical secretaries.

The agency determines the number and configuration of staff for each Peace Corps health unit depending on a variety of factors, including:

- Health care system available to Volunteers in the country,

- Peace Corps' experience in the country responding to endemic diseases, serious illnesses, medical evacuations, and environmental hazards,
- Transportation infrastructure in the country, and
- Medical profiles of Volunteers in the country.

The country director at each post oversees the non-clinical responsibilities of the health units including daily management and routine administrative matters.

OFFICE OF HEALTH SERVICES

The Office of Health Services (OHS) is responsible for providing and maintaining a healthy Volunteer population through the implementation of a comprehensive, accountable, and quality Volunteer health program. OHS consists of seven units: the Office of Medical Services, Epidemiology unit, PCMO Support unit, Quality Improvement unit, Financial and Resources Management unit,⁵ Health Informatics unit,⁶ and the Counseling and Outreach unit.

Since the issuance of our 2010 evaluation report OHS has implemented a number of activities to ensure that PCMOs provide Volunteers with quality medical care. Quality improvement initiatives include: chart reviews, OHS site assessments, the quality nurse line, sentinel and unusual events reporting and medical site visits. These are summarized below.

Chart Reviews. To help ensure that PCMOs are providing Volunteers with quality medical care and that PCMOs are properly documenting their clinical interactions, technical guideline (TG) 113 "Clinical Documentation Standards" requires PCMOs to select 10 charts to submit to OHS for review every three months. Charts are typically reviewed by the quality improvement nurses and RMOs and given a score of 'Excellent,' 'Meets Standards,' or 'Needs Improvement.' After PCMOs consistently score 'Excellent' for four consecutive submissions, OHS only requires chart submissions twice a year. If a PCMO receives a 'Needs Improvement' score, OHS may require the PCMO to submit charts every two weeks until the charts improve. According to OHS's standard operating procedures, if a PCMO's score does not improve by the end of four months, the chief of quality improvement and clinical director will determine if escalation is necessary.

OHS Site Assessments. OHS policy is to conduct site visits of overseas health units at least every three years to assess the health unit. The Quality Improvement unit, PCMO Support unit, Field Support unit, physicians, and RMOs share the assessment responsibilities. So that all site assessments are conducted consistently, OHS has a checklist of items to be assessed which it regularly updates. The OHS staff who conducts the assessment develops a report with recommendations related to observed weaknesses at the health unit.

Quality Nurse Line. The quality nurse line is an email where Volunteers and Returned Peace Corps Volunteers can submit concerns to OHS regarding their medical care. The quality nurse replies directly to the Volunteer and may also take other follow-up steps depending on the nature of the concern.

⁵ The Financial and Resources management unit supports the administrative needs for OHS.

⁶ The Health Informatics unit develops, manages, and supports the health information systems for OHS; establishes and controls who accesses the systems; and provides the training to and accreditation of all users.

Sentinel Events Reporting. TG 167 “Sentinel Event Procedure” defines a sentinel event as “an unexpected occurrence involving death, serious physical or psychological injury, or a significant risk thereof in a Peace Corps Volunteer or a Returned Peace Corps Volunteer whose event was related to their Peace Corps service.” Since the inception of the sentinel event policy in 2011, 98 sentinel events have been submitted to OHS. See Table 1 for a breakdown of the types of sentinel events. The agency has a sentinel event committee that conducts root cause analyses (RCA) for selected sentinel events. An RCA is an assessment process for understanding the circumstances that led to a poor outcome and to identify changes that may prevent the same negative outcome in the future.

Table 1. Percentage of Sentinel Events

Type of Sentinel Event	Percentage (%)
Mental Health Admit	38
Serious medical emergency	31
Medical Evacuation	13
Volunteer Death	11
HIV Infection	5
Malaria	2

Source: OHS sentinel event documentation since policy inception in 2011

Unusual Events Reporting. In addition to TG 167, “Sentinel Event Procedure,” Peace Corps developed TG 168 on unusual event reporting. Unusual events reports are supposed to identify incidents that could result in Volunteer injury or any deviation from policies. While TG 168 does not contain a clear definition of what constitutes an unusual event, the unusual event reporting form lists the following types of incidents: delay in care, breach of confidentiality, documentation issue, Volunteer injury, medication error, safety/infection control, orders not completed and clinical care issues. Since the inception of the unusual event policy in 2011 through April, 2015, there have been a total of 95 reported unusual events.

Medical Site Visits. According to the *New PCMO Manual*,⁷ “An official visit to a prospective or active Volunteer site by . . . the PCMO is called a ‘medical site visit’ and is highly encouraged of the PCMO.” Medical site visits provide PCMOs an opportunity to assess living conditions and Volunteers’ mental health; better understand Volunteer life, determine distance to their nearest local medical facility; and develop a closer relationship with Volunteers.

REGIONAL MEDICAL OFFICERS

OHS has three regional medical hubs, located in Morocco, South Africa, and Thailand. The agency selected the three posts to be regional medical support hubs based on the quality of health care and infrastructure in the country, time zone, and the relative ease of travel from neighboring Peace Corps countries. The medical hubs are each staffed by two Regional Medical Officers (RMOs) who manage regional medevacs and provide clinical consults to PCMOs in their regions. According to the *New PCMO Manual*:

⁷ The *New PCMO Manual* is a handbook designed to help new PCMOs understand the many elements of the position.

RMOs make periodic visits to posts and work with PCMOs and CDs on all aspects of the Volunteer health system. They assist with the management and operation of the Health Unit including: hiring and training of new medical staff including PCMOs, completing performance evaluations for PCMOs, identifying local resources, identifying health and safety risks, and assisting with health education and training. The RMOs have general clinical oversight of their assigned Health Units and provide clinical care, counseling, and consultation to Volunteers as requested by PCMOs. Lastly the RMOs conduct official site visits to their assigned post every three years. RMOs are hired by Office of Health Services/Office of Medical Services (OHS/OMS) and have a joint responsibility to the Region and Office of Health Services (OHS).

Prior to 2010, OHS employed direct-hire U.S. citizens as area Peace Corps medical officers (APCMOs) to provide consultative support to PCMOs and manage regional medical evacuation hubs. As a response to the OIG recommendation to “provide more direct oversight of PCMOs and encourage a mentoring model in support of commitment to quality assurance,” OHS renamed the position “regional medical officer” and increased the number of RMOs.

The agency did not maintain RMOs for its posts in the Americas or Eastern Europe. OHS determined that Volunteers in these regions could be evacuated relatively easily to the United States or Western Europe if necessary. At the time of the evaluation, PC/Panama received some medevacs from Central and South America and supported those medevacs with a locally-based medical evacuation assistant. For a list of posts in each RMO sub region, see Appendix E.

SECTION A: RESPONSES TO 2010 RECOMMENDATIONS

We sought to understand to what extent actions taken in response to OIG’s 10 recommendations from the 2010 report have led to improvements in clinical oversight, transfer of care, scope of practice management, quality improvement processes, sentinel event reporting, and staffing.

Clinical oversight has become more robust since the death of a Volunteer in Morocco in 2009 and the subsequent OIG evaluation of health services. Specifically, OHS increased the number of headquarters positions and RMOs, developed and updated several policies, and provided multiple trainings to PCMOs. Additionally, in the summer of 2015 OHS launched a new electronic medical records management system.

Clinical oversight has become more robust since the death of a Volunteer in Morocco in 2009.

AREAS WITH NO SIGNIFICANT CONCERNS

Our evaluation found no significant concerns with the following aspects of the agency’s actions to implement recommendations made in the 2010 report. Specifically, we assessed that the Peace Corps health care program improved in the following areas.

Additional RMOs had a positive impact on clinical oversight and emergency response capabilities.

The placement of more RMOs overseas improved the agency's clinical oversight of overseas health units. Staff we interviewed reported that having RMOs based regionally reduced time zone differences and facilitated communication between OHS and posts, which was particularly advantageous in medical emergencies. PCMOs expressed to us that they reported to their RMOs according to the agency's clinical escalation policy, and that they communicated and consulted regularly with their RMOs to ask questions and seek advice when necessary concerning treatment of Volunteers.

OHS site assessments were conducted according to standards.

For the posts we visited, OHS generally met its goal to conduct site visits at least every three years. The posts we examined had received a site assessment per OHS's desired schedule. Guidance used by OHS staff to conduct site visits was clear and regularly updated. Eighty-nine percent of PCMOs we surveyed reported that the site assessments by RMOs or OHS had been effective in supporting quality improvement at their post. Furthermore, we found that OHS had a reliable process for tracking the status of recommendations that had resulted from each site assessment.

The clinical escalation policy functioned as intended.

In the 2010 Peace Corps/Morocco Assessment of Medical care, OIG found that the PCMOs responsible for the Volunteer's care did not notify OHS about the Volunteer's deteriorating medical condition until less than one hour before the Volunteer died. This led OIG to recommend that OMS define a clinical escalation policy. In response the agency developed TG 212 "Clinical Escalation Policy." This guidance requires PCMOs to immediately inform OHS (and RMOs by extension of any Volunteer who has a significant illness. TG 370 further requires PCMOs to send field consults to OMS regarding "any clinical situation that requires information, resources or expertise that exceeds the training, skills, and qualifications of the PCMO and local consultants."

We found that PCMOs adhered to the clinical escalation policy, and that non-adherence to the policy was enforced by OHS. OHS terminated the employment of several PCMOs who had not properly notified OHS concerning a health-related incident that should have been reported per the escalation policy.

PCMOs appreciated the mentoring program.

The OHS mentoring program provided needed support to newly hired PCMOs. When unable to send personnel to post for in-person mentoring, OHS assigned existing PCMOs or RMOs to mentor newly hired PCMOs. PCMOs reported they were satisfied with the mentoring programing.

The scope of practice policy provided helpful guidance for registered nurse PCMOs.

The scope of practice policy had the intended effect of ensuring PCMOs worked within the limits of their clinical credentials, particularly registered nurse PCMOs. OHS exercised oversight for nurses' scope of practice through the Community Health Assessment Manual, and nurses we interviewed expressed an appreciation for the availability of clear guidance.

FINDINGS AND RECOMMENDATIONS IN RESPONSE TO 2010 RECOMMENDATIONS

The RMOs did not have clearly defined responsibilities related to PCMO supervision, including conducting performance reviews of PCMOs in their sub regions.

As former PCMOs who have been promoted, RMOs are some of the most skilled and experienced medical doctors working for Peace Corps. However, the agency had not fully provided RMOs with the supervisory authority to effectively fulfill their responsibilities. According to their contracts, RMOs were responsible for supervising the performance of PCMOs in their sub regions and completing performance evaluations, as required. TG 112 further states that RMOs should “provide observations and feedback to OHS and the CD on PCMO performance.”

OHS had not consistently sought RMO input when completing PCMO performance evaluations.

Despite their job requirements, RMOs were not identified as a supervisor on PCMO contracts and did not have any authority to remove PCMOs from their positions. Furthermore, RMOs reported that OHS had not consistently sought their input when completing PCMO performance evaluations. RMOs each evaluated between six and nine PCMOs in their region; other staff members in OHS completed the evaluations for the remainder of PCMOs in the RMO’s region. To ensure that evaluators had a comprehensive understanding of each PCMO’s performance, OHS maintained a spreadsheet to gather input from staff members in different OHS units. However, there was

no place to gather RMO input on the spreadsheet.

RMOs reported that OHS had not prioritized giving them supervisory responsibilities and authority. One RMO stated, “We are a little bit in no-man’s land. Not part of post, but not part of OHS . . . No one is thinking about policies for us.” Another RMO expressed that the position had not been fully developed and that there were “not really strict borders around the RMO position.”

Without the authority to handle issues with PCMOs, potential problems can go unresolved and the intended benefit of employing RMOs to enhance the agency’s oversight capability is missed. RMOs have in-depth knowledge of PCMO performance and often have the most interaction with PCMOs; however, they do not have the ability to take corrective actions on PCMO performance. In the past, OHS was slow to respond when concerns about performance were raised by an RMO. Without sufficient authority over PCMOs in their sub regions, RMOs’ site assessment recommendations may be viewed by PCMOs as suggestions rather than requirements.

We recommend:

- 1. That the associate director of the Office of Health Services clarify the regional medical officers’ roles and responsibilities regarding the oversight and supervision of Peace Corps medical officers.**

The chart review process had improved, but weaknesses remained.

In the 2010 Peace Corps/Morocco Assessment of Medical care OIG recommended “that OMS assess ways to increase clinical supervision of PCMOs, in accordance with American standards, and work with Global Operations to implement the needed changes.” In response OHS took steps to improve clinical supervision, including strengthening a quarterly chart review process. According to staff from the Quality Improvement Unit, “At first we didn’t really have a review process at all. We went from nothing to a more clinical-based system of review.” Since April 2013, the Quality Improvement Unit has reviewed submitted charts using a stricter scoring process. While this led to a marked decrease in the average chart score, it allowed OHS to focus efforts on PCMOs that were not meeting Peace Corps’ standards.

A number of PCMOs said they would appreciate more clinical feedback in the chart review process.

PCMOs reported that they received consistent feedback through the chart review process, yet they also reported that the chart review process had not yielded much useful feedback on their clinical decisions. They reported that the feedback was directed at chart completeness and not the quality of clinical decisions. A number of PCMOs said that they would appreciate more clinical feedback in the chart review process:

[OHS] should focus more on the clinical aspect of [the chart review process], but it’s more a question of how thoroughly we filled in the blanks. The focus is not in the right area. I forgot to cross the ‘t’s and dot the ‘i’s, but I don’t get points for the good clinical decisions.

When I fill out the chart review we don’t get medical review, we get [a] documentation review. It would be more helpful to get feedback on clinical decisions.

According to OHS, the agency has emphasized documentation thoroughness because many PCMOs, particularly non-Americans, were not familiar with Peace Corps or U.S.-based standards for medical charting. OHS had to first focus on training PCMOs on the agency’s clinical documentation standards. One OHS staff member who reviews charts stated, “Four to five years ago it was ‘did you sign your name to the chart?’ There wasn’t much attention paid to the quality of care.” As PCMOs become more comfortable with Peace Corps’ charting standards in the future, OHS senior staff reported hopes to focus more on clinical care. Several OHS staff stated that the process is “evolving to where it needs to be.”

Another reason that PCMOs were not receiving substantive feedback was the limited availability of OHS staff to review charts. Five people in OHS were responsible for reviewing charts, in addition to their other duties. According to one staff member, it took three to four hours to review one PCMO’s 10 medical records. We estimated that from April 2014 to March 2015, OHS staff involved in chart reviews each spent roughly 50 hours per quarter reviewing PCMO charts. One OHS staff member explained, “As we have more staff, we can focus on clinical issues.”

As a result, many PCMOs reported that the chart review process had limited value. They perceived it to be an administrative, paperwork task rather than an important part of clinical care due to the lack of substantive clinical feedback. In our survey of all PCMOs, 26 percent of PCMOs reported that the chart review process was ineffective in terms of supporting quality improvement. Furthermore, we found that PCMOs who felt the chart review process was ineffective were three times less likely to have a good morale.

Even with the strengthening of the quarterly chart review process, OIG has identified instances of lapses in PCMO documentation of patient information. For example, during this review we learned that a former PCMO failed to document a Volunteer's severe reoccurring health incident. A TDY PCMO only became aware that the Volunteer's health had been at risk when the Volunteer experienced another health scare.

To ensure that PCMOs are aware of Peace Corps' record and documentation standards, OHS has developed several technical guidelines for PCMOs related to clinical documentation, including:

- TG113, which "establish[es] clinical documentation standards which assure accuracy, timeliness, and quality in the recording of clinical data and the provision of care."
- TG 210, which "provides information concerning the format, organization, records management, and documentation of the Peace Corps health record."

In addition, the Quality Improvement Unit of OHS provides refresher trainings at annual continuing medical education conferences for PCMOs.

After we conducted our fieldwork, OHS implemented changes to the chart review process that could mitigate some of the weaknesses we identified. OHS began the transition to PCMEDICS, a global electronic medical records system. PCMOs and OHS staff members thought that PCMEDICS would allow OHS to review charts at any time without requiring PCMOs to scan and submit paper-based charts, a tedious and time-consuming task. Furthermore, in September 2015 OHS switched to a weighted chart review process to place more emphasis on the quality of clinical decisions. This change should mitigate the perception among PCMOs that the chart review process did not generate useful clinical feedback.

Due to existing training and recent changes made, we are not issuing a recommendation to improve the chart review process as the result of this review.

Overseas health units that had experienced PCMO turnover and staffing gaps were not consistently transferring information to each other on Volunteer care.

In the 2010 Peace Corps/Morocco Assessment of Medical Care, OIG found that Peace Corps did not have a clear policy on transferring patient information when there is a transfer of care. There was a lack of clear policies from OHS about when and what PCMOs should communicate with one another. In addition, chart documentation was not consistently complete, and PCMOs were not always able to review Volunteers' charts before attending to them due to incomplete information, or if a call from a Volunteer was received outside work hours.

Since that time, the agency has created additional guidance intended to improve the continuity of Volunteer care. OHS developed TG 113 “Clinical Documentation Standards” to establish standards for recording clinical data and provision of care. In addition, TG 216 “Telephone Triage” requires PCMOs to capture each communication with Volunteers in a daily call log that is to be used during working and non-working hours. PCMOs also are expected to have “morning meetings” as a means to transfer patient information between providers. While OHS trains PCMOs on the importance of these meetings, there is no policy requiring PCMOs to hold morning meetings.

Of the nine posts visited, posts with PCMO turnover in the past year also received the most complaints by Volunteers concerning ineffective transfer of care information.

Most health units we visited had regular morning meetings where PCMOs consulted with each other. However we found that PCMO turnover and related health unit staffing gaps—which OHS had often filled by rotating temporary PCMOs to health units—had negatively affected the continuity of Volunteer care. Of the nine posts we visited, those that had experienced PCMO turnover in the past year had also received the most complaints by Volunteers concerning ineffective transfer of care information among PCMOs in the health unit. One Volunteer explained, “These past few months, with an ever-changing string of PCMOs, things are bound to get muddled and lost between PCMOs from week to week. Personally, I feel that some information was lost, not conveyed, [and] misconstrued.”

Prior to the creation of the new Peace Corps’ electronic medical records system through PCMEDICS, temporary duty (TDY) PCMOs were unable to familiarize themselves with Volunteer records until they arrived at post and had access to the paper charts. Furthermore, since TDY PCMOs did not always overlap at post, many had to depend on the previous PCMO’s efforts to document Volunteer interactions and provide notes on the Volunteers who required followed-up care. Poor documentation and transfer of patient information puts Volunteers health and safety at risk, in particular at posts that experience PCMO turnover and staffing gaps.

We recommend:

- 2. That the associate director of the Office of Health Services develop and provide guidance on the transfer of care between Peace Corps Medical Officers, TDY providers, and backup providers to facilitate continuity of care for Volunteers.**

The agency's performance indicator did not reflect the quality of Volunteer medical and mental health services.

In the 2010 Peace Corps/Morocco Assessment of Medical Care, OIG found that the agency's performance indicators for its goal to "provide quality medical and mental health services to trainees and Volunteers" were only measured by Volunteer satisfaction ratings. Volunteers may rate their satisfaction with medical and mental health support provided to them based on factors unrelated to the quality of health care provided by Peace Corps. Furthermore, Volunteer "satisfaction" with medical and mental health services did not shed light on important aspects of health unit operations like medical emergency preparedness, clinical documentation, health unit communication, local provider relationships, and PCMO medical knowledge and experience. For these reasons OIG concluded that Volunteer satisfaction was not a reliable and useful indicator of the quality of health care provided and recommended that the agency determine more appropriate indicators of quality of medical and mental health services provided to Volunteers.

Our evaluation assessed that the agency continued to rely too heavily on Volunteer satisfaction ratings as a basis for tracking its performance: thirty-five percent of the performance goals in Peace Corps' FY 2014-2018 Strategic Plan were measured using Annual Volunteer Survey (AVS) responses that captured Volunteer satisfaction ratings. For its first strategic objective, "Volunteer Well-Being: Enhance the safety, security and health of Volunteers through rigorous prevention and response systems and high quality medical and mental health services," the agency was using AVS responses as the basis for determining how well it had met its performance goal 1.2: "Reduce the percentage of Volunteers 'dissatisfied' or 'very dissatisfied' with medical and mental health support to 7.0 percent by FY 2016."

The Peace Corps continued to rely too heavily on Volunteer satisfaction ratings as a basis for tracking its performance.

Senior members of OHS stated that they wanted to change the current approach to assessing performance under the Volunteer well-being goal. OHS has planned for a future version of PCMEDICS that, if funded, will provide the agency with a data library that would combine and organize information from a variety of sources, as well as a predictive analytics system to anticipate and better understand Volunteers' needs.

By relying excessively on Volunteer survey responses that express dissatisfaction with medical and mental health services, the agency did not gather alternative information that could shed more light on specific aspects of its medical and mental health operations and functions. Additionally, by relying so heavily on Volunteer satisfaction as a basis for measuring its performance, staff (including PCMOs) may feel unnecessary pressure to provide care to a Volunteer that the Volunteer prefers, rather than (or in addition to) care that the PCMO has determined is needed based on his or her qualified assessment of the Volunteer's condition. PCMOs and OHS should not fear that the quality of Volunteer medical care will be judged solely on the basis of AVS results.

In short, we found that the recommendation OIG made in the 2010 Peace Corps/Morocco Assessment of Medical Care did not have the intended effect. The agency should reconsider its approach and develop additional performance goals and indicators of Volunteer medical and mental health services. By funding the collection of data necessary for administering a robust quality improvement program, the agency will gain a more reliable understanding of its performance related to providing medical care and promoting Volunteer well-being.

We recommend:

- 3. That the associate director of the Office of Health Services determine appropriate indicators—in addition to Volunteer satisfaction data obtained through the annual Volunteer survey—of the quality of Volunteer medical and mental health services and incorporate them into future strategic plans.**
- 4. That the Director analyze, prioritize and plan for the resources necessary to measure and track the identified indicators of the quality of Volunteer medical and health services.**

Volunteers and trainees were not consistently aware of the quality nurse line.

To promote the quality nurse line, OHS developed two posters for health units to display, as well as business cards that posts are asked to pass out during pre-service training. Each promotional product contains the quality nurse line’s mission statement and contact email. According to TG 302 “Volunteer Concerns,” posts are required to display “the headquarters quality improvement email address and instructions on how to file a concern.” In addition, CDs are asked to send reminders about the quality nurse line in their emails to Volunteers and reference the quality nurse line in the Volunteer handbooks. During our fieldwork we confirmed that eight of nine posts we visited had displayed information about the quality nurse line as required, and country directors had made efforts to promote awareness of the quality nurse line. Many staff we interviewed expressed appreciation for availability of the quality nurse line, reporting that it was an effective mechanism for Volunteers to express dissatisfaction with their medical care and



possibly get a second opinion. Furthermore, when used well, the quality nurse line relieved country directors of the burden of responding to Volunteer medical complaints.

However, our survey of Volunteers and trainees indicated that 61 percent claimed to have never heard of the quality nurse line. This appeared to be due to inconsistent promotion of the quality nurse line by PCMOs. While some PCMOs told us that they appreciated the presence of the quality nurse line, others viewed it as a mechanism that could essentially “get them into trouble.” One PCMO believed that by

advertising the quality nurse line a PCMO would send the message to Volunteers that they may not be receiving quality medical care, and that Volunteers could lose confidence in the PCMO as a result.

Due to the high percentage of Volunteers and trainees who were unaware of the quality nurse line, quality issues may not have been consistently reported to OHS. For example, a number of the respondents to the Volunteer survey who indicated that they wanted to report quality concerns to the OIG were not aware that they could report those concerns to the quality nurse line. Without reliable reporting to the quality nurse line, OHS may be unaware of the need to improve the quality of care at particular overseas health units or in certain areas of care that may be affecting Volunteers in multiple countries. OHS should explore new ways to more effectively raise Volunteer awareness of the Quality Nurse Line, for example, encouraging Peace Corps medical officers to add contact information for the Quality Nurse in their email signatures, and/or sending the contact information periodically via text message to Volunteers.

We recommend:

- 5. That the associate director of the Office of Global Operations and the associate director of the Office of Health Services explore new ways to raise Volunteer and trainee awareness of the Quality Nurse line.**

The agency's sentinel event policy has not had the intended effect.

OHS implemented a sentinel event policy after the 2010 Peace Corps/Morocco Assessment of Medical Care recommended that the agency develop a sentinel event policy.

The agency's technical guidance 167 "Sentinel Event Procedure" uses root cause analysis (RCA) to identify basic and causal factors that led to an unfortunate and unexpected outcome. The RCA is a means to learn from an event and introduce changes that would prevent the same negative outcome in the future. OIG relied on the expertise of two physician inspectors, including one expert in root cause analysis, from the U.S. Department of Veteran's Affairs Office of Inspector General to assess whether the agency's sentinel event process was having the intended effect.⁸ The experts evaluated the components of each root cause analysis Peace Corps had done, and assessed whether the following elements were included:

- The sentinel event team was identified.
- The timeline of the incident was documented.
- The root cause(s) of the sentinel event were identified.
- The action plan(s) in response to the sentinel event were developed.
- The action plan(s) addressed the root cause.
- The root causal statements were written.

⁸ The expert in root cause analysis evaluated a sample of 30 sentinel events, 18 of which had undergone a root cause analysis by the Peace Corps' sentinel event committee.

- The action plan had a stated measure.
- There was delineation of what constituted a successful measure.
- There was a stated date of implementation of the action plan.

The experts' review of sentinel events found four deficiencies in the Peace Corps' sentinel event process: too many events were being reviewed, members of the sentinel review committee had conflicts of interest with the cases, the root cause analyses were not comprehensive, and the reviews did not result in systemic change.

Too many events were considered sentinel to be reviewed by OHS effectively.

OIG's external experts determined that the agency required a more thorough screening process to ensure that its sentinel event committee was not selecting too many cases for a root cause analysis, or missing cases that would have been appropriate to consider. Staff described problems with the way that current policy automatically categorized certain negative health outcomes as sentinel events (e.g. malaria, cancer, HIV infection). By instituting an initial screening process, the sentinel event committee could avoid selecting too many cases, and could identify those cases most appropriate for an RCA.

Sentinel event committee members often had conflicts of interest.

One of the key elements of a root cause analysis is that team members first, should be chosen based on expertise required by the case, and second, should have no conflict of interest resulting from direct involvement in the case(s) under review. Peace Corps OHS staff acknowledged that "not infrequently, people [involved in the sentinel event review] know the case." We found that the OHS staff assigned to review sentinel events often had been involved in the case as part of their clinical oversight responsibilities, and therefore had a conflict of interest.

Critical components of the root cause analyses were missing and insufficient.

For each case that had been identified as needing a root cause analysis, the agency had developed a thorough timeline of events in the case that provided team members with sufficient information to be able to conduct a root cause analysis. However OIG external experts concluded that many of the components of a root cause analysis that should have been present were missing for most of the cases they reviewed (see Figure 3).

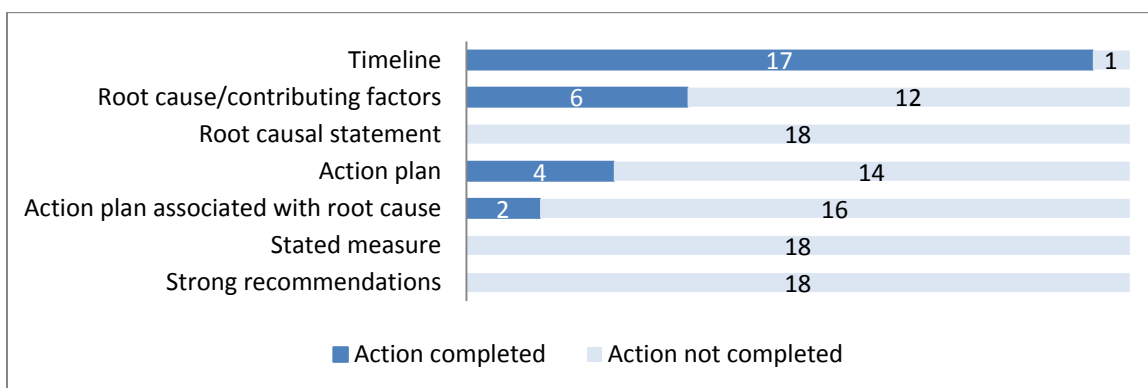


Figure 3. Number of completed components in the 18 root cause analyses conducted in a sample of 30 sentinel events.

Source: Expert Analysis

Root causal statements should be based on the fact finding by team members who have identified contributing factors such as poor communication, fatigue, equipment malfunction, environmental concerns, procedural/policy breaches, and/or failure of safeguards. Root causal statements serve as the basis for recommending action plans. Two-thirds of the sentinel events that had undergone a root cause analysis did not identify root causes or contributing factors. Of the six analyses that identified contributing factors, none included a root causal statement to clearly identify the problem that contributed to the event (i.e. the cause and effect).

OIG's experts also assessed that most analyses did not address each event in the documented sentinel event timeline, as required. Furthermore, only four out of the 18 root cause analyses in the sample included an action plan, and just two out of the four existing action plans were clearly associated with the root cause that had been identified.

Finally, according to our subject matter expert's review, none of the action plans had strong recommendations on how to prevent further incidents. None of the action plans delineated how a successful outcome would be defined and measured. In one case, a recommendation was made to change providers' awareness of differential diagnoses. However, this recommendation did not include any specific plans for implementation nor did it include a method to gauge effectiveness. Additionally, many action plans did not include implementation dates, which would ensure that action plans are improving the system of medical care. OHS staff acknowledged that follow-up needed improvement, "[We have] not been wonderful with follow-up. Need to get better . . . [We] need to have educational piece in the next CME."⁹

The root cause analysis process focused on individuals, not systems.

Without the critical components described above, many of the root cause analyses focused on individual providers instead of the systems that contributed to the event. For example, in one case a Volunteer who had been seeing a mental health provider in-country was hospitalized for alcohol intoxication. The resulting analysis did not address aspects of the agency's Volunteer recruitment, clearance, and placement systems that had led to the acceptance of Volunteers with severe mental health problems, or whether or not the Peace Corps was sufficiently prepared to support such Volunteers. Instead the root cause analysis determined that the in-country mental health provider had not met Peace Corps' expectations.

Many of the root cause analyses focused on individual providers instead of the systems that contributed to the event.

Some PCMOs we interviewed reported feeling fearful of the sentinel event reporting system and reluctant to report sentinel events. One staff member noted, "No one is submitting sentinel event reports, and what does that tell you? People are afraid to send them in." The OHS staff member comment below illustrates the ambiguity inherent in the agency's current approach to sentinel

⁹ Continuing Medical Education (CME) is an annual conference that provides PCMOs with ongoing medical training.

event reviews—acknowledging that while the sentinel event process should focus on systemic problems it may also address an individual’s clinical error:

[The] whole process of documenting sentinel and unusual events—want to change thinking to help empower staff to do better through training and education. It is about helping patient and doing things better. Don’t want it to be seen as a punishment. We know human beings make mistakes. We try to make it a process improvement, more than a specific improvement plan for an employee. That being said, if someone kills somebody due to negligence that changes the picture.

As a result of these shortcomings in the agency’s approach to selecting sentinel events and conducting root cause analyses, the value of the agency’s sentinel event review process was diminished, and the sentinel event policy put in place since 2010 has not had the intended effect.

We recommend:

- 6. That the associate director of the Office of Health Services implement a screening process for root cause analyses that considers severity and frequency of negative health outcomes.**
- 7. That the associate director of the Office of Health Services ensure staffing is sufficient to adequately implement a more effective sentinel event reporting system and that staff involved in root cause analyses have not had direct involvement in the case.**
- 8. That the associate director of the Office of Health Services perform all root cause analyses in a manner that includes key components (system focus, cause/effect, action plan and measures).**
- 9. That the associate director of the Office of Health Services improve staff understanding of best practices for selecting sentinel events for review and for carrying out root cause analyses.**
- 10. That the associate director of the Office of Health Services clarify the agency’s policies and procedures related to sentinel event reviews to focus on and address systemic causes.**

SECTION B: MEDICAL EMERGENCY PREPAREDNESS

Peace Corps assumes a high degree of risk in placing Volunteers in very remote locations with limited infrastructure. The medical emergency section of the evaluation attempts to answer the question, “Are Peace Corps posts adequately prepared to respond to medical emergencies?”

Staff generally felt that posts were well prepared to respond to medical emergencies. However, this evaluation uncovered some gaps related to medical emergency preparedness, most significantly with respect to how frequently PCMOs assessed local medical facilities and providers, and the post’s participation in medical emergency preparedness drills.

Medical evacuation plans were incomplete.

As stated in TG 380 “Medical Evacuation,” each Peace Corps post is required to maintain an up-to-date medical evacuation (medevac) plan, which is to serve as a “comprehensive, country-specific resource designed to assist each Peace Corps post with the safe and efficient evacuation of Volunteers.” TG 380.5.3 states that PCMOs should update the medevac plan annually and review it with the CD, Director of Management and Operations (DMO), and other support staff who may be involved in a medical evacuation. The agency has provided guidance to PCMOs on the contents of the medevac plan in TG 380, TG 385 “Emergency Medical Evacuation,” and manual section (MS) 264 “Medical Evacuation Procedures.”

In our review of nine post medevac plans, many of the plans were missing required information when compared to the outlined criteria. The majority of post medevac plans included the emergency contact information for Peace Corps staff, local hospitals, local emergency providers, local ambulance services, and procedures for emergency air rescue. However, fewer medevac plans had contact information for in-country emergency air rescue services, the embassy, Volunteers, or other required information. See Appendix F for details.

Medevac plans were incomplete because the Peace Corps had not provided clear guidance related to medical evacuation plans.

Medevac plans were incomplete because the agency had not provided clear guidance related to medical evacuation plans. Guidance on the contents of medevac plans was in three different areas: TG 380, TG 385, and MS 264 Procedures. In addition, much of the criteria were challenging to comply with; for example, TG 380 contained vague and outdated criteria. Several OHS staff acknowledged that the medevac plan guidance needed to be updated. As one person said, “[There is] not a lot of guidance on what is a medical emergency plan. Other than a hodge-podge of contact lists, it is not very clear.” A few posts had developed shorter reference documents to use as a more practical resource in an emergency.

Medevac plans were also incomplete due to a lack of oversight. Of the seven CDs we interviewed, only one claimed to have done a careful review of the medevac plan. In addition, the requirement that OHS review the medevac plan during site assessments had been

accidentally removed from the site assessment checklist in December 2012 and not reinstated until February 2015. It was not clear if medevac plans were consistently reviewed during OHS site visits in the interim two years.

Without complete and comprehensive medevac plans, health unit staff at some posts may not be aware of all of the procedural requirements. While most post staff members understood the need to consult with OHS and/or the RMO about the medical evacuation of a Volunteer, they had a less clear understanding of some of the detailed steps required during a medevac. For example, in the medical emergency scenario exercise that OIG conducted, one-third of posts did not mention that they would communicate with the international health coordinator, as required by TG 380. Few posts said the PCMO and DMO would complete the medevac checklist (TG 385 Attachment A). Only six of the nine posts stated that they would determine the Volunteers' wishes regarding notification of immediate family members as per TG 380.7.5.

Since a medical emergency can happen at any time, it is important that the medevac plan be clear and concise so that a temporary PCMO or back-up PCMO can reference it and act quickly and appropriately. As one PCMO explained, "[The back-up PCMO] should be able to look at the plan and know what to do. It's a very important document. It's probably the most important document we have."

We observed two best practices related to medevac plans during fieldwork. First, some posts maintained both electronic and hard copies of the medevac plans which expedited access to the information should a medical emergency occur during off-hours when the PCMO was not in the office, or in the event of a disaster. A second best practice was for the PCMO and safety and security manager to conduct joint site safety and medical facility visits.

We recommend:

- 11. That the associate director of the Office of Health Services ensure that medical evacuation plan guidance is complete, up to date, relevant, and that inconsistencies in the guidance in agency policy are reconciled.**
- 12. That the associate director of the Office of Health Services and the associate director for Global Operations develop and implement a process to regularly ensure that posts' medical evacuation plans align with agency guidance.**

Medical emergency drills were not taking place.

MS 264 Procedures, section 4.2(d) requires that "The CD must ensure that all staff members are familiar with the medical evacuation plan, and at a minimum . . . Hold periodic drills to ensure that staff can perform their assignments." Only one out of the nine countries visited reported having completed a medical evacuation drill. While staff members at the remaining eight

countries said they regularly hold a general emergency preparedness drill to test the emergency action plan, emergency action plan drills did not always specifically cover posts' responses to medical emergencies. Furthermore, as shown in Figure 4, nearly half of all PCMOs surveyed (40 percent) had never participated in a medical emergency preparedness drill.

Posts were not conducting medical emergency drills because there was little guidance on how to do so or what constitutes a drill. There was no information available on how to develop a drill, who is responsible for facilitating the drill, and who should participate. OIG was only able to deliver the tabletop

By not regularly conducting medical emergency drills, posts may not be prepared to respond efficiently to an actual emergency.

scenario exercise after consulting with OHS and the Office of Safety and Security. One CD wondered if posts that frequently responded to medical emergencies should still be required to conduct periodic drills.

By not regularly conducting medical emergency drills, posts may not be prepared to respond efficiently to an actual emergency. A medical emergency drill provides an opportunity to discuss plans of action in a less stressful situation. During our tabletop scenario exercise, which was structured similarly to a medical emergency drill, we observed how the exercise gave

post staff the opportunity to talk through the logistics of an emergency response. For example, several posts that had not recently responded to an emergency spent some time discussing how they would acquire a Volunteer's passport in the event of a medical evacuation. In an actual emergency, posts could lose valuable time figuring out logistical details.

We recommend:

- 13. That the associate director of the Office of Health Services provide clear guidance to posts on when and how to conduct a medical emergency preparedness drill.**

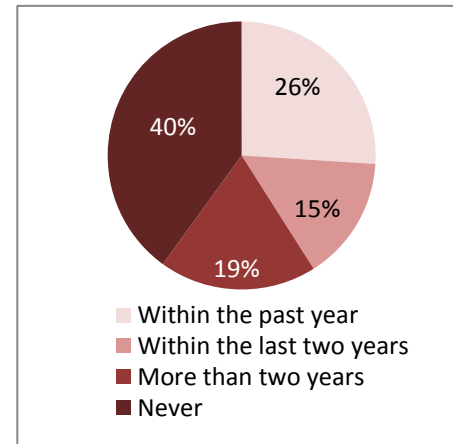


Figure 4. PCMO survey responses to "How long has it been since you participated in a medical emergency drill?"

Source: All PCMO Survey

Staff had not received instructions on steps to take in a life-threatening emergency.

As required in MS 264 Procedures section 4.2(e), the country director should:

Provide each staff member with information listing the immediate steps to be taken in case of life-threatening emergencies. This information must be carried by all staff and kept close to telephones in staff residences and offices. The information must also contain the name of the Embassy staff person most likely to be able to assist the PCMO. Information must also be printed in the host country language, if necessary.

We took a random sample of 10 percent of staff in six out of the nine countries that we visited and asked if they had received instructions of what to do in the event of a life-threatening emergency. In total, we asked 23 Peace Corps staff if they had received instructions. All 23 staff reported that they had not received such instructions or cited guidance that did not conform to the MS 264 Procedure requirements, such as post phone trees or the annual trainings on the emergency action plan.

Posts were not in compliance with these requirements because CDs were not aware of their oversight responsibilities in MS 264 Procedures. Further, when OIG shared this guidance with them, most CDs expressed that the guidance was unclear and impractical. One CD thought the requirement was unnecessary because Volunteers knew to contact the PCMOs.

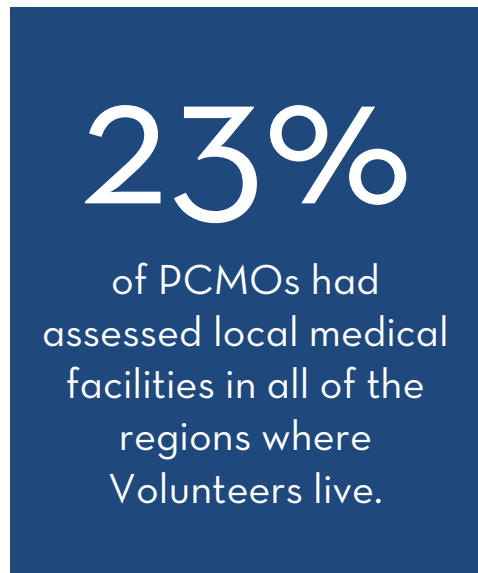
We recommend:

14. That the associate director of the Office of Health Services implement and clarify MS 264 *Medical Evacuation Procedures*, section 4.2(e), to include the type of emergencies for which instructions should be provided to staff.

PCMOs were not regularly conducting assessments of local medical providers and facilities.

According to the *New PCMO Manual*, “Maintaining an in-country referral network of health care providers in various specialties and health care facilities is the responsibility of PCMOs at each post.” TG 110 further requires PCMOs to establish and maintain “an in-country referral network of health care providers through the identification and evaluation of consultants and services.” The *Characteristics and Strategies of a High Performing Post* report states that “PCMOs must research, cultivate, and maintain an up-to-date network of necessary and qualified referrals to support and supplement the health care program for Volunteers.” There is no guidance from OHS on how frequently a facility or provider assessment should be completed.

Most PCMOs were not conducting facility and provider assessments on a regular basis, particularly in regions of the country with few Volunteers. According to our PCMO survey, only 23 percent of PCMOs had assessed local medical facilities in all of the regions where Volunteers live. PCMOs had not assessed local medical facilities and providers due to their heavy workload. As one PCMO explained, it was difficult to travel because “the amount of work here in the health unit is restricting.” An RMO elaborated that between the daily activities of providing care, and the periodic Volunteer conferences, there was limited time for PCMOs to leave the office long enough to assess local facilities.



We concluded that another reason PCMOs had not assessed local medical facilities was the lack of clear expectations regarding the frequency with which such assessments should be conducted. Without clear agency-wide guidance and expectations, each post had determined its own schedule for carrying out these assessments, with the result that the frequency of local facility assessments ranged from twice a year to every other year. Furthermore, the lack of clear guidance and expectations regarding local facility assessments reduced the likelihood that posts would prioritize local medical facility and provider assessments and thus provide PCMOs with the necessary funds and resources to travel and carry out the assessment.

Without having assessed medical facilities throughout the country, posts were less prepared to respond to a medical emergency. PCMOs who do not understand the capabilities of local facilities and providers throughout the country could lose valuable time figuring out where to send Volunteers in the event of an emergency.

We recommend:

- 15. That the associate director of the Office of Health Services clarify guidance on how frequently posts are expected to conduct medical facility and provider assessments, prioritizing assessments in countries with limited health infrastructure.**

PCMOs were not regularly conducting medical site visits of Volunteers.

OHS does not provide guidance to PCMOs on how frequently they should be conducting medical site visits of Volunteers. In the [IG-13-01-E Final Report on the Program Evaluation of Peace Corps/Namibia](#), OIG recommended, “That the Office of Volunteer Support¹⁰ clarify the

¹⁰ In 2013 the Office of Volunteer Support was renamed the Office of Health Services.

requirement for Peace Corps medical officer visits to Volunteer sites and establish policy and procedures to guide posts in this activity.” That recommendation is still open.

According to the Volunteer survey, 74 percent of Volunteers reported that a PCMO had not visited them at their site. The PCMO survey further showed that in the past year, each PCMO had visited an average of 20 Volunteer sites and a median of 12 sites. Of the 83 PCMOs who responded to the question, 10 percent stated that they had not visited any Volunteers in the past year.

We found that CDs and PCMOs had different views regarding the expectation for PCMOs to visit Volunteers at their sites. Some PCMOs believed they were required to visit each Volunteer once a year; others thought that the requirement was once during a Volunteer’s service. One RMO summarized the confusion regarding site visit expectations: “There is no consistent guidance from Washington regarding medical site visits and their frequency and necessity and what to look for. Most posts have it on their wish-list... Most posts do not have a systematic process for Volunteer site visits.”

PCMOs identified high workload, distance to Volunteers, and lack of resources as barriers that prevented them from conducting medical site visits.

74%

of Volunteers reported that a PCMO had not visited them at their site.

In addition to the confusion caused by unclear expectations, PCMOs identified high workload, distance to Volunteers, and lack of resources as barriers that prevented them from conducting medical site visits. Furthermore, we found CDs were not always providing sufficient oversight to ensure that visits were being conducted.

Characteristics and Strategies of a High Performing Post stresses that if PCMOs do not conduct site visits, “their own knowledge of the Volunteers’ situations is incomplete, and they may not be reaching certain Volunteers who do not come in.” Furthermore, the PCMOs we spoke to stated that the site visits allowed them to assess Volunteers’ living conditions and mental health, better understand Volunteers’ daily life,

determine distance to local medical facilities, and develop a closer relationship with Volunteers.

Because there is currently an open OIG recommendation to clarify agency guidance to all PCMOs regarding medical site visits, we are not issuing a separate recommendation. However, results from this evaluation served to underscore the importance of better guidance and support for PCMOs to facilitate their ability to visit Volunteers at their sites.

SECTION C: IDENTIFICATION OF SYSTEMIC ISSUES

In the previous sections we discussed issues related to specific OHS and overseas health unit operations. In the process of evaluating operations, we observed some systemic issues that impeded health units' ability to complete many required preventative healthcare and emergency preparedness tasks. The issues discussed in this section are related to unclear guidance, insufficient resources and support, and low PCMO morale.

Oversight responsibilities were not clear, and agency guidance was spread across multiple policies and technical guidelines.

The standard PCMO scope of work states that the PCMO reports to both the associate director for OHS and the country director. According to MS 261, "Medical Offices and Peace Corps Medical Officers," OHS is responsible for clinical oversight, while CDs are in charge of non-clinical oversight, comprising of day-to-day management and supervision of PCMOs.

CDs were not always aware of all their health unit oversight responsibilities.

Our fieldwork revealed that a number of CDs were not always aware of all of their oversight responsibilities. Because CDs receive limited training on their health unit oversight responsibilities,¹¹ it is important they have clear guidance to reference. However, we found that the agency's oversight guidance was dispersed across many policies and technical guidelines, and the division of oversight responsibility was sometimes unclear.

Agency guidance is fragmented throughout Peace Corps manual sections and technical guidelines. TG 110, TG 112, MS 264, MS 264 Procedures, and MS 734 all contain guidance on the CD's health unit oversight responsibilities. TG 110 contains the most comprehensive list of a CDs' oversight responsibilities, but does not mention that CDs are required to approve the medical evacuation plan (found in MS 264), or hold medical emergency drills (found in MS 264 Procedures).

We also concluded that CDs were not always aware of their oversight responsibilities because it was not always clear which of the PCMOs' many tasks and responsibilities were non-clinical and which were clinical in nature. As one senior staff member of OHS commented, "there is a huge blurred line between what is medical and non-medical."

In order to better understand who is responsible for overseeing which aspects of the health unit operations, OIG created the table in Appendix G. The table contains a list of all PCMO responsibilities identified in TG 110. Using Peace Corps guidance, we identified the position that appeared accountable for overseeing each PCMO responsibility. For several of the listed responsibilities, it was not obvious whether it fell under OHS's clinical oversight or the CD's

¹¹ Overseas staff training is a training that all CDs attend prior to or soon after relocating to their first post assignment. During the training, CDs also receive a joint training with PCMOs on PCV health and well-being.

non-clinical oversight. For example, both OHS and the CD could be responsible for ensuring that PCMOs conduct medical facility and provider assessments. On the one hand, such assessments are an important aspect of clinical care because PCMOs document which facilities can care for Volunteers, and which they should avoid. On the other, traveling to visit and assess local providers can be considered a non-clinical activity, and CDs are in a better position to ensure that PCMOs have the time, coverage, and budget to conduct such assessments. As a result of the oversight ambiguity, with the exception of OHS site assessments—which happen only once every three years—few PCMOs have someone actively ensuring that they regularly conduct medical facility and provider assessments.

Without an effectively functioning oversight model, it is difficult for the agency to recognize when health units are unable to complete required activities. If country directors are unaware of all of their oversight responsibilities, the agency cannot ensure that critical tasks, such as emergency medevac plans and local facility and provider assessments, are getting done.

We recommend:

- 16. That the associate director of the Office of Health Services and the associate director for Global Operations ensure that country directors receive clear guidance on all of their health unit oversight responsibilities.**
- 17. That the associate director of the Office of Health Services and the associate director for Global Operations update agency guidance to ensure that the division of oversight responsibility for the health unit is clear and that all health unit responsibilities are covered.**

The agency had not provided sufficient resources and support to ensure that the full range of PCMO and RMO job responsibilities could be fulfilled effectively and efficiently.

In the 2010 Peace Corps/Morocco Assessment of Medical Care, OIG’s medical experts reported that prevention and an earlier diagnosis may have prevented the Volunteer’s death. OIG recommended “that the agency assess whether resources and expertise are aligned to provide sufficient oversight to overseas health units.” The agency made significant efforts to ensure that resources and expertise are available to health units when there is a medical emergency. As one PCMO stated, “If there is an emergency, money is not an issue. If we don’t have money [at the post], Washington will wire the money.” However, the agency had not provided health units and RMO hubs with sufficient resources to carry out more routine and preventative health care responsibilities. Many RMOs and PCMOs lacked resources such as timely cash advances, access to vehicles, back-up provider coverage, and administrative support to fulfill the full range of their job responsibilities.

Many RMOs and PCMOs lacked resources such as timely cash advances, access to vehicles, back-up provider coverage, and administrative support to fulfill all of their job responsibilities.

PCMO role in budget development. One reason PCMOs and RMOs had not received the resources necessary for routine and preventative healthcare operations was because health units were not consistently and sufficiently included in their posts' planning and budget development processes. During fieldwork we found that very few PCMOs were sufficiently included in the development of their medical budgets.

Cash Advances. Since many of its staff must travel, Peace Corps' policy is to provide non-U.S. citizens (who are not authorized to use a government-provided credit card) with travel advances to cover authorized costs. The Peace Corps Overseas Financial Management Handbook states in section 55.5.5 that non-U.S. staff can receive 100 percent of the estimated amount for per diem and other expenses in advance.

However, both PCMOs and RMOs reported that they did not always receive the travel advance before their scheduled travel, or that they only received an advance for a portion of the allotted amount. As a result, they were often forced to use their personal funds and receive later reimbursement from Peace Corps, which risks creating a financial strain for some staff. We were unable to determine the full range of reasons that cash advances were not made available in a timely manner. We encourage the agency to identify ways to improve this process for PCMOs and RMOs.

Drivers and Vehicles. The health unit staff at five of the nine posts reported difficulty accessing drivers and vehicles when seeking to provide non-emergency medical care to Volunteers. One PCMO reported, "We only have one driver so most of the time we are doing our own driving. That can be challenging because we have a lot going on." Another stated, "Sometimes we have challenges finding a driver. [There is] no assigned driver for medical. We find solutions all the time but sometimes it can make us lose a lot of time waiting for a driver."

MS 522 Procedures, "Motor Vehicle Use and Insurance" states that "At least one Peace Corps vehicle is available at all times for medical treatment of Volunteers." OHS also informs CDs during overseas staff training that cars and drivers should always be available 24/7.

Post staff found the requirement for a Peace Corps vehicle to be "available" at all times ambiguous. Several PCMOs thought that this requirement meant that there should always be a vehicle and driver available exclusively for the use of the medical unit. However, CDs tended to think that ensuring there was always at least one available duty driver and vehicle in the same city as the Peace Corps office satisfied the requirement. One CD said, "When I read that policy, I have to think about efficiency and effectiveness. I read that if the duty driver is available 24/7, that is sufficient." One staff member from OHS reported that the standard at posts should be that the health unit gets priority if the PCMO identifies a need.

As a result of the different interpretations of the policy, we observed tension amongst staff at some posts. At one post we visited, the tension had led to delays in Volunteer care. One member of the health unit staff reported, “You request transport, and [the drivers] have to provide it. But the [drivers] respond like I am threatening them... even if it is urgent, the drivers say you have to put in a transport request.”

Back-up Provider Coverage. Because Peace Corps posts are responsible for providing 24/7 medical coverage to Volunteers, posts should have designated local back-up providers to ensure that posts are able to provide health care coverage to Volunteers when PCMOs are away. At posts with smaller health units, back-up providers may also alleviate PCMO workload by carrying the duty phone periodically. *Characteristics and Strategies of a High Performing Post* further states that Volunteers’ should feel confident in the back-up provider’s medical care.

We found that very few posts regularly utilized their back-up providers. At one post, the back-up had never carried the duty phone or even visited the Peace Corps office. At another, the back-up PCMO was primarily asked to help out during Volunteer conferences such as pre-service training, mid-service, and close of service. One post with a larger health unit preferred to not have a back-up provider.

Posts were not using back-up providers for several reasons: back-up providers were insufficiently prepared to respond to a medical emergency; had received little training on their role; and posts had not planned and budgeted for their use. Furthermore, because the agency did not provide clear guidance on how frequently posts should employ their back-up providers, or how to oversee use of back-ups, there was little pressure on posts to train and employ back-up providers. One RMO emphasized the need for posts to regularly employ their back-up provider: “I tell posts that they need to use the back-up often enough that the person knows Peace Corps... There may be a pressure of funds to not use the back-up, but I don’t think that is an excuse.”

PCMOs were not benefitting from the workload relief that the back-up provider model was intended to offer them.

As a result of not using the back-up provider as intended, PCMOs were not benefitting from the workload relief that the back-up model was intended to offer them. This particularly impacted posts with only one PCMO. One PCMO explained, “One of the things I am supposed to do is take two weekends off a month, but I don’t always do it.” Other PCMOs who did use back-up providers said they still had to be available by phone to respond to any questions the back-up provider may have. We assessed that the lack of effective use of back-up providers had exacerbated workload strains among PCMOs and was a factor that contributed to high staff turnover in overseas health units.

Administrative Support for Regional Medical Hubs. Not all of the RMOs received enough administrative support. While some RMOs did not mention that the administrative workload was

an issue, others identified their lack of administrative support as primary source of low morale and job dissatisfaction.

RMOs spent a significant amount of their time doing administrative work that could have been completed by a staff member with lower qualifications and experience.

At the time of fieldwork, each regional hub had a different administrative support staffing configuration. The RMOs in Morocco received assistance from the post's medical assistants, causing a drain on the post's resources. The regional hub in Morocco was in the process of requesting money to hire regional support staff. In South Africa, the RMOs shared a regional medical administrative assistant with the post. The regional medical administrative assistant, whose primary responsibility was to pay medical bills and issue guarantees of payment, was supervised by the DMO and essentially part of the Peace Corps/South Africa administrative unit, but worked out of the medical building. This created difficulties for the RMOs, who were unable to set work priorities for the regional medical administrative assistant. Finally, Thailand had a regional medevac clinical coordinator who was a registered nurse and a former PCMO. The

regional medevac clinical coordinator, who was supervised by the RMOs, handled the majority of the administrative work for the medical hub.

Each hub was configured differently because the agency had not identified the ideal configuration of staffing resources to efficiently and effectively manage a regional medical evacuation hub. As a result of the inconsistent support for regional medical hubs, some RMOs (among the agency's most qualified and high-performing medical officers) spent a significant amount of their time doing administrative work that could have been completed by a staff member with lower qualifications and experience. One RMO explained that the RMO job was far less fulfilling than past jobs due to the amount of bureaucracy and limited clinical care. Another compared the administrative workload to "pulling teeth without using anesthesia."

We recommend:

- 18. That the associate director of the Office of Global Operations and the associate director of the Office of Health Services provide coordinated communication to posts that clarifies expectations about PCMO participation in posts' planning processes, including integrated planning and budgeting (IPBS) and annual operating plan formulations.**
- 19. That the associate director of the Office of Health Services and the associate director for Global Operations clarify policy and guidelines related to the**

vehicle availability for overseas health unit medical staff.

20. That the associate director of the Office of Health Services clarify guidance and expectations for training and use of back-up providers.

21. That the associate director of the Office of Health Services assess the amount of administrative support required to allow regional medical officers to work effectively and efficiently, and request the required resources.

PCMOs' dissatisfaction with workload, compensation and professional development opportunities undermined the agency's ability to retain them as staff.

PCMO Turnover. The agency has experienced unwanted PCMO turnover. At the time of this evaluation Peace Corps had roughly 135 PCMOs. Between FY11 and FY14, the estimated annual PCMO turnover rate was 16 percent. Approximately 21 PCMOs left the agency each year.

PCMO turnover created a significant cost to the agency. New PCMOs required intensive mentoring and training, including being brought to headquarters for a three-week orientation. The formal mentoring process for PCMOs lasted 3 months though, informally, mentoring continued for a period of a year. In addition, an OHS employee typically visited a new PCMO on site for a period of several weeks. Staff described that it generally took between one and three years for a PCMO to become fully trained. This training process was particularly costly to the agency given that the median length of employment for a PCMO is just 3.6 years. In addition to the cost associated with recruitment and training, the agency spent a substantial amount of money providing temporary coverage for health units with PCMO vacancies. Between FY12 and FY14, OHS spent roughly \$1.1 million to provide temporary coverage for post health units. Furthermore, as described in the medical emergencies section, PCMO turnover and coverage problems create an element of risk for the Peace Corps.

The majority of PCMOs surveyed reported generally good morale overall (75%), as well as satisfaction with support from the office of health services. However, when asked about different aspects of their job, PCMOs reported low levels of satisfaction that may help to explain high rates of turnover. Nearly half of all PCMOs surveyed (42%) reported being either unsatisfied or very unsatisfied with their workload. Likewise, 41% of PCMOs were either unsatisfied or very unsatisfied with their salaries and benefits. Finally, a third of PCMOs (33%) reported being unsatisfied or very unsatisfied with opportunities for professional development. Though it was not within the scope of this evaluation to interview those PCMOs who had already left their position, qualitative in-depth interviews with current staff supported the areas of job dissatisfaction identified in the PCMO survey.

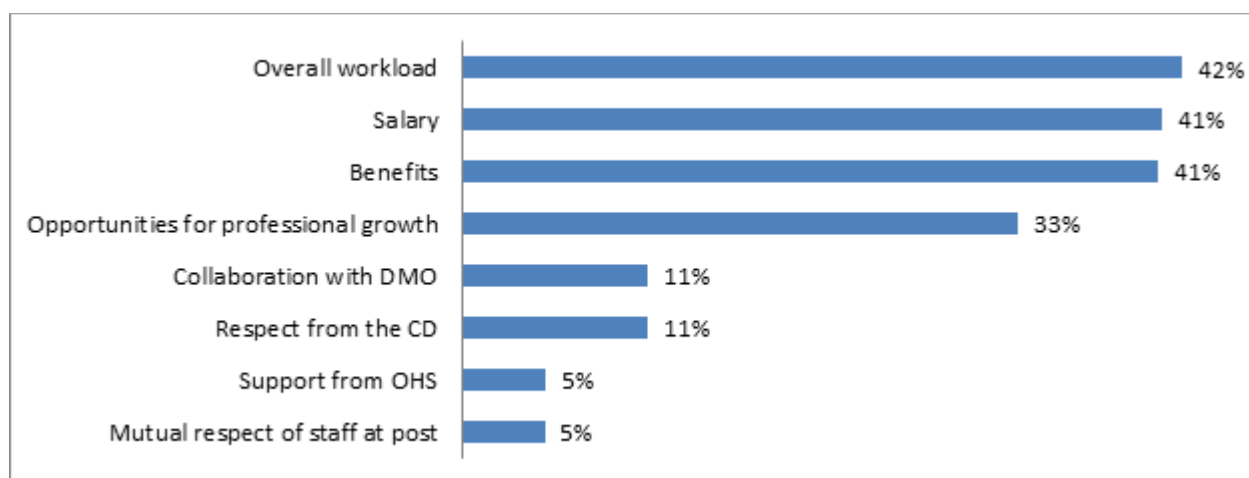


Figure 5. Percent of PCMO respondents who reported that they were "unsatisfied" or "very unsatisfied" with the following aspects of their job.

Workload. PCMOs reported that an unrealistic workload negatively affected their morale. PCMOs were particularly unsatisfied with their non-clinical responsibilities. One health unit staff member said, "I liked my job before [Peace Corps] more than this job. It was a clinical job. I could see happy eyes when I worked with patients . . . Now it's a lot of bureaucracy." Seventy-six percent of PCMOs said that non-clinical workload had a negative impact on their ability to provide quality medical care. Furthermore, 39 percent of PCMOs reported that they were frequently asked to perform non-clinical duties outside of their job descriptions.

Dissatisfaction with the high administrative workload had been exacerbated by the gap between the key tasks required in the PCMO job description and PCMOs' skill and training levels. Our evaluation found that registered nurse PCMOs were less likely to consider non-clinical and administrative work to be outside of their job description. However, since 2010, Peace Corps health units had shifted away from hiring registered nurse and mid-level PCMOs, to hiring primarily medical doctor PCMOs with higher level clinical skills. At the same time, Peace Corps also increased the amount and type of administrative and non-clinical tasks it required PCMOs to carry out.

To account for this skill gap, OHS encouraged posts to hire administrative staff with clinical backgrounds. Posts found that medical assistants with clinical backgrounds were helpful because they could take on additional tasks such as giving vaccines or assisting in the health training for Volunteers and trainees. As one PCMO said the MA "took a lot of ordering and management of medications and forms off the PCMOs' shoulders." However, as of August 2015, only 31 percent of posts had administrative staff with medical training. Furthermore, 40 percent of the administrative staff hired since 2011 did not have clinical experience.

76%
of PCMOs said that non-clinical workload had a negative impact on their ability to provide quality medical care.

OHS encouraged posts to hire administrative staff with clinical backgrounds yet as of August 2015 only

31%

of posts had administrative staff with medical training.

Compensation. Salaries and benefits were one of the major factors associated with PCMO job dissatisfaction. This evaluation identified two causes that explain why PCMO compensation packages contributed to job dissatisfaction. Following the passage of the Kate Puzey Volunteer Protection Act of 2011, Peace Corps determined to no longer treat U.S. personnel services contractors as self-employed independent contractors for tax purposes.¹² This resulted in Peace Corps beginning to withhold their required federal taxes and to treat their allowances and benefits in the same manner as those paid to U.S. direct hire employees.¹³ These changes resulted in a decrease in the take-home pay of U.S. personal service contractor PCMOs. While OHS did revise the salary scale for U.S. citizen PCMOs, the changes still resulted in a significant income cut.¹⁴

In addition, staff throughout the agency acknowledged that Peace Corps did not always provide contracted host country national PCMOs with competitive

compensation packages because posts were not consistently conducting local market research before hiring them. To conduct local market research, the DMO, as the contracting officer, must survey hospitals, embassies, and other organizations to determine what they pay someone in a position with similarly required qualifications, skill sets, and work requirements. Senior staff we interviewed at post believed that the U.S. embassy conducted the local market research for PCMO contracts during the development of the embassy's local compensation plan. However, at most embassies the local compensation plan was generally developed for hiring secretaries, drivers, and programming staff, not medical professionals. Embassies' local compensation plans did not always include a pay scale for licensed medical doctors, and therefore was not useful for establishing competitive contracts for PCMOs. The Peace Corps Office of Acquisitions and Contract Management (OACM) reported that they did not proactively provide guidance to posts on how to deviate from the local compensation plan; OACM expressed that doing so would undermine the compensation packages of other positions that were based on the plan.

¹² Per CFO Bulletin No. 13-1, the agency planned to amend all contracts with U.S. personnel services contractors by May 10, 2013.

¹³ Prior to the Kate Puzey Act, Peace Corps treated U.S. personnel services contractors as eligible for the foreign earned income exclusion, the foreign housing exclusion, and the foreign housing deduction.

¹⁴ As of August 2015, seven percent of PCMOs are U.S. PCMOs.

Staff at headquarters advised that posts should conduct their own market research before hiring a PCMO. One OACM staff member stated, “One comment I would make to DMOs is that they should stay in tune to the local markets.” However, as post and headquarter staff reported, conducting market research was often a difficult process. The process was a challenge because there were rarely local organizations with a position comparable to a Peace Corps medical officer. As one DMO said, “There is no true equivalent in the local market. They are looking for such a unique set of skills. The closest is at the embassy—and that is a [United States Direct Hire]. How do you do it?” It was also difficult to solicit responses from local nationals for the local market survey. Another DMO explained that she had to “beg” local doctors to provide their salary information to Peace Corps. Finally, posts experienced difficulty in conducting local market surveys because contracting officers did not receive sufficient training in this area. Post contracting officers received only 40 hours of contract-related training prior to obtaining contracting authority. Due to these challenges, we found that posts often experienced difficulties recruiting and retaining a qualified local PCMO.

Staff at headquarters advised that posts should conduct their own market research before hiring a PCMO, but there were rarely local organizations with a position comparable to a Peace Corps medical officer.

Professional Development. An additional challenge for PCMOs was the perceived lack of opportunity and support for professional development. Only 39 percent of PCMOs were satisfied with their opportunities for professional growth. Peace Corps provided CMEs annually. However, because licensure requirements varied greatly across countries, Peace Corps’ internal CME did not consistently meet professional requirements for all PCMOs. Furthermore, Peace Corps did not have a policy to provide PCMOs funding or professional leave to meet their licensing requirements. As one former PCMO explained: “Once in five years I need to recertify. You go through the class and courses and you get a certificate. Peace Corps does not provide support with time or finances. CME does not meet the requirement.”

We recommend:

- 22. That the associate director of the Office of Health Services develop a plan, in collaboration with other offices as appropriate, to address the causes of PCMO job dissatisfaction and improve retention of qualified PCMOs.**
- 23. That the associate director of the Office of Health Services assess staffing configurations at posts and regional medical hubs and develop a plan to provide health units with sufficient clinical and administrative support staff.**

LIST OF RECOMMENDATIONS

WE RECOMMEND:

1. That the associate director of the Office of Health Services clarify the regional medical officers' roles and responsibilities regarding the oversight and supervision of Peace Corps medical officers.
2. That the associate director of the Office of Health Services develop and provide guidance on the transfer of care between Peace Corps Medical Officers, TDY providers, and backup providers to facilitate continuity of care for Volunteers.
3. That the associate director of the Office of Health Services determine appropriate indicators—in addition to Volunteer satisfaction data obtained through the annual Volunteer survey—of the quality of Volunteer medical and mental health services and incorporate them into future strategic plans.
4. That the Director analyze, prioritize and plan for the resources necessary to measure and track the identified indicators of the quality of Volunteer medical and health services.
5. That the associate director of the Office of Global Operations and the associate director of the Office of Health Services explore new ways to raise Volunteer and trainee awareness of the Quality Nurse line.
6. That the associate director of the Office of Health Services implement a screening process for root cause analyses that considers severity and frequency of negative health outcomes.
7. That the associate director of the Office of Health Services ensure staffing is sufficient to adequately implement a more effective sentinel event reporting system and that staff involved in root cause analyses have not had direct involvement in the case.
8. That the associate director of the Office of Health Services perform all root cause analyses in a manner that includes key components (system focus, cause/effect, action plan and measures).
9. That the associate director of the Office of Health Services improve staff understanding of best practices for selecting sentinel events for review and for carrying out root cause analyses.

10. That the associate director of the Office of Health Services clarify the agency's policies and procedures related to sentinel event reviews to focus on and address systemic causes.
11. That the associate director of the Office of Health Services ensure that medical evacuation plan guidance is complete, up to date, relevant, and that inconsistencies in the guidance in agency policy are reconciled.
12. That the associate director of the Office of Health Services and the associate director for Global Operations develop and implement a process to regularly ensure that posts' medical evacuation plans align with agency guidance.
13. That the associate director of the Office of Health Services provide clear guidance to posts on when and how to conduct a medical emergency preparedness drill.
14. That the associate director of the Office of Health Services implement and clarify MS 264 *Medical Evacuation*, section 4.2(e), to include the type of emergencies for which instructions should be provided to staff.
15. That the associate director of the Office of Health Services clarify guidance on how frequently posts are expected to conduct medical facility and provider assessments, prioritizing assessments in countries with limited health infrastructure.
16. That the associate director of the Office of Health Services and the associate director for Global Operations ensure that country directors receive clear guidance on all of their health unit oversight responsibilities.
17. That the associate director of the Office of Health Services and the associate director for Global Operations update agency guidance to ensure that the division of oversight responsibility for the health unit is clear and that all health unit responsibilities are covered.
18. That the associate director of the Office of Global Operations and the associate director of the Office of Health Services provide coordinated communication to posts that clarifies expectations about PCMO participation in posts' planning processes, including integrated planning and budgeting (IPBS) and annual operating plan formulations.
19. That the associate director of the Office of Health Services and the associate director for Global Operations clarify policy and guidelines related to the vehicle availability for overseas health unit medical staff.
20. That the associate director of the Office of Health Services clarify guidance and expectations for training and use of back-up providers.

21. That the associate director of the Office of Health Services assess the amount of administrative support required to allow regional medical officers to work effectively and efficiently, and request the required resources.
22. That the associate director of the Office of Health Services develop a plan, in collaboration with other offices as appropriate, to address the causes of PCMO job dissatisfaction and improve retention of qualified PCMOs.
23. That the associate director of the Office of Health Services assess staffing configurations at posts and regional medical hubs and develop a plan to provide health units with sufficient clinical and administrative support staff.

APPENDIX A: OBJECTIVE, SCOPE, AND METHODOLOGY

EVALUATION FIELDWORK

From June 2015 to August 2015 we visited nine countries to interview staff, review documentation, and conduct a tabletop exercise to test the emergency medical preparedness of staff. The countries we visited (Belize, Cambodia, Cameroon, Eastern Caribbean, Morocco, Namibia, Panama, South Africa, and Thailand) included the agency's three regional medical hubs. We selected the nine countries based on a range of factors including posts with various PCMO credentials, the size of the post, and the rate of Volunteer medical evacuations.

Our fieldwork included an exercise to observe medical emergency preparedness at the post. The tabletop exercise was developed by the evaluation team with input from OHS and the Office of Safety and Security. The exercise consisted of presenting a gradually escalating medical scenario and asking post staff to explain how they would respond to each update. In addition to this tabletop exercise, we reviewed documentation at each post that included their medical emergency plan and facility/provider assessments. We reviewed documentation at headquarters that included chart review data, quality nurse line data, and site assessment documentation.

During fieldwork we interviewed the country directors, Peace Corps medical officers, directors of management and operations, safety and security managers, medical assistants and secretaries, backup medical providers, regional medical officers, and others. We also interviewed staff at headquarters, including the Field Support Unit, Quality Assurance Unit, PCMO Support Unit, OHS senior leadership, and OACM. For a complete list of individuals interviewed, see Appendix B.

OIG SURVEYS OF PEACE CORPS MEDICAL OFFICERS AND VOLUNTEERS

In addition to visiting to nine posts and conducting staff interviews, we issued a survey to all PCMOs to gather feedback on their views of the Peace Corps quality assurance processes, barriers to hiring, scope of practice policy, and medical emergency preparedness. We received 88 responses, for a 66 percent response rate.

We also surveyed all Volunteers at each of the 9 posts we visited using an on-line survey tool. We received 456 responses, for a 45 percent response rate. The survey gathered Volunteer viewpoints concerning their medical care at the post and allowed Volunteers to request that OIG contact them individually. We contacted an additional 27 Volunteers through this process. Results from both surveys can be found throughout the report.

Finally, we engaged subject matter experts to review the agency's sentinel event reporting process and provide their independent assessment of it. We have incorporated the results from their review into the section on Quality Improvement. The review of sentinel events was also informed by our consultation of the literature on industry standards for sentinel event reporting. Standards from the Joint Commission and the U.S. Department of Veterans Affairs National Center for Patient Safety were used to develop a standardized rating template to assess a sample of Peace Corps sentinel events.

This evaluation was conducted in accordance with the Quality Standards for Inspections, issued by the Council of the Inspectors General on Integrity and Efficiency. The evidence, findings, and recommendations provided in this report have been reviewed by agency stakeholders affected by this review.

APPENDIX B: INTERVIEWS CONDUCTED

As part of this evaluation, we conducted interviews with 73 staff in-country, 13 representatives from Peace Corps headquarters in Washington D.C., and 2 officials from U.S. Embassies.

Table 2: Interviews Conducted with Post Staff

Position	Office
Backup Peace Corps Medical Officer (2)	Africa Operations
Country Director (2)	Africa Operations
Director of Management and Operations (2)	Africa Operations
Director of Programming and Training (Acting CD)	Africa Operations
Financial Assistant (Acting DMO)	Africa Operations
Human Resources and Volunteer Support Specialist	Africa Operations
Medical Assistant	Africa Operations
Medical Secretary (3)	Africa Operations
Peace Corps Medical Officer (6)	Africa Operations
Peace Corps Medical Officer (former)	Africa Operations
Regional Medical Assistant Manager	Africa Operations
Safety and Security Manager (3)	Africa Operations
Volunteer Support Liaison	Africa Operations
Backup Peace Corps Medical Officer (3)	Inter-America and the Pacific Operations
Country Director (2)	Inter-America and the Pacific Operations
Director of Management and Operations (3)	Inter-America and the Pacific Operations
Director of Programming and Training	Inter-America and the Pacific Operations
Director of Programming and Training (Acting CD)	Inter-America and the Pacific Operations
Medical Assistant (3)	Inter-America and the Pacific Operations
Peace Corps Medical Officer (5)	Inter-America and the Pacific Operations
Safety and Security Manager (3)	Inter-America and the Pacific Operations
Backup Peace Corps Medical Officer	Europe, Mediterranean, and Asia Operations
Country Director (2)	Europe, Mediterranean, and Asia Operations
Director of Management and Operations (2)	Europe, Mediterranean, and Asia Operations
Expert	Europe, Mediterranean, and Asia Operations
Language and Cross Cultural Coordinator	Europe, Mediterranean, and Asia Operations
Medical Assistant (2)	Europe, Mediterranean, and Asia Operations

Peace Corps Medical Officer (6)	Europe, Mediterranean, and Asia Operations
Regional Medevac Clinical Coordinator	Europe, Mediterranean, and Asia Operations
Roving Director of Management and Operations	Europe, Mediterranean, and Asia Operations
Safety and Security Assistant	Europe, Mediterranean, and Asia Operations
Safety and Security Manager (2)	Europe, Mediterranean, and Asia Operations
Regional Medical Officer (6)	Office of Health Services
Regional Mental Health Officer	Office of Health Services

Table 3: Interviews Conducted with Peace Corps Headquarters Staff

Position	Office
Chief Acquisition Officer	Office of Acquisitions and Contract Management
Overseas Support Specialist	Office of Acquisitions and Contract Management
Supervisory Contract Specialist	Office of Acquisitions and Contract Management
Associate Director, Office of Health Services	Office of Health Services
Chief Administrative Officer	Office of Health Services
Chief of Quality Improvement	Office of Health Services
Director of the Office of Medical Services	Office of Health Services
Field Support Manager	Office of Health Services
Health Care Advisor	Office of Health Services
Peace Corps Medical Officer Program Coordinator	Office of Health Services
Peace Corps Medical Officer Support Unit Manager	Office of Health Services
Quality Improvement Nurse Supervisor	Office of Health Services
Supervisory Education Specialist	Office of Health Services

Table 4: Interviews Conducted with U.S. Embassy Officials

Position	Agency
Medical Attaché	U.S. Embassy, Cameroon
United States Ambassador	U.S. Embassy, Namibia

APPENDIX C: LIST OF ACRONYMS

AVS	Annual Volunteer Survey
CD	Country Director
CHAM	Community Health Aid Manual
CME	Continuing Medical Education
DMO	Director of Management and Operations
FY	Fiscal Year
MA	Medical Assistant
MS	Manual Section
OACM	Office of Acquisitions and Contract Management
OHS	Office of Health Services
OIG	Office of Inspector General
OMS	Office of Medical Services
PC	Peace Corps
PCMO	Peace Corps Medical Officer
RCA	Root Cause Analysis
RMO	Regional Medical Officer
TDY	Temporary Duty
TG	Technical Guideline
USDH	United States Direct Hire

APPENDIX D: CURRENT STATUS OF OHS' RESPONSE TO RECOMMENDATIONS MADE IN 2010

The 2010 Morocco Assessment of Medical Care included 15 recommendations, all of which are closed. Recommendations 2, 4, 5, 6, and 10 were specifically related to operations of the PC/Morocco health unit and are not presented below. The remaining 10 recommendations (1, 3, 7, 8, 9, 11, 12, 13, 14 and 15) were aimed at broader Agency operations. The current status of these 10 recommendations, based on documentation submitted to OIG by OHS, is detailed below.

Recommendation 1: *That the agency assess whether resources and expertise are aligned to provide sufficient oversight to overseas health units.*

OHS Response: In 2010, OHS established the Quality Improvement Unit, which consisted of a manager, one nurse, administrative assistant and credentialing specialist. Since then, staffing of the unit has increased every year to include additional positions.

Recommendation 3: *That OHS develop standard definitions of morbidity and significant illness.*

OHS Response: OHS developed a clinical escalation policy (TG 212).

Recommendation 7: *That OHS develop a policy on scope of practice.*

OHS Response: In 2010, OHS issued a new scope of practice policy (TG 114), which was discussed at the 2010 and 2011 CMEs. Since then, there have been no major revisions to the policy. OHS works with the Office of Global Operations and OACM to ensure appropriate staffing.

Recommendation 8: *That OHS develop an oversight mechanism to ensure sufficient clinical oversight of scope of practice.*

OHS Response: OHS implemented a weekly credentialing committee to review and approve new staff hires in 2010. In 2011, OHS implemented a policy on license renewal for PCMOs (TG 118) and issued standing orders for nurse PCMOs (TG 605). In 2012, a rover PCMO was hired to provide formal mentoring. In 2015, OHS created a PCMO support unit to enhance clinical oversight through mentoring and issued a contract with a patient safety organization.

Recommendation 9: *That Global Operations, OHS, and OACM ensure personal services contracts specify and delineate PCMO clinical responsibilities, particularly when they differ based on level of training or experience.*

OHS Response: New PCMOs are reviewed by the credentialing committee and are required to function within their scope of practice. Clinical privileges are granted by the Director of OHS according to the PCMO's licensure. In addition, nurses are required to practice with standing orders based on CHAM. OHS verifies the credentials of foreign trained doctors based on the Foundation for Advancement of International Medical Education and Research. Performance records of U.S. hires are verified through the National Practitioner Database.

Recommendation 11: *That OHS assess ways to increase clinical supervision of PCMOs, in accordance with American standards, and work with Global Operations to implement the needed changes.*

OHS Response: OHS has taken a number of steps to increase clinical supervision of PCMOs, including strengthening the process for conducting PCMO performance evaluations (TG 112), implementing quarterly chart review, developing a PCMO support unit, hiring additional PCMO mentors, and working with Global Operations and OACM in hiring new PCMOs.

Recommendation 12: *That Volunteer Support, Global Operations, and [the Office of Strategic Information, Research, and Planning] determine appropriate indicators of quality of medical and mental health services provided to Volunteers.*

OHS Response: Currently, OHS has indicators that are based on the Agency's strategic goals. OHS has worked with the Counseling and Outreach unit staff to develop 14 new indicators which will be aligned with [Healthy People 2020](#) and launched once the electronic medical records system is operable.

Recommendation 13: *That Global Operations and OMS determine a system for sufficient oversight of PCMOs to ensure quality and accountability of clinical processes.*

OHS Response: In 2010, OHS formed a Quality Council and developed the Quality Improvement Plan, which is updated annually. PCMO evaluations are conducted annually between OHS, CDs and PCMOs. Post site assessments are conducted every three years, and more frequently, if necessary. In 2011, OHS instituted the quality nurse email (TG 302) to address Volunteer concerns with health care.

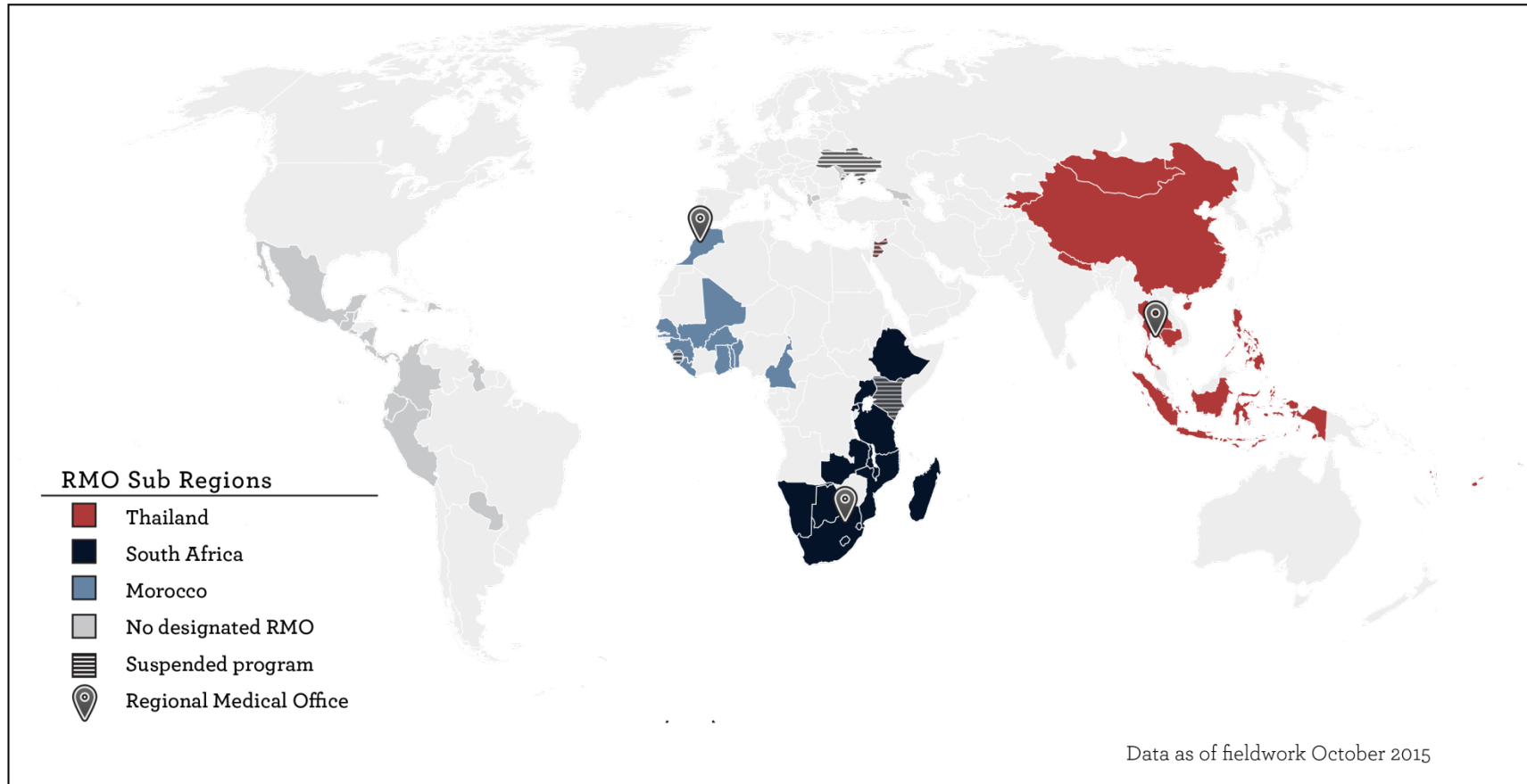
Recommendation 14: *That OMS evaluate its current assessments and modify, as necessary, to ensure quality and accountability of clinical processes.*

OHS Response: OHS developed a tool for conducting site assessments and has initiated the standardization of health units across posts. OHS hired a roving PCMO to serve as a mentor and provide temporary coverage for the health units. In 2014, OHS brought together staff from high performing posts in the Summit of Champions, to discuss potential solutions to common issues. In 2015, OHS created the PCMO support unit to manage the medical assistant and medical secretary functions.

Recommendation 15: *That the agency develop a sentinel event policy.*

OHS Response: OHS developed a sentinel event policy in October of 2010. In 2013, the policy and tools for implementation were reviewed and updated.

APPENDIX E: REGIONAL MEDICAL OFFICER SUB REGIONS



APPENDIX F: MEDEVAC COMPLIANCE

TG 380 5.1	No. of Posts
Medevac Procedures	
Medevac checklist for the PCMO, CD and DMO	6
TG 380 "Medical Evacuation"	6
Manual Section on Medical Evacuation	3
Emergency Contacts	
OMS, including after-hours duty officer contact information	9
Peace Corps staff, e.g. CD, DMO, Regional Medical Officer (RMO)	9
U.S. Embassy staff to include Duty Officer, Administrative Officer	6
Local and regional ambulance services	7
Local and regional hospitals	9
Local and regional emergency providers, e.g., cardiologist and general surgeon	7
Local and regional laboratories, e.g., emergency blood typing, HIV testing	7
Local and regional emergency radiology facilities, e.g., ultrasound, CT scan	7
Maps to important medical locations	2
Volunteer Contact Information	
Volunteer "Emergency Locator Forms"	3
Volunteer telephone numbers and addresses	5
Maps to Volunteer sites	2
Communication Systems	
Sample medevac field consult (see TG 380.6.1)	7
Sample medevac estimated time of arrival (ETA) fax or cable (see TG 380.7.6)	4
Instructions for use of in country communications services, e.g., government, [non-governmental organization], missionary, and police radio networks	4
Instructions for use of cell phones, pagers, beepers, and hand-held radios	2
Transportation Systems	
Procedures for emergency use of the Peace Corps vehicle	4
Local ambulance services	7
Airline schedules	3
Government and military services for helicopter and charter aircraft	2
Train and bus schedules	2
Taxi services	5
Contact information for airport security, customs officials, and immigration officials	2
Emergency Air Rescue	
TG 385 "Emergency Medical Evacuation"	7
Contact information for medical evacuation and rescue services in country, to include description of services and recommendations for use	6
Contact information for international air rescue services	5
Procedures for obtaining clearance for the use of the local airports by air emergency services	2
Procedure for obtaining permission to take an ill Volunteer on a commercial aircraft	2
Military Services: telephone numbers, addresses, contact information, and procedures for use	1
Emergency Transfusion Procedures	
Contact information for facilities and providers competent to perform emergency blood or blood products transfusions	2
U.S. Embassy walking blood bank procedures, if applicable	2
Lists of Volunteers, staff and others and their blood type	0
Emergency Supplies and Equipment	
Location of emergency supplies and equipment	4
Instructions for access to the health unit, supply room and emergency pharmaceuticals	3
Volunteer Evacuee Documents	

Pre-departure instructions for medically evacuated Volunteer;	4
Copy of “Welcome to Washington”	6
Instructions for access to Volunteer Health Record, [World Health Organization] card, Health Benefits identification card, passport	2
Accompaniment Documents	
Accompaniment MS	1
Accompaniment procedures and responsibilities	3
Administrative and Fiscal Information	
Instructions for using medical funds	4
Cash advance and petty cash	5
Form PC-477: “Certification of Non-Indebtedness and Accountability for Property”	4
Power of Attorney form	4
Release of Medical Information	4
Regional Medevac Procedures	
Instructions for sending a Volunteer to a regional medevac destination	6
Contact information at the regional location	6
Regional medevac checklist for the PCMO	4
MS 264.4.1 Procedures	
In-country medical facilities and physicians and medical facilities	9
Physicians in neighboring countries that provide regular and specialized services	4
Local resources that could be used in an emergency	9
Available transportation (U.S., host country or neighboring country) systems; this should include information on availability, request procedures and landing field capabilities	3
Available transportation (U.S., host country or neighboring country) systems; this should include information on availability, request procedures and landing field capabilities	3
Available transportation (U.S., host country or neighboring country) systems; this should include information on availability, request procedures and landing field capabilities	1
Current State Department regulations concerning medical evacuations, if relevant	1
Current format used by embassy or consulate to request aeromedical evacuation and all required standard information	0
TG 385 3	
Emergency air rescue procedures	7
Contact information for in-country and international air rescue services	6
Emergency transfusion procedures	1
Information on access to a local trauma facility, general surgeon, and cardiologist or internist	7
Capabilities of local operating suites, intensive care units, and emergency departments	5
Location of emergency medical equipment and supplies in the health unit	4

APPENDIX G: OVERSIGHT OF PCMO RESPONSIBILITIES

PCMO Responsibilities (TG110)	OHS	CD	Unclear
Operates the in-country Volunteer health program in compliance with Peace Corps policies and procedures as outlined in the Peace Corps Manual and the Technical Guidelines			X
Establishes and operates a health unit			X
Maintains supplies of medications and medical equipment to manage anticipated routine and emergency health needs			X
Advises the CD and OHS of needed support, including administrative assistance, equipment, and additional clinical staff, when applicable	X	X	
Trains administrative and clinical support staff in the health unit			X
Maintains administrative records and planning systems, and participates in the [Integrated Planning and Budget System] planning and budget process		X	
Maintains clinical records that ensure medical confidentiality and compliance with the provisions of the Privacy Act, Peace Corps Manual Section and Technical Guideline			X
Establishes in-country, regional, and U.S. medevac plans, and educates in-country staff on urgent and non-urgent medevac procedures			X
Assists the CD in ensuring the availability and accessibility of health care services		X	
Coordinates and ensures 24/7 coverage for the health unit by a medically qualified individual		X	
Provides the CD with periodic status reports on in-country health and safety concerns, identified in-country health risks, and the objectives of the health care program		X	
Informs the CD of major health and safety problems that may have a programmatic impact, including assaults or illnesses that interfere with Volunteers' activities or that require medevac.		X	
Provides OHS with required reports, i.e., monthly epidemiological surveillance reports, regional medevac reports and in-country hospitalization reports. Submits an annual report to [OHS] and the CD via the performance evaluation process	X		
Attends annual CME courses and [overseas staff training] in Washington for new PCMOs		X	
Plans, coordinates, and provides health education to Volunteers during pre-service, in-service, and close of service trainings, and throughout their tours through the use of newsletters, health handbooks, individual health education sessions, and other activities		X	
Provides preventive health services, including immunizations, periodic health evaluations, and preventive treatments	X		
Participates in the process of site selection including the evaluation of Volunteers' living, work, and training sites; makes professional recommendations for site improvements or changes if indicated		X	
Conducts ongoing site evaluation visits to identify potential health or adjustment problems		X	
Provides clinical care, including the assessment and management of Volunteer health problems, either directly through the services of the health unit or through referral to in-country health care providers and facilities	X		

Establishes and maintains an in-country referral network of health care providers through the identification and evaluation of consultants and services			X
Documents all care provided to Volunteers, including counseling, referrals, and individual health education sessions (see TG 210 "Health Records")	X		
Seeks consultation with the RMO or OHS to assist with case management and referrals; seeks prompt consultation with OHS for all health conditions that may place a Volunteer at high risk of morbidity or mortality	X		
Provides emotional support and short-term counseling services to Volunteers	X		
Provides clinical assessment and management of psychiatric emergencies either directly through the services of the health unit or through referral to in-country health care providers and facilities	X		
Provides clinical care and counseling support to victims of physical and sexual assault	X		
Remains alert for signs and symptom of emotional disorders and substance abuse, and evaluates those who may need support or referral	X		
Establishes a referral care network and oversees referral care provided by local providers			X
In collaboration with OHS, implements quality improvement activities for the in-country health program, including monitoring, evaluation, and problem-solving activities	X		
Participates in process improvement initiatives in collaboration with OHS and the region			X

APPENDIX H: AGENCY'S RESPONSE TO THE PRELIMINARY REPORT



Since 1961.

Memorandum

To: Kathy Buller, Inspector General

Through: Anne Hughes, Acting Chief Compliance Officer

From: Paul Jung, Associate Director, Office of Health Services

Date: March 14, 2016

CC: Carrie Hessler-Radelet, Director
Carlos Torres, Deputy Director
Laura Chambers, Chief of Staff
Rudy Mehrbani, General Counsel
Ken Yamashita, Associate Director for Global Operations
Barry Simon, Director, Office of Medical Services
Donna Richmond, Chief, Quality Improvement, Education and Training
Cathryn Thorup, Director, Office of Strategic Information, Research, and Planning
Joaquin Ferrao, Deputy Inspector General
Jerry Black, AIG/Evaluations

Subject: Agency Response to the Preliminary Report on the OIG Follow-Up Evaluation of Issues Identified in the 2010 PC/Morocco Assessment of Medical Care (Project No. 15-Eval-02)

Enclosed please find the agency's response to the recommendations made by the Inspector General as outlined in the Preliminary Report on the OIG Follow-Up Evaluation of Issues Identified in the 2010 PC/Morocco Assessment of Medical Care (Project No. 15-Eval-02) sent to the Agency on January 27, 2016.

The agency has addressed and provided supporting documentation for nine of the twenty-three recommendations provided by the OIG in its Preliminary Evaluation Report, and will work to address the remaining recommendations by the set target dates.

Recommendation 1

That the associate director of the Office of Health Services clarify the regional medical officers' roles and responsibilities regarding the oversight and supervision of Peace Corps medical officers.

Concur:

Response: The Regional Medical Officers (RMO) play a crucial role in the Peace Corps health system. As noted in the Follow-Up Evaluation Report, the RMO contract requires RMOs to provide medical and administrative support, as well as clinical supervision of Peace Corps Medical Officers (PCMOs). In addition, RMOs are to communicate with PCMOs, the Office of Health Services (OHS), and the Region regarding relevant health and medical administrative matters. Although RMOs are responsible for providing clinical input into PCMO performance, the Follow-Up Evaluation Report indicates that this input has not always been sought or utilized.

On June 17, 2014, the Director of the Office of Medical Services (OMS) sent an email to all PCMOs clarifying the role of RMOs. This email directed PCMOs to include RMOs in all consultations to OMS, including any notifications to OMS as outlined in TG 212 "Clinical Escalation Policy." The email also indicated, "the RMOs act as the clinical supervisors, along with the Director of OMS, of the PCMOs at the posts for which they are responsible and they will contribute to the PCMOs' Annual Performance Evaluations."

The Office of Health Services (OHS) will review with the PCMOs and the RMOs the points in the June 2014 email and reinforce the issue in the 2016 CME conferences.

Documents Submitted:

- The RMO contract statement of work
- Email memo to PCMOs on June 17, 2014 clarifying the role of RMOs
- TG 212 "Clinical Escalation Policy"

Documents to be Submitted:

- OHS spreadsheet of PCMO evaluations with space for RMO input
- Session notes from 2016 CMEs

Status and Timeline for Completion: September 2016

Recommendation 2

That the associate director of the Office of Health Services develop and provide guidance on the transfer of care between Peace Corps Medical Officers, TDY providers, and backup providers to facilitate continuity of care for Volunteers.

Concur:

Response: Continuity of medical care is dependent upon verbal and written communication between the provider relinquishing care and the provider assuming care. The bulk of this communication is done through the medical record. With the implementation of PCMEDICS in the majority of countries by December 2015, and the accompanying updated guidance for its use, medical records should always be current. Since all PCMOs, whether TDY or full time, have access to PCMEDICS, continuity of care should be assured. This depends on an appropriate depth and quality of documentation in the medical record. OHS is currently, and will continue to, striving toward better clinical documentation by its PCMOs through its medical record review process and PCMO mentoring.

As far as the PCMO's ability to assume care of a new trainee, key elements of PCMEDICS are populated by the preservice data base MAXx. Key information regarding medical problems, medications, medication allergies and vaccination status are immediately available to the PCMO even if the PCMO did not have the opportunity to review the medical record of a trainee ahead of time.

In the circumstance where coverage is being provided by a community backup provider, instructions for transfer of care are outlined in TG 185 "Back-up Healthcare Providers" and its attachments.

Documents Submitted:

- TG 185 "Back-up Healthcare Providers" (revised June 2015)
- TG 185 Attachment A: Back-up Healthcare Provider Information (revised June 2015)
- TG 185 Attachment B: Back-up Healthcare Provider Statement of Work (revised June 2015)
- TG 113 "Clinical Documentation Standards" (revised July 2015)
- TG 113 Attachment A: MD Mid-Level PCMO Review Form (revised July 2015)
- TG 113 Attachment B: RN PCMO Review Form (revised September 2015)
- TG 113 Attachment C: Sexual Assault Clinical Documentation Criteria (revised December 2015)
- TG 113 Attachment D: PCMO Standard Chart Submission Schedule

Status and Timeline for Completion: Completed, February 29, 2016

Recommendation 3

That the associate director of the Office of Health Services determine appropriate indicators—in addition to Volunteer satisfaction data obtained through the annual

Volunteer survey—of the quality of Volunteer medical and mental health services and incorporate them into future strategic plans.

Concur:

Response: OHS is leading a Health Indicators working group called Healthy Volunteer 2020 modeled after Healthy People 2020. There are currently 11 health indicators in four topic areas, representing the greatest causes of morbidity and mortality. Work on this started in 2014 with the initial meetings. In 2015, the four topic areas were decided upon: Physical and Mental Health, Tobacco and Alcohol Use, Environmental Quality, and Health Services. During this time, draft Action Plans were developed, the Epidemiology Unit met with the Healthy People organizers at the Department of Health and Human Services, and corresponded with the Healthy Campus coordinators, who are responsible for a similar demographic group.

The working group was launched in December 2015 and consists of representatives from the Office of Health Services/ Epidemiology Unit (OHS/EPI), Education and Training, Field Support, PCMO support, and Quality Improvement. Inter-departmental collaboration is important in achieving the indicator goals, so additional Units representing the Office of Safety and Security (SS) and the Office of Strategic Information and Research Planning (OSIRP) are included in the process.

To ensure that this is not only a Headquarters-driven approach, two overseas colleagues were included in the group--a Regional Mental Health Officer from the Counseling and Outreach Unit, and a Peace Corps Medical Officer who will be on the front lines of data collection. The working group meets on a monthly basis, concentrating on a focus area each time with and a different person reporting to the group, which has oversight from OHS/EPI. After the data is analyzed by the OHS/EPI, the progress will be reported on to Peace Corps Medical Officers and Regional Medical Officers.

Reporting updates occur on a quarterly basis to agency leadership at the Quality Council meeting and monthly at the Quality Improvement Committee meeting.

As this will be an ongoing, iterative project, OHS/EPI intends to continue collecting data and reporting on it. Some data may influence the direction of the agency, in terms of resources allocated to meet certain objectives. Ultimately, the objectives are set for 2020, so there is time to shift course and change the action plans depending on the trend of the indicators.

Documents Submitted:

- Health Indicators Draft, February 2016
- Health Indicators Presentation to QC December, 2015
- Working Group #1 Minutes from December 2015
- Working Group #2 Minutes from February, 2016
- Health Indicators Update to QC March, 2016
- Sample Action Plans

- Plan for Working Group Meetings for 2016

Status and Timeline for Completion: Completed, March 1, 2016

Recommendation 4

That the Director analyze, prioritize and plan for the resources necessary to measure and track the identified indicators of the quality of Volunteer medical and health services.

Concur:

Response: OHS fully deployed PCMEDICS worldwide in 2015. The deployed version of PCMEDICS provides a basic, functional electronic medical record that allows for portability of medical information. Subsequently, OHS submitted a plan to create a fully functional electronic medical record (PCMEDICS) with the capability of data analysis and predictive analytics, which will allow the agency to utilize health data for data-driven decision-making. The PCMEDICS plan was presented to the agency's Technology Advisory Board on February 29 and approved. With the agency's financial support, OHS is planning on developing PCMEDICS for full functionality, starting with inventory control capabilities in 2016-2017, and the ability for predictive analytics in 2018.

Documents Submitted:

- PCMEDICS budget plan
- Email indicating Technology Advisory Board approval of PCMEDICS plan

Status and Timeline for Completion: Completed, February 29, 2016

Recommendation 5

That the associate director of the Office of Global Operations and the associate director of the Office of Health Services explore new ways to raise Volunteer and trainee awareness of the Quality Nurse line.

Concur

Response: The Office of Health Services and Office of Global Operations have the following quality nurse promotional activities and tools in place:

- Introduction to the quality nurse email during PST and IST with issuance of quality nurse contact information (i.e. wallet cards)
- Wallet cards issued to PCVs and trainees by PCMO, and placed in PCV waiting areas, regional houses, lounges, etc.
- Posters provided for health unit and Volunteer resource center/lounge(s)
- Ongoing education of PCMOs at CMEs and OSTs regarding the importance of the Volunteer Concern/Quality Nurse program (TG 302 "Volunteer Concerns")

- Site assessment evaluations include documentation that the quality nurse email posters/wallet cards are present in health unit and Volunteer resource center/lounge(s)
- Posts provide Quality Nurse contact information in newsletters

OHS actively explores methods to further promote the awareness of the quality nurse email. We have recently enlisted the input of OHS RPCVs who have provided the following suggestions:

- Blast text messages to the PCVs in the 15 countries who use PCMEDLINK
- Provide posters for regional/transit houses - Completed March 8, 2016
- Provide decorative small posters with Quality Nurse information for PCV's homes (RPCVs will work on a design)
- Quality Nurse "swag" (budget prohibits this promotional tool)

Documents Submitted:

- TG 302 "Volunteer Concerns"
- Wallet card sample
- Poster sample (TG 302 "Volunteer Concerns", Attachment B)
- Sample Quality Nurse introduction for Post to distribute to PCVs via email and newsletter
- Documentation that posts have distributed Quality Nurse contact information to PCVs
- PST slide introducing quality nurse
- PCMO email notification to distribute posters to regional/transit houses
- Proposed language for text blast

Status and Timeline for Completion: Completed, March 2016

Recommendation 6

That the associate director of the Office of Health Services implement a screening process for root cause analyses that considers severity and frequency of negative health outcomes.

Concur:

Response: The Office of Health Services implemented a sentinel event policy and process after the 2010 Peace Corps/ Morocco Assessment of Medical Care recommendation was given. It was recognized that too many events were considered sentinel to be reviewed by OHS effectively. The quality improvement unit has recently revised TG 167 "Patient Safety Events" (formally named *Sentinel Event Policy*).

With the Safety Assessment Code (SAC) Matrix (attachment C), the Office of Health Services will implement a method of identifying and prioritizing all risk-based patient

safety events. It is an explicit, risk-based root cause analysis (RCA) prioritization system that is superior to one based solely on the harm or injury that a patient experienced. The purpose of the SAC scoring process is to provide a framework to prioritize future actions. The SAC is divided into two categories: severity and probability.

Orientation to this new process has been introduced to OHS leadership and approved by the Clinical Standards Committee. The quality improvement unit staff will be conducting on-going orientations with staff and unit staff meetings, which will be completed March 31, 2016. The updated TG “Patient Safety Events” and attachments will be released to PCMOs/RMOs through email with training through OST and upcoming CMEs throughout 2016.

Documents submitted:

- Revised TG 167 “Patient Safety Events”
- TG 167 Attachment C: Safety Assessment Code Matrix
- Patient Safety Events - *TG 167 Updates* slide set presentation

Status and Timeline for Completion: Completed, February 26, 2016

Recommendation 7

That the associate director of the Office of Health Services ensure staffing is sufficient to adequately implement a more effective sentinel event reporting system and that staff involved in root cause analyses have not had direct involvement in the case.

Concur:

Response: The revised TG 167 “Patient Safety Events” includes guidance on establishing review teams that do not include staff that are intimately involved in the event in order to avoid a real or perceived conflict of interest.

The Office of Health Services (including RMOs, PCMOs and headquarters staff) is comprised of health care professionals with a wide variety of clinical backgrounds and expertise that could be utilized as review committee members. The review team is defined as those individuals who see the RCA process through from beginning to end. It will be limited in size to no more than four to six members. A standard operating procedure (SOP) is being drafted to support this process. If necessary, external consultants could be identified through our professional network of providers or recommendations from the patient safety organization.

With the implementation of the new policy, staffing needs will be assessed on an on-going basis.

Documents submitted

- Revised TG 167 “Patient Safety Events”
- TG 167 Attachment A: Sentinel Event Report Form
- TG 167 Attachment B: RCA Report Form
- TG 167 Attachment C

Documents to be Submitted:

- Review Team Process SOP

Status and Timeline for Completion: March 31, 2016

Recommendation 8

That the associate director of the Office of Health Services perform all root cause analyses in a manner that includes key components (system focus, cause/effect, action plan and measures).

Concur:

Response: With the implementation of the safety assessment codes to identify and prioritize patient safety events, it is believed that the number of events currently captured with the harm-based system will be reduced to allow for enhanced analysis and action planning with this risk-based system.

A risk-based system will allow the quality improvement unit to prioritize cases, therefore allowing time to conduct more effective root cause analysis and contributing factors with appropriate action planning.

Documents submitted:

- Revised TG 167 “Patient Safety Events”
- TG 167 Attachment A: Sentinel Event Report Form
- TG 167 Attachment B: RCA Report Form
- TG 167 Attachment C

Status and Timeline for Completion: Completed, February 26, 2016

Recommendation 9

That the associate director of the Office of Health Services improve staff understanding of best practices for selecting sentinel events for review and for carrying out root cause analyses.

Concur:

Response: Ongoing education with OHS staff and PCMOs will be performed by quality improvement staff during routine OHS unit staff meetings and educational venues for PCMOs (CME, OST, etc.). Topics covered include an outline of major changes to TG 167 “Patient Safety Events”, descriptions of the safety assessment codes, newly established review team and an overview of the patient safety evaluation system (see *TG 167 Updates* slide set).

Documents Submitted:

- Patient Safety Events - *TG 167 Updates* slide set presentation
- Revised TG 167 “Patient Safety Events”

Documents to be Submitted:

- CME Agenda for PCMOs
- CME Presentation
- OHS Staff Education Materials

Status and Timeline for Completion: April 15, 2016

Recommendation 10

That the associate director of the Office of Health Services clarify the agency’s policies and procedures related to sentinel event reviews to focus on and address systemic causes.

Concur:

Response: Newly revised TG 167 “Patient Safety Events” addresses the action planning and reporting of RCAs. The quality improvement unit will also incorporate dialogue and discussion amongst headquarters and PCMOs/RMOs about the *Just Culture* Model. This model is not new to healthcare but is designed to create an atmosphere of trust and encourages the reporting of mistakes. The goal of these developments is to better understand errors in an effort to fix system issues.

On-going education has begun with headquarters staff through unit meetings and will continue with OHS sponsored trainings at OST and CMEs.

Documents submitted:

- Revised TG 167 “Patient Safety Events”
- TG 167 Attachment A: Sentinel Event Report Form
- TG 167 Attachment B: RCA Report Form
- TG 167 Attachment C
- Patient Safety Events - *TG 167 Updates* slide set presentation

Documents to be submitted:

- CME agenda for PCMOs
- CME Presentation

Status and Timeline for Completion: April 15, 2016

Recommendation 11

That the associate director of the Office of Health Services ensure that medical evacuation plan guidance is complete, up to date, relevant, and that inconsistencies in the guidance in agency policy are reconciled.

Concur:

Response: Revised TG 385 “Medical Action Plan” assures that each post has a comprehensive medical action plan (MAP) to address urgent or emergent medical needs of the Volunteers. The MAP provides guidance on the component and organization of a post medical action plan (PMAP), regional medical action plan (RMAP) and individual medical action plans (IMAP). Templates for each component are provided to post as attachments to TG 385.

The MAP is distinct from the post Emergency Action Plan (EAP) which is formulated by the CD and SSM. The two plans may be used in concert and are both critical in assuring the health and safety of Volunteers.

Annual training and review of the MAP is required in the form of a table-top exercise involving all critical members of the post team including, but not limited to all health unit personnel, CD, SSM and DMO.

Documents to be Submitted:

- Revised TG 385 “Medical Action Plan” and Attachments

Status and Timeline for Completion: April 30, 2016

Recommendation 12

That the associate director of the Office of Health Services and the associate director for Global Operations develop and implement a process to regularly ensure that posts’ medical evacuation plans align with agency guidance.

Concur:

Response: Revised TG 385 “Medical Action Plan” requires annual training and review of the medical action plan (MAP) in the form of a table-top exercise involving all critical members of the post team, including but not limited to all health unit personnel, CD, SSM, and DMO. OHS provides a template for such exercises as an attachment to TG 385. MS 264 *Medical Evacuation Procedures*, Section 4.0 Medical Action Plan is currently under revision and, as agreed upon by OHS and OGO, will reflect guidance found in TG 385.

Documents to be Submitted:

- Revised TG 385 “Medical Action Plan”
- Template for Table-Top Exercise
- Revised MS 264 *Medical Evacuation Procedures*

Status and Timeline for Completion: April 30, 2016

Recommendation 13

That the associate director of the Office of Health Services provide clear guidance to posts on when and how to conduct a medical emergency preparedness drill.

Concur:

Response: Revised TG 385 “Medical Action Plan” (MAP) requires annual training and review of the MAP in the form of a tabletop exercise involving all critical members of the post team including but not limited to all health unit personnel, the CD, SSM, and DMO.

Clear guidance on how to conduct the drill is provided in form of a template for the drill and is an attachment to TG 385.

Documents to be Submitted:

- Revised TG 385 “Medical Action Plan”
- Template for Annual Drill

Status and Timeline for Completion: April 2016

Recommendation 14

That the associate director of the Office of Health Services implement and clarify MS 264 Medical Evacuation, section 4.2(e), to include the type of emergencies for which instructions should be provided to staff.

Concur:

Response: Revisions to TG 380 “Medical Evacuations” and TG 385 “Medical Action Plans” are currently being finalized. The goal is to clarify definitions, processes and eliminate conflicting guidance. The revised TGs outline the medical evacuation procedures and introduce the concept of country wide, regional and individual medical action plans which document how emergency access to care will reach each Volunteer.

TG 385 requires an annual emergency simulation exercise for post staff. TG 380 is currently under revision. Once TG 380 and TG 385 are completed, OHS will recommend a revision of MS 264 Procedures, Section 4.2 (e) to bring the documents in line.

Documents to be Submitted:

- Revised TG 385 “Medical Action Plans”
- Revised TG 380 “Medical Evacuation”
- Revised MS 264 Procedures

Status and Timeline for Completion: June 2016

Recommendation 15

That the associate director of the Office of Health Services clarify guidance on how frequently posts are expected to conduct medical facility and provider assessments, prioritizing assessments in countries with limited health infrastructure.

Concur:

Response: TG 204 “Peace Corps Volunteer Site Visits/Health Facility Assessment,” published in January 2016, provides requirements for PCMO assessment of health facilities and providers. PCMOs are required to visit all facilities and providers which provide healthcare to Volunteers at a minimum of once every three years utilizing the facility and provider assessment tools provided by OHS (TG 204 Attachments C-I). All assessment tools must be stored electronically and in hard copy.

Documents Submitted:

- TG 204 “Peace Corps Volunteer Site Visits/Health Facility Assessment” and Attachments C-I

Status and Timeline for Completion: Completed, January 2016

Recommendation 16

That the associate director of the Office of Health Services and the associate director for Global Operations ensure that country directors receive clear guidance on all of their health unit oversight responsibilities.

Concur:

Response: Upon completion of Recommendation 17 of this report, the Office of Health Services and the Office of Global Operations will determine the best method of disseminating the guidance, such as email and/or sessions at CD and CME conferences.

Documents to be Submitted:

- Guidance on Health Unit Oversight Responsibilities
- Messaging to field/Country Directors on Guidance developed per Recommendation 17

Status and Timeline for Completion: December 2016

Recommendation 17

That the associate director of the Office of Health Services and the associate director for Global Operations update agency guidance to ensure that the division of oversight responsibility for the health unit is clear and that all health unit responsibilities are covered.

Concur:

Response: Technical Guidelines 110 and 112, MS 264, MS 264 Procedures and 734 provide information on the role of Country Directors in health unit oversight responsibilities. As the Follow-Up Evaluation Report points out, some roles are not distinct between CDs and PCMOs and can be clarified. The Office of Health Services and the Office of Global Operations will work to identify and delineate the specific roles that CDs and PCMOs plan in health unit oversight, and then decide where these roles should be defined, including agency policy or other guidance.

Documents to be Submitted:

- Revised Guidance on Health Unit Oversight Responsibilities

Status and Timeline for Completion: October 2016

Recommendation 18

That the associate director of the Office of Global Operations and the associate director of the Office of Health Services provide coordinated communication to posts that clarifies expectations about PCMO participation in posts' planning processes, including integrated planning and budgeting (IPBS) and annual operating plan formulations.

Concur:

Response: OHS recognizes the need for PCMO inclusion in local budget planning. This issue was identified in the OHS "Summit of Champions" as critical to a well-functioning health unit and post. The primary guidance for IPBS at the post level is developed by OSIRP and OCFO in coordination with the Office of Global Operations. OGO disseminated the guidance for FY2017-2018 to posts on December 17, 2015. This step-by-step guidance provides posts with detailed information on how to plan their local budget, in line with the agency's strategic plan.

Although the guidance asks for information on health issues that may affect posts, previously there was no specific mention of including the PCMO in the process. OHS and OGO have worked together to specifically include how the PCMO should assist the

posts in developing the local budget, including the needs of the health unit, in the IPBS process, with the 2017-2018 IPBS guidance.

Documents Submitted:

- Email announcing FY 2017-2018 IPBS guidance for posts
- FY 2017-2018 IPBS guidance for posts
- Summit of Champions executive summary

Status and Timeline for Completion: April 2016

Recommendation 19

That the associate director of the Office of Health Services and the associate director for Global Operations clarify policy and guidelines related to the vehicle availability for overseas health unit medical staff.

Concur:

Response: OHS and OGO are currently collaborating on developing language which will clarify the policy and guidelines for vehicle and driver availability for overseas health unit medical staff and the transport of ill and injured Volunteers.

Documents to be Submitted:

- Revised MS 522 *Vehicle Use Procedures*

Status and Timeline for Completion: June 2016

Recommendation 20

That the associate director of the Office of Health Services clarify guidance and expectations for training and use of back-up providers.

Concur:

Response: OHS has proposed revisions to MS 261 *Medical Offices and Peace Corps Medical Officers* that clarify guidance and expectations for training and use of back-up providers. These revisions are scheduled for review at the upcoming Senior Policy Committee Meeting. Upon approval and issuance, the revised policy will be submitted to address this recommendation.

Documents to be submitted:

- Revised MS 261 *Medical Offices and Peace Corps Medical Officers*

Status and Timeline for Completion: April 30, 2016

Recommendation 21

That the associate director of the Office of Health Services assess the amount of administrative support required to allow regional medical officers to work effectively and efficiently, and request the required resources.

Concur:

Response: OHS and OGO are collaborating on a plan that outlines the roles and responsibilities of regional hub staff and the staff of the hosting post. OHS has surveyed the regional medical officers to establish a catalogue of services that need to be provided at regional hubs. Next steps include identifying the administrative support necessary to accomplish the duties above.

Documents to be Submitted:

- Regional Hub Operational Manual
- Standard Operating Procedures

Status and Timeline for Completion: December 31, 2016

Recommendation 22

That the associate director of the Office of Health Services develop a plan, in collaboration with other offices as appropriate, to address the causes of PCMO job dissatisfaction and improve retention of qualified PCMOs.

Concur:

Response: OHS has implemented several strategies in the past few years to address several issues that may lead to job dissatisfaction. For example, in 2014 we held a “Summit of Champions” to identify issues that distinguish high-functioning health units. From this Summit, along with other assessments conducted with PCMOs, OHS identified several issues similar to those identified in this Follow-Up Report. Below are some of the issues identified and the ways that OHS has addressed them:

- 1) **Workload:** Due to several factors, PCMOs felt overburdened by the administrative requirements of their job (both generally, and specifically as related to the procedures surrounding sexual assault). Mental health issues were also identified as a particularly demanding aspect of their clinical requirements. As a result, OHS responded by creating a PCMO Support Unit in 2015 specifically to assist PCMOs with the administrative, non-clinical aspects of their job. The PCMO Support Unit provides mentoring, assistance with paperwork, guidance for non-clinical procedures, as well as suggestions on how to handle non-clinical situations at post.

OHS also removed the artificial guideline that suggested a certain number of PCMOs per number of Volunteers in the field. Given the unique aspects of every post, we suggested that each post develop a plan to determine the correct PCMO::Volunteer ratio, including the opportunity to utilize medical assistants and medical secretaries as needed. This has resulted in some posts increasing their number of PCMOs, some reducing their number, and several utilizing medical assistants and secretaries.

To address the mental health needs of the PCVs and to lift some of the burden from the PCMOs, OHS placed three Counseling and Outreach Unit mental health counselors at our regional medical hubs (Morocco, South Africa, Thailand) to provide psychological assistance to PCMOs. By being closer to the field, these Regional Mental Health Officers (RMHOs) can provide phone-counseling in nearby time zones and can also assist posts with in-person mental health needs with only the need for regional travel. In addition, OHS selected mental health as the subject topic for the 2016 CME conferences.

The implementation of PCMEDICS has made a huge difference in PCMO productivity. As PCMEDICS is specifically designed for PCMO needs and matches PCMO workflow, it has significantly improved PCMO efficiency. One PCMO wrote, “Just went out to the training site and saw four PCVs. I was able to chart on them real time into PC medics offline and synched right up when I got back here to the office. What a miraculous game changer! I love PC Medics even more!!!! Thank you!!!!!!”

Finally, OHS has currently proposed a revision of MS 261 *Medical Offices and Peace Corps Medical Officers* to the Senior Policy Committee to mandate the use of community backup providers to give PCMOs some time off; this requirement has been a practice recommended by OHS in the past, but it has never been enforced (or enforceable as it was never in policy) and this had resulted in some PCMOs not having a single day or weekend off in *years*.

- 2) **Compensation, Benefits, and Post Perception of PCMOs:** Salary and benefits for PCMOs (and all PSCs) at the Overseas Contracting Issues Council (OCIC) in 2014 and 2015. In fact, substantial benefit improvements related to health insurance were enacted in 2015 for all MS 744a contractors. Improvements to leave carryover policies were also implemented in 2015. Increases in salary were not enacted at the OCIC level due to the fact that salaries are set at the post-level and not at headquarters. A proposal to change the title of PCMO to Director of Volunteer Health (DVH) in an attempt to elevate the position of the PCMO was voted on and approved by OCIC, but later rescinded due to strong complaints from posts about the nature and implication of the title change. Although only some benefits were improved, and not all changes affected all PCMOs, these policy changes did reveal a willingness of the agency to enact improvements for PCMOs.

To further improve post perception of PCMOs, they are now part of Overseas Staff Training as members of the larger OST group. They have their own PCMO track with session specific to their roles as Medical Officers, but they now join with the larger group (consisting of Country Directors, Directors of Programming and Training, and Directors of Management and Operations) for sessions on annual planning, IPBS, Peace Corps Strategic Planning, etc.

- 3) **Retention:** In 2014, OHS identified a correlation between high PCMO turnover and low AVS scores for satisfaction with health care. In addition to all the efforts noted above, OHS initiated a certificate program to recognize the longest-serving PCMOs, with certificates being handed out at the CMEs in front of their peers.
- 4) Although the Follow-Up Report indicates that 25% of PCMOs report low job satisfaction, no data was presented on the causes of dissatisfaction specific to this fraction of PCMOs. Data presented in the report show that all PCMOs rated lower satisfaction with salary, overall workload, opportunities for professional growth and benefits, but the lack of data makes it difficult to ascertain whether the 75% of PCMOs who have high satisfaction rated these aspects of their job any differently than the 25% of PCMOs reporting low satisfaction. Therefore, it is not clear whether the low ratings for salary, workload, professional growth, and benefits are the actual cause of job dissatisfaction, especially since there is no relative data to make any comparisons.

Regarding turnover, although we are not implying that this analysis appears to be looking for problems where they do not exist, we do appreciate that this follow-up report agrees with the 2015 OHS Q2 Performance Snapshot where we formally correlate PCMO turnover with Volunteer satisfaction related to healthcare. And surely this report is not intimating that PCMOs with marginal performance be retained (with improved pay, benefits and professional opportunities) simply to reduce turnover. Several PCMOs in the past few years were either terminated or did not have their contracts renewed due to poor performance and this may explain PCMO turnover. Our PCMO turnover percentages are on par with data from the Partnership for Public Service that shows federal healthcare turnover rates at 15% in 2014.

Regardless, low job satisfaction and turnover should always be addressed regardless of the lack of clear data indicating that these issues are an obvious problem or not. OHS believes that the efforts noted above will positively affect job satisfaction among PCMOs.

Documents Submitted:

- Summit of Champions Executive Summary
- Decision Memorandum Establishing PCMO Support Unit
- FY 2015 OHS Operations Plan – Noting PCMO:PCV Ratio at Post
- TG 200 “Overseas Health Units”, Revised June 2015, Section 11 on Health Unit Staffing

- Announcement of Regional Mental Health Officers
- PCMEDICS Announcement, Email Dated December 31, 2015
- Overseas Contracting Issues Council Meeting Minutes, July 2015; February 2015
- PCMO Track OST Agenda
- Certificate Program Documentation
- 2015 OHS Q2 Snapshot
- 2014 Federal Departures Data

Status and Timeline for Completion: Completed, March 2016

Recommendation 23

That the associate director of the Office of Health Services assess staffing configurations at posts and regional medical hubs and develop a plan to provide health units with sufficient clinical and administrative support staff.

Concur:

Response: OHS acknowledges the staffing challenges at posts. Due to the uniqueness of the Peace Corps environment, there is no set formula that can be used to determine optimal staffing of clinical and support staff in the health units. Representatives of OHS meet regularly with regional staff to discuss health unit staffing needs and recommend adjustments accordingly. The work load of PCMOs and health unit support staff is also assessed regularly through OHS site visits, regional staff visits and OIG audits.

OHS recommends that every post has at a minimum a medical secretary, but preferably a medical assistant. TG 110 “Volunteer Health Program” outlines the roles and responsibilities of post staff and rationale for staffing.

Documents Submitted:

- TG 110 “Volunteer Health Program”, Revised September 2015

Status and Timeline for Completion: Completed, February 29, 2016

APPENDIX I: OIG COMMENTS

Management concurred with all 23 recommendations, which remain open. In its response, management described actions it is taking, or intends to take, to address the issues that prompted each of our recommendations. OIG will review and consider closing recommendations 1, 2, 4,5,7, and 9 through 21 when the documentation reflected in the agency's response to the preliminary report is received. OIG requires additional documentation to consider closing recommendations 3,6,8, 22 and 23. Recommendations will remain open pending confirmation from the chief compliance officer that the documentation reflected in our analysis below is received.

We wish to note that in closing recommendations, we are not certifying that the agency has taken these actions or that we have reviewed their effect. Certifying compliance and verifying effectiveness are management's responsibilities. However, when we feel it is warranted, we may conduct a follow-up review to confirm that action has been taken and to evaluate the impact.

Recommendation 3

That the associate director of the Office of Health Services determine appropriate indicators—in addition to Volunteer satisfaction data obtained through the annual Volunteer survey—of the quality of Volunteer medical and mental health services and incorporate them into future strategic plans.

Concur:

Response: OHS is leading a Health Indicators working group called Healthy Volunteer 2020 modeled after Healthy People 2020. There are currently 11 health indicators in four topic areas, representing the greatest causes of morbidity and mortality. Work on this started in 2014 with the initial meetings. In 2015, the four topic areas were decided upon: Physical and Mental Health, Tobacco and Alcohol Use, Environmental Quality, and Health Services. During this time, draft Action Plans were developed, the Epidemiology Unit met with the Healthy People organizers at the Department of Health and Human Services, and corresponded with the Healthy Campus coordinators, who are responsible for a similar demographic group.

The working group was launched in December 2015 and consists of representatives from the Office of Health Services/ Epidemiology Unit (OHS/EPI), Education and Training, Field Support, PCMO support, and Quality Improvement. Inter-departmental collaboration is important in achieving the indicator goals, so additional Units representing the Office of Safety and Security (SS) and the Office of Strategic Information and Research Planning (OSIRP) are included in the process.

To ensure that this is not only a Headquarters-driven approach, two overseas colleagues were included in the group--a Regional Mental Health Officer from the Counseling and

Outreach Unit, and a Peace Corps Medical Officer who will be on the front lines of data collection. The working group meets on a monthly basis, concentrating on a focus area each time with a different person reporting to the group, which has oversight from OHS/EPI. After the data is analyzed by the OHS/EPI, the progress will be reported on to Peace Corps Medical Officers and Regional Medical Officers.

Reporting updates occur on a quarterly basis to agency leadership at the Quality Council meeting and monthly at the Quality Improvement Committee meeting.

As this will be an ongoing, iterative project, OHS/EPI intends to continue collecting data and reporting on it. Some data may influence the direction of the agency, in terms of resources allocated to meet certain objectives. Ultimately, the objectives are set for 2020, so there is time to shift course and change the action plans depending on the trend of the indicators.

Documents Submitted:

- *Health Indicators Draft, February 2016*
- *Health Indicators Presentation to QC December, 2015*
- *Working Group #1 Minutes from December 2015*
- *Working Group #2 Minutes from February, 2016*
- *Health Indicators Update to QC March, 2016*
- *Sample Action Plans*
- *Plan for Working Group Meetings for 2016*

Status and Timeline for Completion: Completed, March 1, 2016

OIG Analysis:

In addition to the documents submitted, please provide a description of how OHS intends to incorporate and use indicator data related to the quality of medical and mental health services to inform its strategic plans.

Recommendation 6

That the associate director of the Office of Health Services implement a screening process for root cause analyses that considers severity and frequency of negative health outcomes.

Concur:

Response: The Office of Health Services implemented a sentinel event policy and process after the 2010 Peace Corps/ Morocco Assessment of Medical Care recommendation was given. It was recognized that too many events were considered sentinel to be reviewed by OHS effectively. The quality improvement unit has recently revised TG 167 “Patient Safety Events” (formally named *Sentinel Event Policy*).

With the Safety Assessment Code (SAC) Matrix (attachment C), the Office of Health Services will implement a method of identifying and prioritizing all risk-based patient

safety events. It is an explicit, risk-based root cause analysis (RCA) prioritization system that is superior to one based solely on the harm or injury that a patient experienced. The purpose of the SAC scoring process is to provide a framework to prioritize future actions. The SAC is divided into two categories: severity and probability.

Orientation to this new process has been introduced to OHS leadership and approved by the Clinical Standards Committee. The quality improvement unit staff will be conducting on-going orientations with staff and unit staff meetings, which will be completed March 31, 2016. The updated TG “Patient Safety Events” and attachments will be released to PCMOs/RMOs through email with training through OST and upcoming CMEs throughout 2016.

Documents submitted:

- Revised TG 167 “Patient Safety Events”
- TG 167 Attachment C: Safety Assessment Code Matrix
- Patient Safety Events - *TG 167 Updates* slide set presentation

Status and Timeline for Completion: Completed, February 26, 2016

OIG Analysis:

Please provide documentation that describes how OHS will apply the SAC Matrix. This may include, but is necessarily limited to, the OST and CME staff training materials. Additional documentation should indicate how OHS will use the SAC Matrix to determine what events are selected for root cause analysis. Please describe whether or not OHS intends to conduct aggregate root cause analyses for events that occur frequently, but are not considered severe. If the intent of the SAC Matrix is to reduce the number of RCAs to improve their quality and impact, describe how OHS will determine when to undertake root cause analyses.

Recommendation 8

That the associate director of the Office of Health Services perform all root cause analyses in a manner that includes key components (system focus, cause/effect, action plan and measures).

Concur:

Response: With the implementation of the safety assessment codes to identify and prioritize patient safety events, it is believed that the number of events currently captured with the harm-based system will be reduced to allow for enhanced analysis and action planning with this risk-based system.

A risk-based system will allow the quality improvement unit to prioritize cases, therefore allowing time to conduct more effective root cause analysis and contributing factors with appropriate action planning.

Documents submitted:

- Revised TG 167 “Patient Safety Events”
- TG 167 Attachment A: Sentinel Event Report Form
- TG 167 Attachment B: RCA Report Form
- TG 167 Attachment C

Status and Timeline for Completion: Completed, February 26, 2016

OIG Analysis:

In addition to the provided documents, OIG will request a sample of completed root cause analyses for review after OHS has conducted them using the revised TG 167.

Recommendation 22

That the associate director of the Office of Health Services develop a plan, in collaboration with other offices as appropriate, to address the causes of PCMO job dissatisfaction and improve retention of qualified PCMOs.

Concur:

Response: OHS has implemented several strategies in the past few years to address several issues that may lead to job dissatisfaction. For example, in 2014 we held a “Summit of Champions” to identify issues that distinguish high-functioning health units. From this Summit, along with other assessments conducted with PCMOs, OHS identified several issues similar to those identified in this Follow-Up Report. Below are some of the issues identified and the ways that OHS has addressed them:

- 5) **Workload:** Due to several factors, PCMOs felt overburdened by the administrative requirements of their job (both generally, and specifically as related to the procedures surrounding sexual assault). Mental health issues were also identified as a particularly demanding aspect of their clinical requirements. As a result, OHS responded by creating a PCMO Support Unit in 2015 specifically to assist PCMOs with the administrative, non-clinical aspects of their job. The PCMO Support Unit provides mentoring, assistance with paperwork, guidance for non-clinical procedures, as well as suggestions on how to handle non-clinical situations at post.

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- *PCMO Track OST Agenda*
- *Certificate Program Documentation*
- *2015 OHS Q2 Snapshot*
- *2014 Federal Departures Data*

Status and Timeline for Completion: Completed, March 2016

OIG Analysis:

OIG acknowledges the efforts that OHS has made to address factors that negatively impact PCMO job satisfaction and can lead to unwanted turnover of qualified PCMOs. It may be that some of these initiatives had yet to bear fruit at the time of the fieldwork for this evaluation. OIG also recognizes that OHS has actively managed under-performing PCMOs, and that some PCMO turnover is indicative of effective oversight and management. Recommendation 22 is focused on addressing factors that limit the agency's ability to attract and retain qualified PCMOs and reduce unwanted turnover.

In response to point 4) above, OIG presents data below (Figure 6) on areas of job dissatisfaction among PCMOs who reported low morale. PCMOs with low morale most frequently cited workload as the primary area of job dissatisfaction. Three-quarters of PCMOs who reported low morale were either dissatisfied or very dissatisfied with their workload. Furthermore, 65 out of 85 PCMOs surveyed reported that the amount of their non-clinical responsibilities had a moderately negative or significantly negative impact on their ability to provide quality medical care in the past year.

Among those PCMOs who reported low morale, 57 percent said they were either unsatisfied or very unsatisfied with compensation. Nearly half (48 percent) of PCMOs who reported low morale stated that the lack of opportunities for professional development were unsatisfactory, or very unsatisfactory.

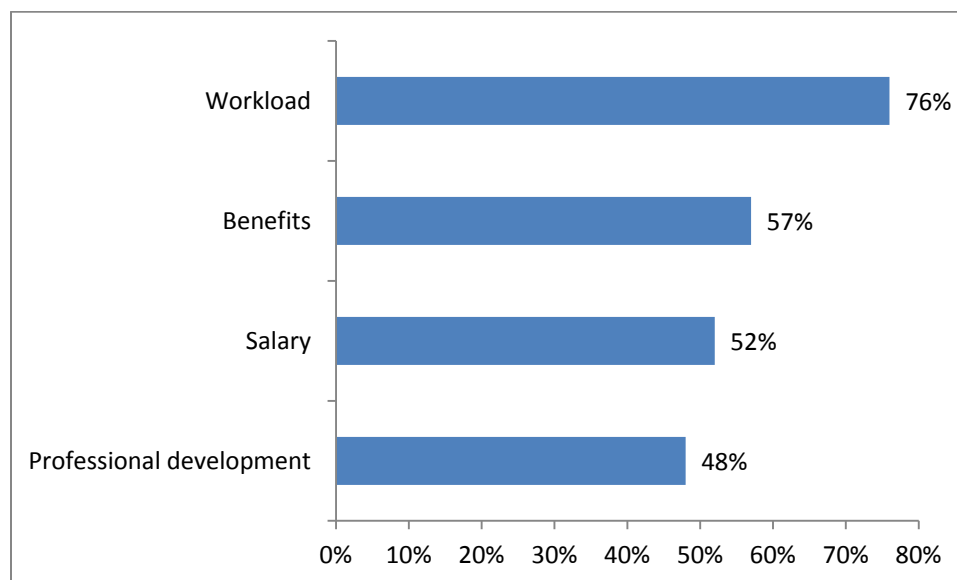


Figure 6. Areas of job dissatisfaction among PCMOs with low morale
PCMO Survey

In addition to the documents submitted, OIG requests that the associate director of OHS provide a plan, developed in collaboration with other offices, that describes how the

agency will try to address the causes of PCMO job dissatisfaction and improve retention of qualified PCMOs. The plan should include a description of actions the agency intends to take to address PCMO workload strain, especially related to non-clinical responsibilities; steps the agency can take to provide more competitive compensation packages as well as professional education and development opportunities for PCMOs; and how the agency will track the results of its efforts over time to attract and retain qualified PCMOs and reduce unwanted turnover.

Recommendation 23

That the associate director of the Office of Health Services assess staffing configurations at posts and regional medical hubs and develop a plan to provide health units with sufficient clinical and administrative support staff.

Concur:

Response: OHS acknowledges the staffing challenges at posts. Due to the uniqueness of the Peace Corps environment, there is no set formula that can be used to determine optimal staffing of clinical and support staff in the health units. Representatives of OHS meet regularly with regional staff to discuss health unit staffing needs and recommend adjustments accordingly. The work load of PCMOs and health unit support staff is also assessed regularly through OHS site visits, regional staff visits and OIG audits.

OHS recommends that every post has at a minimum a medical secretary, but preferably a medical assistant. TG 110 “Volunteer Health Program” outlines the roles and responsibilities of post staff and rationale for staffing.

Documents Submitted:

- TG 110 “Volunteer Health Program”, Revised September 2015

Status and Timeline for Completion: Completed, February 29, 2016

OIG Analysis:

OIG recognizes the current, ongoing work of OHS to address staffing. In addition to the document submitted, please provide a plan that includes an assessment of staffing configurations at posts and regional medical hubs and a description of the steps the agency intends to take to prioritize and provide sufficient clinical and administrative support staff where most needed.

APPENDIX J: PROGRAM EVALUATION COMPLETION AND OIG CONTACT

PROGRAM EVALUATION COMPLETION

This program evaluation was conducted under the direction of Assistant Inspector General for Evaluations Jerry Black, by Senior Evaluator Erin Balch, Evaluator Kaitlyn Large and former Senior Evaluator Susan Gasper. Additional contributions were made by former Assistant Inspector General for Evaluation Jim O’Keefe, Senior Evaluator Greg Yeich, and former Evaluator Apprentice Caroline Hale.

Peace Corps OIG thanks Dr. Thomas Wong and Dr. George Wesley from the U.S. Department of Veteran’s Affairs Office of Inspector General for their expert assistance in assessing Peace Corps approach to reviewing sentinel events and conducting root cause analyses.

In addition, OIG thanks Dr. Lee Adler for his advice on the medical emergency scenario and sentinel event analysis.



OIG CONTACT

Following issuance of the final report, a stakeholder satisfaction survey will be distributed to agency stakeholders. If you wish to comment on the quality or usefulness of this report to help us improve our products, please contact Assistant Inspector General for Evaluations Jerry Black at jblack@peacecorps.gov or 202.692.2912.

Help Promote the Integrity, Efficiency, and Effectiveness of the Peace Corps

Anyone knowing of wasteful practices, abuse, mismanagement, fraud, or unlawful activity involving Peace Corps programs or personnel should contact the Office of Inspector General. Reports or complaints can also be made anonymously.

Contact OIG

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