Peace Corps
Office of Inspector General

Final Program Evaluation Report

Peace Corps' Medical Clearance System

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FINAL PROGRAM EVALUATION REPORT

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Acronyms

COI...Close of Invitation
DFR..Deferral
FECA……………………………………………………Federal Employees' Compensation Act
FIFO...First In, First Out
FTE..Full-Time Equivalent
FY……………………………………………………………………....Fiscal Year
GAO...Government Accountability Office
HHS...Health and Human Services
HSR……………………………………………………Health Status Review
JCAHO………..……………...Joint Commission on Accreditation of Healthcare Organizations
MAC...Medical Accommodations Coordinator
MCS…………………………………………………………..…….Medical Clearance System
MNQ...Medically Not Qualify Status
MOU...Memorandum of Understanding
MRQ...Medical Request Queue
NPCA...National Peace Corps Association
OCIO………….....…………………………………..Office of the Chief Information Officer
OIG……………………………………………………Office of Inspector General
OMS…………………………………………………………Office of Medical Services
OSIRP..Office of Strategic Information, Research and Planning
PC……………………………………………………………………....Peace Corps
PCM…………………………………………………………..Peace Corps Manual
PCMO………………………………………………………..Peace Corps Medical Officer
PCV…………………………………………………………...Peace Corps Volunteer
PEM...Pugh Ettinger McCarthy Associates
PND...Pend Case
QI……………………………………………………...………..Quality Improvement
QUA...Medically Qualify Status
REJ...Reject Status
RPCV...Returned Peace Corps Volunteer
RST...Medical Restriction/Medical Accommodation
SN………………………………………………………………Screening Nurse
SOP……………………………………………………….. Standard Operating Procedure
SRB...Screening Review Board
SQL...Structured Query Language
TG…………………………………………………Technical Guideline
TR...Trainee Request
VA...Veterans Administration Hospital
VDS…...…………………………………………………Volunteer Delivery System
VHS…………………………………………………………...Volunteer Health System

EXECUTIVE SUMMARY

WHY WE DID THIS EVALUATION

The Office of Inspector General conducts regular reviews of Peace Corps operations. The last evaluation of the Volunteer Delivery System was conducted in 2003, of which the Medical Clearance System was one component of the study.

The Peace Corps' Medical Clearance System (MCS) is responsible for medically screening applicants to ensure that Peace Corps posts are provided with healthy Volunteers who can serve for 27 months without undue disruption. The MCS is one component of the Volunteer Delivery System (VDS), a continuous cycle of Volunteer recruitment, screening, and placement that allows the Peace Corps to deliver healthy, qualified, and suitable Volunteers to host countries.

On a yearly basis, the Pre-Service Unit medically clears more than 84% of applicants who complete the medical screening process. In FY 2006, Peace Corps posts requested headquarters to provide 4,640 Trainees to enter the field and become Peace Corps Volunteers. In response to this request, the Office of Medical Services (OMS) reviewed 7,517 medical files and cleared 5,323 applicants in FY 2006.

Applicants Medically Qualified	5,323
Applicants Qualified with Restrictions	864
Applicants Requiring Two or More Medical Accommodations	121
Applicants Medically Deferred	763
Applicants Medically Not Qualified	446
Total:	7,517

 * FY 2007 data provided by Office of Volunteer Services/OMS.

Year to year, the OMS Screening unit, responsible for operating the MCS, has ensured that the annual request for Trainees is consistently fulfilled.

In FY 2006, the average time to process an applicant from application received until the applicant entered on duty was 335 days. On average, applicants over the age of 50 years (50+ applicants) took 122 more days to process compared to applicants under 50 years of age. The greatest time difference between 50+ and applicants under 50 years of age was during the medical review, in which 50+ applicants took an average of two months longer to medically screen than under 50 applicants (see table below).

2006 Applicant Processing Time in Days

50+ (431 days)	91	85	103	42	6	104
All Applicants (335 days)	62	87	54	38	9	85
Under 50 (309 days)	51	75	44	29	9	73

Scale: 0 60 120 180 240 300 360 420 480

- Application to Nomination
- Nomination to Kit Received by OMS
- Kit Received to Medical Qualification
- Medical Qualification to Invitation
- Invitation to Acceptance
- Acceptance to Enter on Duty
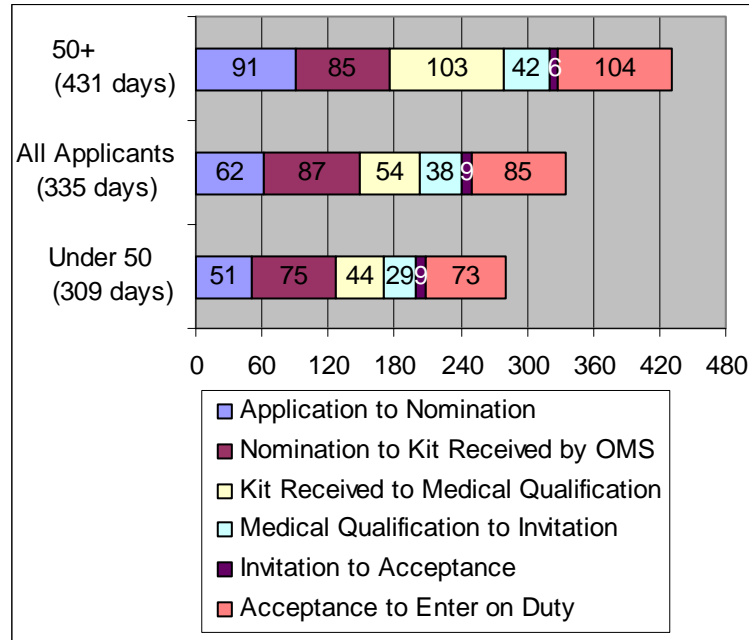
*The 133 days in the MCS was generated by adding the time from nomination to medical qualification and then subtracting the average number of days from nomination to applicants receiving their medical kit in the mail, which is not included on this chart but according to the Pre-Service System Reports Menu was an average of 8 days in FY 2006.

On average, applicants spent approximately 133 of the 335 days in the medical clearance portion of the VDS process. The 133 days includes the time it takes the applicant to schedule medical and dental appointments, send in the Medical Kit, respond to requests from Peace Corps for additional required medical documentation, and a screening nurses' review of the applicant's complete Medical Kit and subsequent medical disposition. Although a significant portion of the 133 days is dependent upon how quickly the applicant schedules exams and sends in the Medical Kit, there are concrete changes that the Peace Corps can implement to improve the effectiveness and efficiency of the Peace Corps Medical Clearance System.

RESEARCH METHODOLOGY

The MCS evaluation plan was designed to collect information from a variety of sources in an effort to objectively identify ways to improve the medical clearance process and the Volunteer Delivery System as a whole. The MCS Evaluation methodology included a comprehensive evaluation plan consisting of an analysis of applicant feedback from over 1,100 OIG surveys, a document review of prior VDS studies, an Office of Management and Budget (OMB) approved online

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survey to capture feedback from three major sub-groups of applicants (see table below), a case study of three 50+ applicants that followed their experience through the MCS in real-time, and extensive face-to-face interviews with multiple Peace Corps staff and outside offices.

Applicant Type	Emailed	Responded	Response Rate
Did not Serve	1,114	266	24%
Volunteer	1,114	513	46%
RPCV	1,118	324	29%
Total	**3,346**	**1,103**	33%

Survey Demographics	OIG Survey Respondent Demographics (valid %)	Peace Corps FY2006 Applicant Demographics (valid %)	Peace Corps FY2006 Volunteer Demographics (valid %)
Gender	68% Female	59% Female	59% Female
Age	78% 20-29	82% 20-29	85% 20-29
Ethnicity	88% White	81% White	83% White
Education	89% College Degree or Higher	91% College Degree or Higher	96% College Degree or Higher
Marital Status	90% Single	92% Single	92% Single

Our scope was expanded due to the introduction of the Director's 50+ Initiative and S. 732: The Peace Corps Volunteer Empowerment Act.

The Medical Clearance System evaluation marks the first time the Peace Corps has obtained OMB approval to collect information from general public applicants who went through the Peace Corps application process but either were denied medical clearance or decided not to continue their application.

The Medical Clearance System evaluation systematically analyzed a host of complex issues from both the applicants' and the Peace Corps staffs' perspectives including the screening review systems and procedures, the screening review timeframe, medical screening guidelines, communicated guidance, transparency, interoffice communication, customer service, staff training, and the reimbursement fee schedule.

MCS BEST PRACTICES

In conducting our evaluation, we were impressed with the effectiveness of the following screening systems and processes:

- *Screening Review Board* – Each Wednesday, the Screening Review Board, composed of OMS screening staff, doctors and managers, meets to review medical screening applicants appeal cases. The process is comprehensive, effective, and represents an example of Volunteer empowerment in the MCS. Recently, the Director of OMS eliminated the applicant's ability to appeal a second time subject to review solely by the Director of OMS. This decision to eliminate the second round of appeals increased the efficiency of the appeals process without sacrificing oversight.
- *Cross Training* – The Medical Support Supervisor presents an overview of OMS and the MCS at new recruiter trainings held at headquarters. In addition, the medical support supervisor and other screening staff make field visits to regional recruitment offices and other events in order to inform, develop working relationships with recruiters, and collectively identify best practices to facilitate applicants through the MCS. Data from our survey corroborated that this is a good practice. Eighty-six percent of applicants reported that the medical clearance system information provided by the recruiters and OMS staff was consistent.
- *Production Meetings* – Every week, placement officers communicate to screening nurses their needs for upcoming close of invitations (COIs) in order to fill upcoming Trainee classes. These weekly meetings with placement officers and screening nurses are a great example of inter-office communication and support.
- *Automation of Medical Kit Launch* – Although the Medical Kit is still a paper-centric process, the Pre-Service Unit and the OMS computer programmer analyst have worked to better organize and automate this process. In June 2007, the process became fully automated, which eliminated the need to manually review Medical Kit documents prior to mailing. This has decreased the amount of days between nomination and sending an applicant their Medical Kit from eight to three days. On September 17, 2007, OMS presented the Online Medical Kit project to the Peace Corps

Investment Review Board in order to secure agency funding and IT resources.

- *Expert System Improvements* – The Expert System is the computer application used by the Pre-Service Unit to track medical screening records and Pre-Service Unit work. The Pre-Service Unit has worked closely with the OMS computer programmer analyst to consistently make improvements that benefit the staff's ability to log applicant medical documentation and communications, thereby allowing the screening staff to respond specifically to applicants, even if that applicant is assigned to a different screening staff member.

- *Screening Assistants* – The screening manager (employed at the agency during the period April 2000 – March 2007) created three positions within the Pre-Service Unit to be the frontline for customer service calls. Many applicant calls are administrative in nature and do not require medical expertise. These positions freed up the screening nurses to concentrate on medically screening applicants.

We commend the OMS Screening unit for their recent improvements to the MCS, for continually meeting the annual request for Trainees, and for fulfilling their core functions.

AREAS FOR IMPROVEMENT

However, external and internal criticism have mounted regarding the MCS pertaining to lack of transparency, exceedingly long time frames for issuance of medical dispositions, lack of quality improvement, lack of technological improvements, poor quality of customer service, inadequate reimbursement fee schedules, and lack of agency accountability.

Our results from the Medical Clearance System Survey show that of the applicants who withdrew their application from Peace Corps, 80% withdrew during the Medical Clearance process. Our results also show that when asked why they withdrew from the application process, the four most frequently cited reasons were "medical screening took too much time," "burdensome medical costs," "burdensome dental costs," and "poor communication with medical screening." Overall, 61% of applicants who applied to Peace Corps but did not serve, answered that they were "not at all satisfied" or "minimally satisfied" with the Medical Clearance System. Our

evaluation concluded that the problems with the MCS can be traced to the following causes within OMS:

- Failure to implement recommendations from previous agency and consultant reports.
- Failure to prioritize and communicate Pre-Service goals.
- Failure of the Pre-Service Unit to follow a standard process for reviewing an applicant medical file.
- Failure of the Pre-Service Unit to work with the field.
- Failure to use data in medical screening decision-making.
- Failure to establish and enforce Pre-Service Unit performance standards.

The State Department has a system by which they medically clear potential Foreign Service Officers. They recently made several changes to their medical clearance system which fixed many of the same types of problems currently found in the Peace Corps Medical Clearance System. The bottom line is that the Peace Corps Medical Clearance System can be improved, and the State Department is an example of how system changes to a medical clearance system can make it more effective and efficient.

Our evaluation found significant weaknesses in the following areas and we make recommendations focusing on the following:

- **Quality Improvement**
  OMS and particularly the Quality Improvement (QI) Unit have not been proactive in leading quality and process improvements to the Medical Clearance System. Standard Operating Procedures for screening applicants do not exist and Standard Operating Procedures for the storage of confidential medical information are not enforced. When we commenced our review of the Medical Clearance System, screening databases and medical screening guidelines were out of date and documents contained inaccurate or incomplete information which lengthened screening and placement and may lead to placing applicants in countries that do not have the resources to accommodate them, potentially putting Volunteers at unnecessary risk. OMS recently completed their update of the Peace Corps medical screening guidelines in November 2007.

- **Data Collection and Analysis**
  Although screening data is collected in the Expert System and is analyzed and presented in reports, the data is generally unreliable and analysis techniques are not supportive of performance measurement and process improvement efforts.

- **Interdepartmental Communication**
  The Pre-Service Unit is not working with the Field and Post Support Units to identify whether the medical clearance process is asking the best health questions to effectively and efficiently screen applicants for service.

- **Customer Service**
  According to our survey, only 32% of applicants who called the OMS main telephone number listed in the Medical Kit reached a live representative the first time they called. Customer service problems like this and others have persisted because OMS has no means for systematically collecting applicant feedback and does not enforce customer service standards.

- **Staffing Needs**
  The OIG evaluation team was unable to determine whether Peace Corps requires additional Pre-Service nurses. OMS reports provided to our evaluation team for the purpose of making this determination lacked information or were based on faulty analysis. In addition, it is clear that the five-year rule is a significant detriment to the Medical Clearance System on account that it forces out the most experienced screening nurses and creates vacancies in screening nurse positions that remain unfilled for an average of two months.

- **Cost to Applicant**
  OMS did not provide applicants with information regarding the average out-of-pocket expenses to complete the medical screening process. Additionally, OMS cannot justify why Peace Corps reimburses applicants according to the current fee schedule. No documentation exists on the criteria for: 1) assessing the adequacy of the reimbursement fee schedule, or 2) adjusting the schedule for inflation or new Medical Kit requirements.

- **MCS Timeframe**
  Applicants need to make arrangements prior to becoming a Peace Corps Volunteer and were frustrated that Peace Corps did not provide them with an average

timeframe for completing the MCS process. Poorly organized and unclear Medical kit instructions confused some applicants and their health care providers adding additional time to the MCS process.

- **Veterans Administration Hospitals**
There is inconsistent information provided to applicants, inconsistent applicant knowledge, and low applicant usage of the Veterans Administration Hospitals for medical screening tests.

- **The MCS and Applicants 50 Years and Older**
Applicants 50 years and older have a very different experience navigating through the Medical Clearance System than their colleagues under 50 years of age and consequently require more screening unit resources.

- **Streamlining the MCS**
Peace Corps has identified but not implemented technological improvements to the MCS that would improve transparency and accessibility.

- **Prior Report Recommendations have not been Implemented**
OMS staff concede that prior reports have accurately identified needed MCS improvements. However, many of these recommendations have been left ignored.

Our report contains 55 recommendations, which if implemented, should improve internal controls and correct the weaknesses outlined above.

MEDICAL CLEARANCE SYSTEM

The Peace Corps' Medical Clearance System (MCS) is responsible for medically screening applicants to ensure that Peace Corps posts are provided with healthy Volunteers who can serve for 27 months without undue disruption. The MCS is one component of the Volunteer Delivery System (VDS), a continuous cycle of Volunteer recruitment, screening, and placement that allows the Peace Corps to deliver healthy, qualified, and suitable Volunteers to host countries.

Once an applicant is nominated for Peace Corps service, the applicant is sent a Medical Kit, which includes medical, dental, and reimbursement forms with instructions for completing the forms. The Office of Medical Services Pre-Service Unit is responsible for the MCS and mails all nominated applicants a Medical Kit of medical and dental forms with guidance for completing the required evaluations, tests, x-rays and documentation requests. Instructions to complete the Medical Kit are found in both the "Comprehensive Medical and Dental Package," a 32-page booklet, and in a customized packet of letters and forms printed from the Expert System.

Once the Medical Kit is completed by the applicant and the applicant's examining physician, dentist, optometrist, and any specialists, as appropriate, a screening nurse reviews the applicant's Medical Kit and reaches a determination of medical clearance (QUA), clearance with restrictions (RST), deferral (DFR), or disqualification (MNQ). If an applicant is cleared with restrictions, the Pre-Service Unit works with Office of Volunteer Recruitment and Selection (VRS) and the Peace Corps post to ensure that the applicant is sent to a post with reasonable accommodations for the applicant's medical condition(s). If an applicant is medically disqualified, he or she can appeal the decision by submitting new information to the Screening Review Board.

QUALITY IMPROVEMENT

Prior OMS leadership, the Quality Improvement (QI) Unit, and the Pre-Service Unit were not sufficiently proactive in leading quality and process improvements to the Medical Clearance System. Lack of emphasis on the importance of quality improvement, including lack of Standard Operating Procedures (SOPs) for applicant Medical Kits, lack of enforcement of existing Standard Operating Procedures for the secure storage of confidential medical records, and the lack of meaningful performance indicators have had negative impacts on the MCS.

There are no Standard Operating Procedures for reviewing the Medical Kit.

An example of the lack of quality standards is that OMS has no SOPs for reviewing a Medical Kit, for reviewing portions of a Medical Kit such as Personal Statements, and for using the Chronological Notes to record communication between OMS and the applicant in the medical screening electronic application.

Although screening nurses are trained to screen applicants using the same procedures, some nurses have developed different systems for screening applicants. They have not been held to one standard. Several OMS staff stated that the Pre-Service Unit is clearing more applicants now than in the past because of personal preferences. One OMS staff member told us the following:

> *We don't have any guidelines for who we take or reject in the screening process. Under the previous Chief of Clinical Programs we would not take applicants with irritable bowel syndrome (IBS). The new Chief of Clinical Programs says IBS is OK. There isn't a condition that can't be taken care of in South Africa or Thailand. The reason we are accepting more people now is because of personal preferences of [the new Director of OMS and the new Chief of Clinical Programs].*

Former and current OMS staff stated unanimously that there was a lack of interest and a lack of prioritization of quality improvement by the former OMS leadership. Several staff members provided the example that in order to clear out some of the back log of unreviewed applicant medical charts during the spike period (March - September), in 2003 the former Director of Volunteer Support requested applicant files on an irregular basis from screening nurses and made medical dispositions by typically writing by hand "OK" on the chart. OMS staff reported that the former Director of Volunteer Support cleared applications that were missing medical documentation and should not have been cleared.

OMS could not identify how many charts the former Director of Volunteer Services reviewed because he did not document his work in the medical screening electronic applications. Nurses reported that the most time-consuming part of

screening a file is documenting their work and conclusions in the medical screening electronic applications and database.

According to anecdotal evidence, the former Director of Volunteer Services reviewed roughly 150 medical files during the spike period. Several nurses reported that they went back and re-reviewed his work and entered the correct information in the database. However, nurses reported that they were not certain that all nurses had re-reviewed the files.

Standard Operating Procedures (SOPs) for confidential information were not enforced.

According to SOP 3.1 and 3.2, medical files are confidential records and need to be kept in a secure area and tracked if a medical record changes hands. Currently, SOP 3.1 and 3.2 are not enforced and several staff report that the location of medical records is not entered and kept up to date in the computer tracking system. Medical records sit unsecured in desk drawers for extended periods of time. Liability for misplaced files is placed on the medical records staff, which is inappropriate in many cases.

Enforcement of current SOPs and assessment of the medical records process needs to be a priority and guided by the QI unit in maintaining medical confidentiality, compliance, and screening efficiency.

Quality Improvement initiatives in the Pre-Service Unit are lacking.

Several prior reports evaluating the OMS-administered Volunteer health program made findings, recommendations, and in some cases, premature commendations for procedures and initiatives observed in the Pre-Service Unit and the MCS.

The 2002 Pugh Ettinger McCarthy (PEM) Report was the fourth external evaluation of the Peace Corps Volunteer Health System (PCVHS) following the McMannis Associates report and the 1994 and 1997 JCAHO reports. The PEM report's recommendations focused on the PCVHS's compliance with standards developed by the 1997 JCAHO report which among other recommendations, stated that OMS participate in the 1993 Government Performance and Results Act (GPRA). The PEM report found that OMS units lacked performance measures for key work processes. To ensure

agency accountability to the Medical Clearance System, the Quality Improvement Unit should work with OMS managers to develop performance measures and metrics that can be tracked over time demonstrating the effectiveness, efficiency, and quality of the MCS. Once collected and analyzed, performance measure outcomes should be included in strategic planning documents produced and distributed by OMS. Development and consistent monitoring of these measures and metrics will introduce better coordination and efficiencies throughout OMS.

In 2007, OMS reported to be in the process of developing performance measures. However, currently the only mechanisms for monitoring the effectiveness of screening processes are OMS Executive Summary Reports and annual Office of Volunteer Support Performance Indicators.

The following indicators from the PEM report illustrate examples of quality control processes measured by pre-determined rates that would determine an acceptable or unacceptable status:

- Length of time an applicant's completed Medical Kit can be assigned to a screening nurse without being reviewed.
- Screening productivity (spike and non-spike periods).
- Percentage of Medical Kits screened according to first in, first out (FIFO) out of the total numbers of Medical Kits assigned to a screening nurse on a weekly basis.
- Customer service: Percentage of returned telephone messages, e-mails, faxes, etc. by a screening nurses compared to the total correspondence (inclusive of telephone, e-mail, fax) sent by applicants on a daily basis.

However, we found that none of these quality control processes have been implemented.

In addition, the Quality Improvement Unit staff has not been given QI training opportunities. Formalized training in quality improvement would better equip the QI Unit with strategies to implement more effective quality improvement initiatives, oversight, and fulfill the purpose of the QI unit.

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RECOMMENDATIONS

We recommend:

1. That the Pre-Service Unit develop Standard Operating Procedures for all aspects of the Pre-Service process.

2. That OMS enforce SOP 3.1 and 3.2 pertaining to confidential applicant medical records.

3. That the Pre-Service Unit with the assistance of the QI Unit and the Office of Strategic Information, Research, and Planning (OSIRP) determine whether the performance measures recommended in the Pugh Ettinger McCarthy Associates report would accurately capture Pre-Service performance. These performance indicators include but are not limited to the following:
    *   Percentage of Volunteers with accommodations that complete 27 months of service.
    *   Rate of non-injury related Medevac.
    *   Rate of mental health early terminations.
    *   Percentage of Peace Corps offices involved in the VDS that rate OMS performance as excellent.
    *   Percentage of Pre-Service employees that rate their job satisfaction as excellent.
    *   Average time to fill open positions.
    *   Monthly turnover rate.
    *   Cost per Federal Employees' Compensation Act claim.
    *   Cost per screening.
    *   Percentage of Volunteers with significant medical issues not identified in screening.
    *   Percentage of screenings with decisions made within 90 days of receipt.
    *   Percentage of incomplete medical records.

4. That OMS provide Quality Improvement training to their staff to enable the staff to develop meaningful performance indicators to measure the Pre-Service Unit's productivity and other related matters.

SCREENING RESOURCES

The Quality Improvement Unit has allowed updates to critical screening resources, such as the Medical Screening Guidelines and Country Health Resources database, to lapse.

The 1994 Joint Commission on Accreditation of Healthcare Organizations (JCAHO) report cited the review of the medical screening guidelines as an enhancement of clinical care and assessment. However, when we commenced our review of the Medical Clearance System, the medical screening guidelines were in the process of being updated, and several had not been revised since the early 1990s. According to Technical Guideline 100.3.5, last updated in 2001, one of the core functions of the QI Unit is to, "develop and monitor Screening Guidelines for the medical clearance process."

A QI Unit staff member told us that the revision process to update the guidelines began in October 2005 and is anticipated to be completed by November 2007. OMS reported that in the future, medical screening guidelines will be reviewed at a minimum annually and as changes in screening occur.

In addition to not regularly updating the medical screening guidelines as changes in screening occurred, the current Quality Improvement Unit did not verify whether Peace Corps Medical Officers (PCMOs) and posts were annually completing the Country Health Resources Survey which supplies important information on available medical facilities and resources at post to the Country Health Resources database used by the Pre-Service staff for clearing applicants for certain countries. The lack of updating the Country Health Resources database affects the Medical Accommodations database, which contains a list of countries that can manage certain medical conditions. While the Country Health Resources database is tied to performance criteria and is more informational to the Pre-Service Unit, the Medical Accommodations Database is used by the QI Unit for anecdotal information provided by the PCMOs.

The Pre-Service Unit uses both databases in fulfilling its core functions of screening applicants who require one or more medical accommodations. The QI Unit admitted that each of the databases lacks some information needed by OMS units and that each of the databases serves different functions. The QI Unit acknowledged that these updates have been delayed and that there has been no determination of which database provides the best information to screening nurses. More than one OMS staff member emphasized that QI is not the sole responsibility of the QI Unit and needs to be

prioritized by departmental leadership and by the Pre-Service Unit, the recipient of screening improvements.

The 1997 JCAHO report stated that the Country Health Resources Survey, which feeds the Country Health Resources database, "has the potential to touch every aspect of the Volunteer Health System."

The QI Unit should require every PCMO to update the Country Health Resources Survey at a minimum annually or as changes in country healthcare management occur. In addition to routinely updating the databases, it is inefficient to have two databases that both have the purpose of providing screening nurses with information on what medical accommodations posts can support. The QI Unit leadership agreed that this was inefficient and one database containing all relevant medical accommodation information needed for screening should be designed and implemented to streamline the medical accommodations portion of the screening process.

In addition, one screening nurse serves as the Medical Accommodations Coordinator (MAC) who coordinates special applicant cases with PCMOs and country directors. The process consists of the MAC screening nurse contacting the PCMOs and country directors to request approval of whether that country can manage an applicant's medical condition. Delays in medical screening of these cases are attributed to slow PCMO and country director response time to the MAC screening nurse. PCMOs should be held to higher standards by management in regard to more efficient response times to ensure that the medical screening process of special medical applicant cases is conducted in a timely and efficient manner.

STAFF AS A RESOURCE

OMS was not utilizing staff fully as a resource for process improvement.

Office of Medical Services staff members reported that the OIG's current evaluation of the Medical Clearance System was one of the first opportunities their opinion was summoned on systems and processes. A rich but underutilized resource for monitoring the effectiveness and efficiency of the MCS is the Pre-Service Unit, whose experience is embedded and ensures the delivery of the MCS. The only mechanism that asks for staff feedback is the employee exit interview and can be found in OMS Standard Operating Procedure (SOP) 2.5,

which says: "Data from the exit interviews will be tallied and reviewed on a yearly basis by the Senior Managers for planning purposes." Currently, OMS staff members are asked to rate their overall satisfaction with OMS and provide feedback on the strengths and weaknesses of the department ONLY upon departure from Peace Corps during the exit interview process.

This existing method of collecting staff feedback should be applied earlier in an OMS staff member's tour and collected at a minimum, annually. Staff feedback mechanisms need to be developed in which OMS can systematically collect staff responses and recommendations for identifying "strengths and opportunities" for making improvements to the MCS. Staff should be able to give feedback regarding current work flows, screening processes, interoffice communication, quality improvement requests, workload distribution, etc. Establishing systems to conduct periodic data analysis and encouraging discussion forums will build consensus and identify the best ways to make these process and strategic improvements.

RECOMMENDATIONS **We recommend:**

5. **That OMS create policies and procedures to require PCMOs to complete the Country Health Resources Survey as information in their country changes in order to ensure that the headquarters data on the types of medical conditions the post can accommodate is accurate.**

6. **That OMS merge the two duplicative databases, the Country Health Resources database and the Medical Accommodations database, used by screening nurses to place applicants requiring a medical accommodation for efficiency and consistency in the medical accommodations process.**

7. **That OMS create policies and procedures to ensure that the Medical Screening Guidelines are updated at a minimum annually and as screening changes occur.**

8. **That OMS establish a required number of days that a post has to respond to a request from the Medical Accommodations Coordinator to minimize delays in the MCS process.**

DATA COLLECTION AND ANALYSIS

INACCURATE PAR REPORTING

Inaccurate data analysis does not allow for accurate agency goal setting.

The 2006 Performance Accountability Report (PAR) submission of days to medical qualification was inaccurate. Using information provided by OMS, the 2006 PAR (Performance indicator 4.1, line iii) reported that the agency's FY 2006 target for the number of days from receipt of medical qualification to invitation was 32 days and that the FY 2006 results were 30 days. Due to OMS's exclusion of all cases over 89 days from the data analysis, the actual number of days was greater than the reported 30 days.

The Medical Screening Improvement Plan states:

> *Traditionally, the days to medical qualification has been calculated as the difference between the physical exam received date and the medical qualification ('QUA') date and the average numbers of days was reported for all applicants who were medically qualified during the reporting time frame. However, cases that exceeded 89 days to qualification were excluded. This exclusion caused many cases such as those with missing information, deferrals, and pending issues as well as those for Crisis Corps Volunteer re-enrollees to be ignored.*

As a consequence, OMS's decision to exclude cases over 89 days from the data analysis led to the agency reporting inaccurate information and gave the false impression that the medical qualification of an application took less time than it actually did.

Accordingly, the PAR reference to 89 days was incorrect.

CALCULATING THE AVERAGE TIME FOR A NURSE TO SCREEN A MEDICAL KIT

OMS's data collection and data entry system does not allow for the accurate calculation of the average amount of time it takes to medically screen an applicant.

Repeatedly, OMS officials reported that it is difficult to determine how long it takes to screen an applicant because

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they have no control over how motivated the applicant is to complete and send in their Medical Kit. Some OMS staff also explained that they are reviewing individual health histories that are unique and therefore cannot provide an accurate and reliable average timeframe to applicants.

We found that OMS's collection of screening data has serious control issues that go beyond the motivation of an applicant, as follows:

1. Applicant status and timeframes were overwritten if an applicant applied to the Peace Corps more than once. This resulted in information from a first application being overwritten by a second application. If a RPCV is going through the application process when a data request is pulled from the agency database, information will be combined and the applicant's status and timeframe will be inaccurate for both application experiences.

2. Applicants who are deferred, pended, defactoed, or withdraw from the screening process are not given a final disposition and remain in the database, causing problems in finalizing screening performance statistics for a given year.

   As these applicants were not given a final medical disposition, their data was recorded as a negative timeframe and OMS was unable to analyze the average amount of time an applicant was in the Medical Clearance System prior to their decision to withdraw. Information on the amount of time applicants who have withdrawn were in the Medical Clearance System could inform the agency on Volunteer resiliency during the application process.

3. The "physical exam received" date was not always updated or entered correctly and may be overwritten by a re-enrollee. A negative medical clearance timeframe can result if: (a) a physical exam is received after a medical disposition has been entered, as in the case of a screening appeal; or (b) a physical exam is received for a re-enrollee, but OMS has not started a review.

4. Screening appeal cases were not electronically tracked and OMS staff did not believe that they had ever been

analyzed to determine how much time they add to the average medical clearance timeframe. OMS's failure to analyze the data gives an incomplete picture of screening appeals and renders it impossible to accurately determine the time and cost of reviewing medical screening appeals.

5. Screening nurses are able to enter medical actions such as "medical qualification" more than once for an applicant. One OMS official explained:

> *For example, an applicant could be MNQed [medically not qualified] and then later Qualified, so they would be counted in both categories. Also, if the medical team inadvertently enters an action more than once, then it will be counted as such. So this is why you can't compare these numbers to any nom [nomination] counts. I'm sure that these numbers have been used to show the number of quals* [qualified] *and not quals* [medically not qualified] *and that may be fine depending on what you need to convey.*

6. The date that the Medical Kit was sent to an applicant was not always entered correctly. OMS has stated that they need to work with the Office of the Chief Information Officer to modify the Pre-Service computer applications to instill data quality controls to ensure that: screening nurses cannot give multiple medical dispositions for one applicant; the medical kits sent date is recorded accurately; and the physical exam date cannot be recorded as a date after which the medical disposition was given.

7. There was no field in the screening table to show whether a Medical Kit was missing information or the date showing the last time screening nurses worked on the review of the Medical Kit.

Additionally, fields to indicate when a nurse started, stopped, and restarted review of a Medical Kit would allow OMS to calculate the average amount of time the Medical Kit is with the applicant and the average

amount of time it takes the Pre-Service Unit to review an applicant's Medical Kit.

8. There is no field in the screening table to show whether Placement has asked the Pre-Service Unit to expedite a file for an upcoming close of invitation (COI). Screening nurses stated that they practice a combination of first-in, first-out (FIFO) for reviewing an applicant's Medical Kit and that files are prioritized based on the COI date.

    Until there is a field that allows tracking of cases reviewed under FIFO versus cases reviewed based on COI priorities, Peace Corps will not know how long it takes to review a typical medical file.

The OMS computer programmer analyst has stated that she is aware of these data problems and is working with the Office of Strategic Information, Research and Planning (OSIRP) to resolve them and improve OMS performance measurement.

Until there are additional fields that document: 1) if information is missing; 2) the request date(s) for missing information; 3) the date(s) the missing information is received; 4) when a screening nurses starts and stops work on a file; and (5) a request from Placement to expedite an applicant's Medical Kit, OMS will not be able to accurately measure the time it takes a screening nurse to screen an applicant's Medical Kit. Instead, OMS will only be able to measure the time between when an applicant's Medical Kit is received and when the medical disposition is issued.

In the absence of unreliable data and analysis, OMS is unable to identify areas of inefficiencies in the system and recommend areas for improvement. As a result, decisions are made based on anecdotal evidence. For example, there is no systematic analysis for determining whether a medical condition that goes through the appeals process is consistently deemed Medically Not Qualified and therefore should be added to the list of medical conditions that typically are not accepted by the Peace Corps. Currently, this list is based on conditions that screening nurses and post service nurses mention frequently as hard to manage medical conditions overseas.

The agency has stated that it is aware that it needs to improve its ability to strategically and accurately collect and analyze data in order to measure its success and impact in quantifiable ways. In February 2007, the Director announced his Measuring Success and Impact initiative, which will be led by his newly established Office of Strategic Information, Research and Planning (OSIRP). OSIRP will focus on the agency's performance planning and reporting, evaluation and measurement, and data management needs; and specifically will "champion data standards, act as the agency historian, and coordinate data methodology and collection".

COST OF SCREENING AN APPLICANT

OMS cannot provide an accurate cost of screening an applicant.

In order to assess the effectiveness of the screening process and analyze the impact of the 50+ Initiative, OMS should be able to calculate the cost to the agency for screening an applicant less than 50 years of age versus an applicant 50 years and older.

Peace Corps is not able to accurately calculate the cost because of the following data collection issues:

- OMS cannot segregate the total number of FY 2006 dispositions by age groups.
- OMS cannot retrieve historical information.
- OMS cannot provide the number of days between receipt of physical exam to disposition issued (qualified, medically non-qualified or others). OMS provided the number of days to a medical qualification; however, this excludes the other possible dispositions.
- OMS and VRS data have different values for the length of time to medical qualification.
- OMS information regarding number of days to medical qualification was presented separately to us using average and median measurements.

Applicant data is not standardized across agency offices.

OMS applicant data cannot be reconciled with applicant data from other Peace Corps offices because the data is not standardized across agency offices; information and metrics do not flow between offices. Each office collects their own data and creates reports for their own individual office use.

OMS provided the OIG with the following three reasons why OMS data and VRS data cannot be reconciled:

1. OMS data is based on medical actions and there could be multiple medical actions for one applicant. VRS data is based on applicants, not application processing actions.

   OMS does not reconcile medical qualification counts with the applicant nomination or invitation counts, and therefore, applicants could not be tracked through the medical clearance system in a linear fashion.

   This is currently being addressed by the Peace Corps data warehouse project.

2. OMS's applicant information straddled multiple years. Someone that was medically qualified in 2006 could have an enter on duty (EOD) date of 2007.

3. Applicants who withdrew from the medical clearance process were not documented.

   Every applicant screened by OMS is supposed to be designated with one of five final medical clearance dispositions. An applicant may passively defacto from the process before being given an official medical disposition and OMS allowed these applicants to remain in defacto status. For the purposes of accurate performance measurement, all defacto applicants should be tracked and documented annually at the end of the fiscal year (September 30). This was a process that was followed in the past and should be reinstituted. Defacto is defined as an applicant who has not responded to communication from Peace Corps for a period of eight or more weeks but who has not formally withdrawn his/her application.

OMS should be able to reconcile the data and its inability to do so impedes agency offices from sharing and verifying information on Volunteer delivery system performance. These issues need to be resolved in order for the agency to measure the efficiency and the effectiveness of Goal 1 operations – providing Volunteers to the field.

9. **That OMS work with the Office of Strategic Information, Research and Planning (OSIRP) to accurately calculate the average time for a medical qualification for performance measurement and inclusion in the Performance Accountability Report.**

10. **That OMS work with OSIRP to identify the additional data fields that the Pre-Service Unit should collect to accurately measure the time it takes a screening nurse to review a Medical Kit, including stopping the clock for missing information.**

11. **That the Pre-Service Unit work with OSIRP to determine the data elements and data analysis required to implement performance indicators recommended in the 2002 PEM report for inclusion in the 2008 PAR.**

12. **That the Pre-Service Unit and VRS Placement Unit work with OSIRP to standardize application data across agency offices.**

13. **That OMS convert defactos to one of five medical dispositions by September 30th of a given year for performance tracking and measurement purposes.**

14. **That OMS and VRS work with OSIRP to devise a method for tracking applicants through the entire VDS process including the reconciliation of the number of nominations to medical kits sent and medical dispositions to final invitations.**

15. **That OMS work with OSIRP to determine how to accurately calculate the time and cost of a screening appeal and how to factor that time and cost into an average time and cost to screen an applicant.**

16. **That the OCIO correct the problem of applicant status and timeframes being overwritten in Peace Corps Volunteer Database Management System if an applicant applies to the Peace Corps more than once.**

17. **That the OCIO add data fields to the tables in PCVDBMS to capture additional information on the medical screening time frame and to capture when missing information is requested and when missing information is received.**

18. That OMS designate responsibility and provide data collection and analysis training to a staff member to maintain and perform the data methodology, collection and analysis of Pre-Service data as defined by OSIRP.

INTERDEPARTMENTAL COMMUNICATION

The Pre-Service Unit is not working with the Field and Post Support Units to identify whether the MCS is asking the best health questions to effectively and efficiently screen applicants for service.

Best business practices dictate that there should be a continuous communication loop between the supply-side and the demand-side of the Volunteer Delivery System (VDS) to determine if needs are being met and to respond to changes in MCS delivery requirements.

The 1999 Review of the Peace Corps VDS report included the recommendation that the "web-based information management system" be expanded and made more dynamic in order to, "provide internal communication between overseas and domestic staff about...medical and other accommodations." Enhancing the agency's communication tools with overseas posts would provide a direct link to "real-time information... [and] would provide...overseas staff...full understanding of 'supply' constraints."

A mechanism for systemizing and facilitating interoffice communication among OMS units has not been prioritized; it is not a management performance objective nor does it appear in OMS SOPs, Best Practices manuals, or OMS staff position descriptions.

Lack of both cross-unit communication and feedback from post management isolates units in the delivery of the MCS. Each unit is imbedded in individual work processes to the extent that there is no analysis of the effectiveness of medical screening requirements, how they help or hinder post health management, and the impact of changes in post conditions and healthcare.

The Pre-Service Unit periodically requests feedback from posts piecemeal on a case-by-case basis. However, there is no systematic monitoring of whether medical records provided to

PCMOs are effective and used by PCMOs when providing health care to Volunteers in country.

PRE-EXISTING CONDITIONS

The process of screening applicants for pre-existing conditions and/or chronic illnesses should be improved.

The needs of the Post and Field Service Unit should be incorporated into how the Pre-Service Unit's screening nurses review applicants' Medical Kits.

Better communication between the Pre-Service Unit, overseas posts, and the Post-Service Unit would help identify the pre-existing conditions and/or chronic illnesses which typically result in medical evacuations, early termination for health reasons, and FECA claims.

In 2006, the average FECA claim amount paid to 50+ Volunteers was $9,109 compared to $5,667 paid to under-50 Volunteers. In 2006, 29% of 50+ Volunteers became a FECA claimant, compared to 12% of Volunteers under 50 years of age; only 5% of the Volunteer population was 50 years of age or older.

Additionally, 50+ applicants have a higher number of medical separations and a higher number of medical evacuations than other age groups.

Sharing information would allow the agency to make informed changes to the pre-service medical screening requirements and give the agency a better measure of applicant costs.

OMS failure to communicate changes in the Medical Kit requirements caused unnecessary costs and applicant confusion.

Agency policy (Technical Guideline 300) pertaining to immunization procedures is inconsistent with updated OMS policy on applicant immunization requirements. As of January 22, 2007, an immunization requirement was added to the MCS Medical Kit that required applicants to submit documentation of receipt of the following immunizations: 1) Td booster; 2) Polio booster and 3) a measles, mumps, and rubella (MMR) booster. Applicants will not be given medical clearance if they have not received these boosters. However, TG 300 states that these boosters will be provided once a Trainee arrives in

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country and a Trainee's refusal of these boosters is grounds for administrative separation.

The guidance in TG 300, last updated April 2005, is not consistent with the new immunization policy. PCMOs complying with TG 300 will issue duplicative doses of boosters, unnecessarily consuming Peace Corps funds.

When OMS makes any change in its screening requirements, despite how small in scope, it may result in higher costs to applicants, may affect the PCMOs, and may result in longer screening timeframes, thus prolonging the entire application process.

Developing systems to bolster and encourage communication methods between OMS units, VDS units, and overseas posts will promote coordination efforts and ensure that MCS screening requirements and medical records are effective for posts and that posts can manage healthcare for the supply of Volunteers. Increased and systematic communication will strengthen the relationship and confidence between the supply and demand of the MCS delivery system.

RECOMMENDATIONS

We recommend:

19. **That OMS establish a Cross-Unit Board consisting of managers from each of the VS/MS Units: Medical Screening, Medical Field Support, Health Information Services, Programming and Training, Post-Service, Quality Improvement, Medical Records and Epidemiology.**

20. **That the Cross-Unit Board meet on a quarterly basis with VRS to discuss how screening requirements impact applicants, Volunteers, post management of Volunteer health conditions, medical evacuations, and FECA claims.**

21. That OMS designate a staff member or hire an outside consultant to review the screening criteria and assess whether it is useful in the field. Possible questions to ask include:

- **Are posts receiving Volunteers with medical conditions that cannot be supported?**
- **Do posts think Peace Corps should not accept applicants with these conditions?**
- **Are there medical conditions that are screened for that are never a problem in the field and therefore should not be a screening requirement?**

22. That the OMS Cross-Unit Board systematically collect feedback from posts via WebEx or a form of survey to measure the impact of screening requirements.

CUSTOMER SERVICE

OMS customer service to applicants during the medical screening process varies widely.

A critical component of operational effectiveness is to practice consistency in communications and quality customer service. However, applicants and staff reported that despite the introduction of various customer service initiatives to the Pre-Service Unit in the past several years, customer service continues to be practiced inconsistently.

While some medical screening assistants and screening nurses exercise best practices in returning applicant correspondence and expressing patience and helpfulness to applicants, others do not. OMS provided us with a "Screening Best Practices Model," last updated in 1998. One of the indicators that the Pre-Service Unit measured in 1998 was "Standard 3: Communication with applicants is courteous, accurate, and timely." The model also provided Pre-Service Unit staff with scripts to communicate consistent and courteous messaging to applicants, customer service strategies, and important information to give applicants, and telephone protocols.

The 1999 "Review of the VDS" recommended that customer service standards be published for the medical review process in order to "improve accountability, clarify the process…[and]

help applicants feel more fully invested in the process and create greater trust."

The 2003 OIG VDS Evaluation stated that the "application process is unfriendly" because "the bureaucratic structure, processes, and terminology…are confusing" and "lack of responsiveness or regular contact with the Peace Corps." One applicant who responded to our survey wrote the following:

> *I don't know where to begin here, since my experience was so negative. For one thing, you have to have live people available, and you MUST get back to people and answer their voicemail and e-mails in a timely fashion. You must be clear and specific about your objections, and please try to be helpful and supportive rather than cold and distant during this difficult process.*

It is important that Pre-Service Unit staff remember they are the only link applicants have to understanding and completing an expensive and time-consuming Medical Clearance process.

OMS should establish a policy that communicates to the applicant when the Pre-Service Unit receives their Medical Kit forms and faxes. An example of customer service communication in need of improvement is found on page one of the Introduction section in the Medical Kit instruction booklet, "Comprehensive Medical and Dental Package":

> *It [all information] is provided to guide you through the medical and dental process and to prevent you from having to telephone our small staff with common questions...At first glance this information may seem overwhelming, but it is not!"*

Due to inefficiencies and lack of prioritization, we found that customer service was poorly executed in the following ways:

- There was poor organization and quality control of the Medical Kit instructions. OMS screening nurses estimated that approximately 90% of applicant Medical Kits received do not include all required information, such as physician signatures and lab work. OMS is not able to determine whether the Medical Kit instructions need clarification because

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they do not collect applicant feedback. Additionally, OMS leadership has allowed different staff members to take responsibility for updating separate portions of Medical Kit instructions, which may have led to inconsistencies.

- Pre-Service Unit staff do not maintain the philosophy that they are an advocate for the applicant. Some OMS staff viewed the MCS as a rite of passage stating that if the applicants could get through the hurdles of the MCS they will be good Volunteers.

- Lack of enforcing customer service standards. Applicants cannot get in touch with a live person. Applicants reported that despite calling OMS's main number multiple times, they were unable to reach a customer service representative and sometimes unable to even leave a voicemail message because the voicemail was full.

  Out of the 779 applicants who called OMS' main telephone number listed in the Medical Kit (1.800.424.8580, ext 1500), 13% reported that they called more than five times before they were able to speak with a representative. Only 32% reported that they reached a live representative the first time they called. Applicants complained that they were transferred repeatedly and were exasperated by the time they finally reached a live attendant or at times, their voicemail. Some applicants who did reach a customer service representative or a medical screening assistant reported that they were rude or unhelpful.

  Applicants also state that screening nurses are unavailable to take their calls in the late afternoon prior to close of business at 5 pm. According to OMS SOP 2.8, Hours of Duty and Leave: the official OMS hours are 7:30 am-5:00 pm Eastern Standard Time Monday through Friday. The coordination of screening nurse schedules to ensure office coverage from 7:30 am-5:00 pm will ensure responsiveness to applicants who will be calling from different time zones. At least one screening nurse from each regional team could be in the office and available to accept applicant phone calls until 5:00 pm EST in keeping with OMS official hours as per OMS SOP 2.8.

In FY 2007, screening nurses came to work on weekends during the spike period (March - September) due to heavy workloads. However, they were also working on the weekends during non-spike periods in order to create four-day work weeks. As a result, applicants complained that they are not able to reach a live person when calling the OMS Pre-Service Unit and often played "phone tag" for days before reaching a screening nurse.

One Volunteer who took the Medical Clearance System Survey said:

> *Calling the help telephone numbers did no good as you seldom got through, messages you left were usually not returned, but, most frustrating, whenever you did reach a person they usually told you they couldn't help you and would transfer you to another department, who would then tell you they couldn't help you and transfer you right back.*

- Applicants are also unsure of who to contact. According to our survey, 22% of applicants reported that the letter addressed to them in their Medical Kit and introducing them to the medical clearance process left the name of the screening nurse blank.

- Applicants have reported that Pre-Service Unit staff fail to return their phone calls, faxes, and emails in a consistent and timely manner.

Staff often pointed to the fact that the medical clearance staff are the people who are usually in the unenviable position of having to tell an applicant: "You are not going to be a Peace Corps Volunteer." This is news that the applicant does not want to hear and can result in the applicant becoming angry with the Pre-Service staff. This may be true; however, courteous customer service should be emphasized regardless of how an applicant reacts to a medical decision. We found that OMS has not prioritized nor recognized the importance of identifying, implementing and monitoring customer service standards in the Pre-Service Unit.

In addition to customer service standards, customer service would be improved by having two lines and two customer

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service representatives available to answer the 1-800 number and check the voicemail box. OMS should also analyze whether it is feasible to cut out certain levels of the phone tree.

The Pre-Service Unit does not have customer service standards.

The 2003 OIG VDS Evaluation Report referenced the 1995 National Performance Review Report, "Putting Customers First: Standards for Serving the American People." This report gave a description of customer service standards for the MCS. Customer service standards should be established by the Pre-Service Unit and should define actionable standards of communication such as:

- Timeframes to return applicant correspondence via telephone, fax, or e-mail.
- Communication styles appropriate to a diverse pool of applicant ages, backgrounds, attitudes, responsiveness.
- Quality and accessibility of messaging to applicants.
- Standardized responses to common questions.

Upon establishing customer service standards, a training module on how to practice these standards could be developed by OMS. These trainings could be required for all OMS staff and contractors that directly communicate with applicants. Since customer service training and establishing standards of consistent applicant messaging is very important, customer service training should be incorporated into OMS-VRS cross-trainings or during non-spike months, and should be conducted on an annual basis by the medical support supervisor, screening manager and team leaders. Training should focus on customer service best practices, conflict/tension management, review of customer service standards, and identifying new customer service strategies or standards to the Pre-Service Unit.

APPLICANT FEEDBACK

Peace Corps currently has no mechanisms for collecting applicant feedback to inform and improve customer service in the OMS Pre-Service Unit.

The 2002 PEM Report made an observation that applicant feedback and satisfaction is an "important dimension of quality and performance" and that current Peace Corps Volunteer surveys do not assess applicant feedback of the Medical Clearance System. OMS should work with OSIRP to design a customer service feedback survey for distribution to all

applicants upon receiving a final medical disposition. OMS should use this data in monthly staff meetings to assess applicant feedback and OMS customer service performance.

The State Department Medical Screening Division has a short survey that is distributed to every person who was medically screened in a given month. Their input should be sought prior to developing a Peace Corps medical screening survey.

It is interesting to note that OMS' contractor, Seven Corners, maintains a database of complaints in which calls are logged and reoccurring complaints are extracted from the database and brought up during weekly customer service meetings. Reports of reoccurring complaints are then provided to the OMS contracts manager. Establishing a similar process within the Pre-Service Unit of logging complaints and bringing frequently voiced complaints forward during staff meetings for discussion and resolution would be an invaluable step towards customer service.

In order to gauge applicant satisfaction with the MCS, our survey collected customer service feedback. Volunteers and RPCVs responded similarly to the question of how satisfied they were with the Peace Corps medical clearance process. The majority reported they were "More or less satisfied" with the Peace Corps medical clearance process. Our survey results indicated that applicants that did not serve were less satisfied with the MCS. The least satisfied group was 50+ applicants who did not serve (see table below). The stratified number of 50+ applicants was too small to produce statistically significant results.

Were you satisfied with the Peace Corps Medical Clearance process?

	Volunteers Under 50	Volunteers 50+	Did not Serve Under 50	Did not Serve 50+
Not at all to Minimally Satisfied	27%	41%	65%	68%
More or Less Satisfied	50%	38%	23%	24%
Very to Extremely Satisfied	24%	21%	12%	8%

In addition to information not being captured on applicants' satisfaction with the MCS, information is also not captured on applicants' satisfaction with customer service representatives in OMS and Placement.

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Medical Screening Assistants: Our survey indicated that 64% of applicants contacted their Medical Screening Assistant. Forty-six percent of the applicants who contacted their Medical Screening Assistant called them three times or more. Of those applicants who had an opinion, the plurality reported that the customer service provided by the Medical Screening Assistants was More or Less Satisfactory (40%) and the second most frequently occurring response was Very Satisfactory (28%).

Dental Screening Assistant: The majority of applicants (77%) did not contact the Dental Screening Assistant.

Medical Screening Nurses: Fifty-two percent of applicants contacted their screening nurse. Thirty percent of those who called their screening nurse talked with him or her once during the entire Medical Screening process. Applicant satisfaction with the customer service provided by the screening nurses varied by subgroup. Volunteers and RPCVs who served were more satisfied with the customer service provided by screening nurses than the applicants who did not serve. In all categories, the most common response was "More or Less Satisfactory". Applicants who did not serve described screening nurse customer service as "More or Less Satisfactory" 16% of the time, RPCVs 27% of the time, and Volunteers 28% of the time.

Placement Officers: Forty-one percent of applicants contacted their Placement Officer one or more times. The plurality (35%) of applicants reported that the customer service provided by their Placement Officer was "Very Satisfactory". Applicants who did not serve were more likely to contact their Placement Officer (53% contacted their Placement Officer versus 34% for RPCVs and 40% for Volunteers) and more likely to have talked with their Placement Officer two or more times than Volunteers or RPCVs.

Nurse Line: Survey results indicated that 49% of applicants called the Nurse Line. Prior to conducting our survey, Volunteers in the field had told the OIG that it was difficult to reach a nurse. Therefore, our survey posed the question: "How many times did you call the Nurse Line before you were able to speak with a nurse?" Thirty-seven percent of the 513 respondents who called the Nurse Line said that it took three or more times before they reached a nurse on the Nurse Line.

An online alternative to the Nurse Line telephone number could be provided for applicants who cannot reach a live screening nurse using the Nurse Line. In addition to the Nurse Line, a Nurse E-mail address could be instituted to improve OMS accessibility to applicants. Screening nurses assigned to the e-mail rotation should respond to Nurse Line inquiries according to customer service standards. To maintain medical confidentiality policies such as the Health Insurance Portability and Accountability Act (HIPAA) and the Privacy Act, a consent form should be provided by regional recruiting offices or in the Medical Kit before an applicant uses the Nurse E-mail address. According to the Peace Corps Manual section 268.5.3:

> Medically confidential information may be disclosed as authorized in writing by the individual whose medical information is involved.

The State Department Office of Medical Services stated that applicants can send medically confidential information via e-mail. However, State Department OMS staff cannot include particular medical conditions or diagnoses in their responses to applicants.

RECOMMENDATIONS

We recommend:

23. That OMS improve the Medical Clearance System customer service line so that the line always rolls to another phone until a live person is reached. This may be accomplished by instituting the following changes:
- **Coordinating screening nurse schedules to ensure full office coverage and that at least one screening nurse from each regional team is in the office every work day and available to accept applicant phone calls until 5:00pm EST.**
- **Including the direct telephone extension of the screening assistant assigned to the applicant in the Medical Kit.**
- **Adding an additional phone line.**

24. That OMS identify, implement and monitor customer service standards.

25. **That OMS and the Pre-Service Unit with the assistance of OSIRP systematically collect applicant feedback by developing and implementing an applicant feedback survey.**

26. **That the Pre-Service Unit manager meet with the Director of the Medical Screening Division at the State Department to learn about their medical screening survey to capture customer feedback.**

27. **That OMS establish and implement annual customer service training for all OMS staff that have direct communication with applicants. Customer service training should emphasize the importance of coaching applicants through the Medical Clearance System.**

28. **That the Pre-Service Unit develop a Nurse Line email address that can be checked by screening assistants and forwarded onto the proper screening nurse as an alternative to the Nurse Line.**

29. **That the Pre-Service Unit staff log and discuss applicant complaints.**

30. **That the Pre-Service Unit institute quality controls to ensure contact information is not missing from the letter in the Medical Kit.**

STAFFING NEEDS

Internal and external agency reports on the Volunteer Delivery System have suggested that OMS hire additional screening nurses since understaffing has caused decreased efficiency in reviewing Medical Kits and issuing medical dispositions.

According to prior reports, these decreases in efficiency are due to the high volume workload screening nurses experience, which is exacerbated by the spike in applicants that occurs from March to September. Additional negative effects of screening nurse understaffing included poor customer service, decreased consistency and accuracy in decision making, and higher vulnerability to screening burnout.

OMS's attempts to review files according to the "first in first out" (FIFO) method; however, as stagings draw closer, the placement staff can request that certain applicants be reviewed immediately if they have a scarce skill that is needed in an upcoming Trainee class. Currently, applicants who submit their Medical Kit early but do not have a staging event in the next several months complain that they are penalized by the Pre-Service Unit's screening system and that OMS should review files according to when they are first received. Hiring more screening nurses would allow for more flexibility and time to review according to the FIFO model, which would decrease applicant complaints, increase applicant satisfaction with the MCS, and reduce the response time of the medical screening process.

OMS has been unable to justify the staff required due to its inability to use data and analysis to present evidence for their staffing needs.

Based on incomplete data provided by OMS, our evaluation was not able to definitively determine whether the Pre-Service Unit is understaffed, as prior reports stated. The OMS' deputy director stated that according to the data available, OMS does not need additional screening nurses, but rather it needs to increase its efficiency. The OIG analyzed two OMS reports which attempted to analyze screening nurse performance in order to justify additional screening staff needs. We compared the FTE staff scheduled to work 40 hours per week with the actual time they worked per week which for valid analysis should include overtime and compensated time. The first OMS report that we analyzed was titled Multi-year Screening Analysis and mixed complete fiscal year data for years 2002 through 2005 with partial fiscal year data for both 2006 and 2007, and therefore the analysis was not valid. The second OMS report was titled Screening Activity 2005-2006 and the total FTEs for FY 2005 did not agree with the total FTEs found in the first Multi-year Screening Analysis report, which had been prepared by another individual in OMS. Secondly, overtime hours were not tracked for FY 2006 in the Screening Activity 2005-2006 report or the Multi-year Screening Analysis but were tracked in the Multi-year Screening Analysis for fiscal years 2002-2005.

As a result of incomplete data, we were unable to determine if additional screening staff needs are justified based on a review of screening performance that took into account overtime and compensated hours worked.

However, it is clear that screening nurse vacancies combined with the customary two-month processing time to fill screening nurse vacancies, contribute to decreased medical screening efficiency, customer service, performance, and consistent and accurate decision-making. More screening nurses would positively impact better customer service, faster review of medical clearance files, better quality control of communications and letters sent to applicants, and better practices of medical records procedures. In turn, better decisions will be made because screening nurses will not be as fatigued or stressed from working overtime and during the weekends.

SCREENING NURSE PRODUCTIVITY

Screening statistics on the productivity of new versus experienced screening nurses did not include all appropriate and necessary variables.

OMS tracked screening dispositions (qualified and medically non-qualified) for two new screening nurses and three of the more experienced screening nurses for the twelve-month period December 1, 2005 through November 30, 2006.

The rationale for selecting the three nurses was that they were the most experienced. The spreadsheet did not take into account the time they used to coach the new screening nurses. As a result, the experienced nurses' productivity was presented as less than it actually was.

The two new nurses had worked fewer than 12 months during that period. It is unknown whether those months of inactivity are due to a lapse between one nurse leaving and a new nurse starting, which would contribute to a decrease in overall office productivity, or if there was no lapse at all. Thus, accurate new screening nurse productivity cannot be calculated correctly.

The difference in screening productivity between new nurses and experienced nurses was calculated at 8%. When the OIG discussed this calculation with the deputy director of OMS, she stated that 8% does not support the argument that inexperienced nurses are significantly less productive than experienced nurses. However, what does seem to have a significant impact on Pre-Service Unit productivity are lapses incurred between hiring new screening nurses to replace nurses at the end of their tours. Taking vacancy periods into account, the difference in screening productivity is approximately 20%.

This information was based on a judgmental sample selected by the deputy director of OMS. This OIG preliminary analysis should be followed up by a more in-depth comprehensive review by the agency which includes all Pre-Service staff.

The agency approved the hiring of two additional FTE screening nurses on June 5, 2007. According to OMS, interviews for the two new screening nurse positions took place the week of July 18, 2007 and two FTE screening nurses were hired as of August 2, 2007.

We recommend:

31. That OMS conduct a staffing analysis to determine whether the number of screening nurses currently on staff is adequate.

32. That OMS conduct periodic staffing analyses to address new agency initiatives which impact the Pre-Service Unit workload.

The lack of staff with programming and data analysis expertise could leave OMS vulnerable.

OMS has one computer programmer analyst to maintain and streamline technology for all OMS units. OMS staff identified two potential back-ups to support the Expert System should something happen to the computer programmer analyst. OMS and the Pre-Service Unit rely on the computer-based Expert System to screen and document applicants' health conditions and medical records. However, the designated back-up in the QI Unit is the program analyst who lacks Structured Query Language (SQL) programming proficiency and therefore cannot perform the programming aspects of the backup responsibilities. The backup in the Office of the Chief Information Officer (OCIO) has a background in SQL programming, but prior to this evaluation was unfamiliar with the Expert System application. In addition, there is a lack of documentation on the Expert System. These vulnerabilities leave the Pre-Service Unit susceptible to technology weaknesses and can impede the delivery of the MCS. The QI unit should initialize a documentation process for the Expert System to provide technological succession planning.

In addition to the QI program analyst position being designated as the backup to the OMS computer programmer analyst, the position used to require programming and data analysis expertise was down-graded from a FP3 to an FP4 level and these requirements were eliminated from the position description. As a result, OMS lost their ability to strategically collect and analyze data for program and process improvement.

OMS has a profound need for a trained and experienced SQL programmer to fill these data gaps. By not conducting data analysis with reliable data and dedicated staff, OMS is promoting inefficiencies and working against Peace Corps' goals of reducing applicant response time.

The OMS computer programmer analyst is already working with OSIRP to improve data entry, collection and analysis.

RECOMMENDATIONS

We recommend:

33. **That the OCIO designate a backup to the OMS computer programmer analyst with programming proficiency and ensure that he or she receives routine training on the Expert System.**

34. **That OMS routinely communicate changes in the Expert System to the backup programmer.**

35. **That OMS document the Expert System for succession planning.**

FIVE-YEAR RULE

The five-year rule is a detriment to the Medical Clearance System.

According to The Peace Corps Act, U.S. Code Title 22, § 2506, Peace Corps employees are subject to tours of five years and may not serve for more than eight and one-half years. The five-year rule was established to consistently bring in new energy, new talent, and field experience to Peace Corps. However, the five-year rule has had a negative effect on the MCS by causing deficits in institutional knowledge, imposing operational and organizational problems to the Pre-Service Unit, and increasing the potential for errors in medical judgment, exposing Peace Corps Volunteers to potential harm.

Experience and a comprehensive knowledge base of medical screening requirements and the differences between Peace Corps post health conditions are indispensable to screening applicants efficiently, productively, and safely. The effect of the five-year rule essentially forces that valued experience and expertise exercised by the screening nurses out of the agency. The agency must choose new screening nurses out of a lesser experienced and smaller pool who require extensive training and only reach adequate levels of productivity screening applicants and giving quality customer service after one year. The turnover caused by the five-year rule reduces all screening teams' productivity and creates an unnecessary bottleneck in the application process.

The greatest impact on the MCS is the detriment to Volunteers' safety and security in the areas of medical and mental health assessment. Contributing factors are the nationwide nursing shortage, recurrent screening nurse turnover - which takes two to three months to fill and costs 1.2 - 1.3 times a nurse's average salary, and the lack of unit succession planning. The reality is that there are consistent intervals where either inexperienced screening nurses are making medical clearance decisions, experienced screening nurses are busy training new screening nurses, or there are unfilled staff vacancies, which bombard the Pre-Service Unit with overwhelming numbers of applicant medical files to review.

Prior reports point to the five-year rule's adverse effects and support that the negative outcomes outweigh the positive motivations for the five-year rule's inception in this area.

- According to the 2002 PEM Report, because of the five-year rule succession planning in management and internal succession planning were difficult, and organizational memory was impacted negatively.
- The following year, the Office of Inspector General issued the 2003 VDS Evaluation report, which cited the fact that annually Peace Corps experiences 20% staff turnover. The high turnover rate has caused chronic staff vacancies impeding the VDS and the MCS. As a result, normal work would be performed during extended hours and weekends, rendering it difficult to implement quality customer service, quality improvement, training, and process improvements. This evaluation also showed that a

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significant amount of screening work was being conducted during extended hours and weekends.

Under The Peace Corps Act, U.S. Code Title 22, § 2506 (5) and the 2004 Peace Corps Safety and Security Bill, it may be argued that exempting positions within OMS is necessary for the safety and security of the Volunteer. In 2002, it was deemed that the position of Chief of Quality Improvement was a critical position within the Office of Medical Services for ensuring the safety and security of Volunteers overseas and that position was exempted from the five-year rule. The same justification for the decision to exempt the Chief of Quality Improvement can apply to exempting additional key positions within the Pre-Service Unit which will ensure "continuity of functions," quality assurance, quality control, and ultimately, the safety and security of the Volunteer. The lack of institutional knowledge caused by the five-year rule contributes to screening inconsistencies, disorganization, and inordinate timeframes. These voids in process control and assurance impede the MCS and can endanger the Volunteer and post. The experience and organizational memory of these positions is vital to maintaining the screening system and identifying areas that can be improved to optimize the screening process.

In addition, numerous governmental, organizational and journalistic studies report that there is a growing nationwide nursing shortage. The Department of Health and Human Services (HHS) reported that the nationwide nursing shortage would double from 6% in 2000 to 12% by 2010. In response to studies issued by JCAHO and HHS, the U.S. government has addressed the potential dangers of a nursing shortage and taken action. In 2002, President Bush signed the Nurse Reinvestment Act into law creating government nursing scholarships through 2007 to provide more supply of quality nurses. In addition, HHS has awarded more than $30 million in grant awards to address the nursing shortage.

While there are legislative impediments to wholesale exemption of positions in the Office of Medical Services from the five-year rule, this evaluation and previous studies coupled with the growing nation-wide nursing shortage point to the need for Peace Corps to consider a pilot program to exempt Pre-Service nurses. Pre-Service Nurse positions should not be exempted on a permanent basis but renewed for 30-month

tours prior to the completion of their current tour, if excellent job performance is demonstrated.

We recommend:

36. Based upon screening productivity, quality performance, and compliance with policies and customer service standards, that the agency considers a pilot program to exempt screening nurses in the Office of Medical Services from the five-year rule with renewable 30-month tours.

COST TO APPLICANT

There is a lack of documented analysis to support the medical and dental reimbursements rates provided to applicants for Medical Kit expenses.

OMS could not present a justification to the OIG that supported the Plan One (claims submitted by applicants) maximum reimbursement amounts. In addition, OMS could not provide the dates of the last reimbursement schedule increase. Additionally, there was no procedure or criteria in place to require OMS to reevaluate the reimbursement schedule on a periodic basis. Seven Corners, OMS's third party contractor, tracks claims information if provided the healthcare provider's cost of service. However, the director of OMS stated that OMS has analyzed the Seven Corners' claims information and determined it is not useful for justifying adequate reimbursement rates.

Per interviews with the OMS deputy director and the contracts manager, the reimbursement schedule was periodically reviewed over the past several years. However, there was no documentation to prove that any meetings took place or consensus on when the meeting took place. In addition, the supposed conclusion of the last meeting (that occurred two or three years ago) was that increases did not need to be made to the reimbursement schedule because applicants and Volunteers were not reaching the maximum reimbursement amounts allotted for their specific gender and age grouping.

When we asked for supporting calculations or even verbal confirmation of the process for calculating this information, none was provided. The OIG is uncertain if OMS's purported

analysis was based on individual applicant reimbursement claims or an average amount of total reimbursement claims. After analyzing the method employed to make the assumption that applicants are not claiming their allotted maximum reimbursement amounts, an OIG auditor assessed that this is a faulty measurement of determining or not determining increases to the reimbursement schedule. Using an average in this case to determine whether the reimbursement fee schedule is adequate is inappropriate. OMS set the maximum reimbursement amounts and will not pay more than that; therefore, the average will always be below the maximum reimbursement allowed unless every individual submits for the maximum reimbursement amount. The economic levels of the applicants are different, therefore justifying the current reimbursement levels as adequate based on everyone having to submit a claim, does not represent the needs of all applicants.

OMS did provide us with the following information of reimbursement claims allocated by gender and age as of June 30, 2002. The table below shows that the majority of applicants even then submitted claims that exceeded the allotted reimbursement schedule designated for their age group and gender.

Medical Grouping	Percent of Claims Submitted Over Maximum Reimbursement Rate	Maximum Reimbursement Amount
Females under 50	48%	$165.00
Females 50 and over	52%	$290.00
Males under 50	60%	$125.00
Males 50 and over	64%	$175.00
Dental for all groups	79%	$60.00

The anecdotal assumption that applicants were not maxing out is misinformed and the lack of data analysis warrants that a periodic review of the reimbursement schedule be convened to determine increases in the Plan One reimbursement schedule.

The deputy director of OMS reported that they are considering raising the dental reimbursement schedule from $60 to $100. However, OMS admittedly has no basis for supporting that

increase other than anecdotal evidence that the current amount is too low and that $100 would be a reasonable increase. When asked how the staff determined that $100 was an adequate reimbursement amount, OMS could not provide any justification for arriving at that number. Rather, according to OMS, a $100 dental reimbursement seems to be a "fair" cost share of completing the dental requirements for Peace Corps service. These types of critical decisions need to be based on a thorough analysis of applicants' actual costs.

Additionally, the requirement that applicants receive certain immunizations before medical clearance can be granted was implemented in January 2007; however, there was no corresponding increase considered for the medical reimbursement. This was an expense that the Peace Corps had previously paid for and for which the applicant would now be responsible.

A consequence of not having criteria for evaluating the reimbursement schedule is that when screening requirements change there is no process for analyzing the impact of that change and making appropriate adjustments to the reimbursement schedule.

According to OMS, there was not enough negative feedback from applicants to cause a re-assessment of the maximum reimbursement. However, the recent immunization requirements that have been added to the Medical Kit coupled with the real increase in costs of medical and dental exams due to annual inflation are alone justifications for increasing the reimbursement schedule.

The justifications for needing to make changes to the reimbursement fee schedule are two-fold:

1. The reimbursement schedule was reviewed in 2001/2002 and resulted in an increase of the dental reimbursement amount, but not the medical reimbursement. The current schedule has not been increased on a routine basis to account for inflation or other cost increases.
2. It does not take into account new clearance requirements, such as immunizations, that have been added to the Medical Kit.

The reimbursement schedule does not cover applicant medical and dental costs.

Many applicants perceive the term 'reimbursement' as misleading given that the schedule does not cover even half of the costs associated with medical and dental clearance. Applicants are also unaware that there is no time limit on when applicants can submit a reimbursement claim and believe they must submit their reimbursement forms with the Medical Kit.

According to the results of our survey, 22% of applicants did not have health insurance when they applied to the Peace Corps. The plurality (39%) of applicants who applied but did not serve in the Peace Corps spent $101-$500 in out-of-pocket expenses for required medical exams and lab work compared to the plurality (45%) of Volunteers who spent $101-$500 in out-of-pocket expenses for required medical exams and lab work.

According to information provided to the OIG by the VDS Steering Committee 50+ Working Group, 87% of respondents to their survey reported that they had health insurance at the time they applied and were medically qualified for Peace Corps. However, 61% reported that the cost of completing their medical exams for the medical screening process was not covered by health insurance.

One Volunteer wrote:

> *Tell us in advance that we'll probably have to have (and pay for) follow-up examinations or tests. The reimbursement is inadequate for most situations, even at a public health clinic.*

The cost of completing the Medical Kit may deter applicants from completing the medical screening process.

The 2003 OIG Evaluation of the Volunteer Delivery System reported the reimbursement fee schedule for medical and dental was too low, in need of adjustment, and resulted in a possible barrier to service. This evaluation determined that the reimbursement schedule should undergo periodic review for medical, dental, and eyeglass reimbursement amounts because not only does the reimbursement schedule deter desirable and qualified applicants from completing medical screening, but the reimbursement schedule may also act as an unintended barrier to recruiting applicants from diverse socioeconomic levels.

According to the OIG MCS survey:

- Thirty-five percent of applicants who served and 24% of RPCVs reported that they received outside support with Medical Kit costs, compared to 19% of applicants who did not serve.
- Applicants who served (35% received outside support) and RPCVs (24% received outside support) reported they received outside support with Medical Kit costs more often than applicants who did not serve (19% received outside support).
- 41% of the applicants who did not serve did not complete the application process as opposed to being deemed medically not qualified by OMS.
- Of the 266 applicants who applied but did not serve, 94 (35%) withdrew from the application process. The top four reasons given why applicants withdrew from the application process were (1) medical screening took too much time (47%), (2) burdensome medical costs (34%), (3) burdensome dental costs (32%), and (4) poor communication with medical screening (20%).

There is evidence of a potential correlation between individuals of lower socioeconomic levels and their inadequate access to health insurance, increasing the cost burden for this demographic and further preventing them from finishing the application process or even applying to Peace Corps. If the Peace Corps is seeking to increase recruitment efforts for applicants of diverse socioeconomic backgrounds, removing the impediment of an inadequate reimbursement schedule is an important step.

RECOMMENDATIONS

We recommend:

37. That OMS define the purpose of the Plan One reimbursement schedule.

38. That OMS provide applicants with data from the survey they develop with the Office of Strategic Information, Research And Planning that shows average out-of-pocket costs that applicants have incurred in fulfilling the Peace Corps Medical Clearance requirements.

39. That the OMS Health Information Systems Unit establish criteria by which to assess the adequacy of the reimbursement fee schedule by 2008.

40. That immediately after establishing the assessment criteria, the OMS Health Information System Unit assess the adequacy of the current Plan One reimbursement fee schedule and adjust the schedule accordingly.

41. That the OMS Health Information Systems Unit establish a procedure by which they re-evaluate the adequacy of the reimbursement fee schedule biennially or as new screening requirements are implemented.

MEDICAL CLEARANCE SYSTEM TIMEFRAME

Applicants were not made aware of how long it takes to complete the MCS process.

According to our survey, for those applicants who submitted their Medical Kit, they perceived the following basic timeframes for the individual portions of the MCS:

MCS Stage	Most Frequent Response	Percent
Nomination to Received Medical Kit	7-9 Days	29%
Original Medical Kit with Applicant	30 Days	37%
Time Needed for Applicant to Meet Requirements for Additional Medical Information	Less than 30 Days	60%
Sending Complete Medical Kit to Receiving Medical Disposition	1-3 months	53%
Total Timeframe from Medical Kit Received to Medical Disposition	1-3 months	40%

OMS staff state that they cannot post information on application timeframes because each applicant is an individual and the timeframe for processing an individual varies greatly depending on their medical conditions. While this statement is true, data could be gathered and analyzed that would allow an average timeframe for the following:

- Applicants under 50 years of age without medical accommodation.
- Applicants under 50 years of age with medical accommodation.
- Applicants 50 years of age and over without medical accommodation.
- Applicants 50 years of age and over with medical accommodation.

Overall, 48% of applicants were not satisfied with the length of the MCS. The table below stratifies the responses received by age groups. See table below.

Were you satisfied with the length of time of the Medical Clearance process?	Yes	No
Volunteers Under 50 Years	57%	43%
Volunteers 50 Years and Older	45%	55%
Did not Serve Under 50	36%	64%
Did not Serve 50 Years and Older	45%	55%

The respondents who did not serve and were less than 50 years of age were the least satisfied group of those surveyed about the length of time of the MCS process. The number of 50+ applicants was too small to produce statistically significant results.

Applicants need to make arrangements, such as selling their house and quitting their job, prior to Peace Corps service, and were understandably frustrated that Peace Corps did not provide them with an estimated timeframe. The result of this lack of transparency is that applicants do not have a timeframe for properly closing out their obligations before service and Placement must transfer some applicants to a Trainee class with a later start date. Placing applicants twice is an inefficient use of agency and applicant time and may discourage applicants from completing the clearance process.

RECOMMENDATION

We recommend:

42. That OMS provide applicants with the estimated time it will take the Pre-Service Unit to screen a Medical Kit from an applicant under 50 years of age and to screen a Medical Kit from an applicant 50 years and older.

REQUESTS FOR ADDITIONAL INFORMATION

According to our MCS survey, 50% of applicants reported that OMS officials requested additional information or tests not specified in their original Medical Kits.

All three subgroups reported nearly identical percentages for additional requests. Thirteen percent of applicants reported that OMS requested additional information for medical conditions that the applicant had not disclosed on the Health Status Review (a part of the Medical Kit). This suggests the importance of reviewing the Health Status Review for hints of non-disclosed information that may be a medical problem for someone serving overseas. It is also important to note that 23% of the survey respondents who did not serve did not submit a Medical Kit, 38% did not complete the application process, and 35% reported they withdrew their application.

Requesting additional information and/or tests adds increased time to the review of the Medical Kit, an additional cycle of communication between the applicant and the Pre-Service Unit, and may add additional doctor's visits, which may increase the cost to the applicant. The table below provides the types of supplemental information and tests requested.

What type(s) of additional information/testing were requested?	Count	Percent*
Test/Lab results	290	26%
Personal statements	200	18%
Doctor statements	284	26%
Specialist work	171	16%
Follow-up to previous medical conditions	251	23%
Other, please specify	59	5%
Total	1,103	114%

*Total percent exceeds 100 due to respondents' ability to select more than one response for this question.

POOR ORGANIZATION

Medical Kit letters, forms, and instructions were poorly organized.

Our review of Medical Kit instructions showed inconsistent organization of instructions; for example, the "Instructions and Reimbursement Information for the Examining Physician" is found in the packet of Expert Letters, and the "Instructions and Reimbursement Information for the Examining Dentist" and "Instructions and Reimbursement Information about the Prescription Eyeglasses Form" are located in the Medical Kit

instruction booklet. Additionally, OMS reported that applicants comment about feeling overwhelmed by the Medical Kit instructions because it is presented in a 32-page book.

The majority of survey respondents reported that the Medical Kit instructions were "More or Less Clear to Extremely Clear;" however, their additional open-ended survey comments pointed out areas for improvement.
In response to the Medical Clearance System Survey, one Volunteer wrote the following about the Medical Kit:

> *The way it was organized took many times to read and reread to figure out which doctor needed what. It wasn't completely unclear, because obviously I'm here, but I remember it took several times to read it to make sense of it for me, and then even my doctors had some questions about what was needed.*

Another Volunteer wrote:

> *Some of the instructions were partially repeated, forms were called by a variety of names, and in one case I felt it was necessary to cut a portion out of the booklet based on the instructions. Those items to be filled out by the applicant need to be organized and clearly separated. Information had inconsistencies, and was often confusing.*

A former applicant who did not complete the application process commented:

> *I received a pile of papers that were not stapled together or organized in a significant way; it was not completely clear which forms were supposed to be filled out by which doctors. I'm not sure that the forms were clear from the doctor's perspective either.*

Forty-seven percent of the respondents wrote an open-ended comment on the Medical Kit Instructions. (Note: Additional open-ended comments can be provided to the Pre-Service Unit for input into program improvements.)

A former Peace Corps official stated recently:

OMS needs to be held to the same standard as everyone else in terms of quality and clarity of communications.

We concur that OMS, particularly the Pre-Service Unit, should be held to the same standards of communication and quality that all Peace Corps offices are held.

After assessing the Medical Kit instructions and listening to OMS staff feedback and applicant feedback of the instructions, we found that the Medical Kit letters, forms, and instructions were poorly organized, lacked quality control, and caused confusion to some applicants. The location of all Medical Kit instructions and forms for completion should be clear to the applicant and accurately referenced in the booklet. These three sets of instructions are equally important and should be consolidated into the same location when sent to the applicant. The result of unclear instructions and forms may be that an applicant and physician will overlook a required signature and submit the Medical Kit with incomplete information, which slows down the process.

The Office of Medical Services reported that they are currently condensing the 32-page Medical Kit booklet of instructions, creating a shorter checklist of instructions and critical information from the condensed booklet, and making both versions available online. These efforts will improve accessibility of instructions and highlight the most critical information relevant to completing the Medical Kit for timely return to OMS. OMS reported that they are also working with the Office of Communications and the 50+ Working Group to improve quality and accessibility of OMS collateral materials.

INCOMPLETE INFORMATION

Medical Kit instructions may be confusing to an applicant's physician.

OMS staff reported they do not believe that applicants are always providing the physicians with the Medical Kit instructions and that is why the instructions are not always followed.

This assumption is contrary to the results of our survey which showed that 84% of applicants responding to the survey said they showed their Medical Kit instructions to their physician

and 78% of applicants said their physician read all or partially read the Medical Kit instructions.

In addition, 80% of applicants said they showed their dental instructions to their dentist and 78% of applicants said their dentist read all or partially read the instructions. The table below stratifies responses by subgroup of respondents.

Applicant Type	Showed Physician	Showed Dentist	Physician Read	Dentist Read
Did not Serve	78%	76%	49%	54%
RPCV	85%	78%	53%	61%
Volunteer	86%	84%	56%	67%

Survey respondents and case study participants stated that their physicians read the Medical Kit instructions but were reported to be confused or overwhelmed by the instructions. One case study participant forwarded the following quote from their health care provider:

> *For the most part, I have to say I found the*
> *form sent me to be nitpicking and redundant*
> *~ paper for paper's sake.*

Applicants also indicated similar concerns. One applicant who responded to our survey recommended the following:

> *More clarity and less redundancy on*
> *instructions. Almost drove me away from*
> *application process.*

Another applicant who responded to our survey provided the following comment:

> *Make instructions clearer to physician*
> *about recommended tests in order to*
> *minimize out of pocket expenses,*
> *especially for healthy applicants like*
> *myself.*

Providing more clarity in the Medical Kit instructions will eliminate multiple trips to the doctor and unnecessary frustration with the medical clearance process.

We recommend:

43. That OMS work with the Office of Communications to improve the Medical Kit instructions by eliminating contradictory and vague guidance and highlight the most critical information.

44. That OMS consolidate the location of instructions and medical forms for completion by applicant or a healthcare provider and ensure that they are accurately referenced on paper and online.

VETERANS ADMINISTRATION HOSPITAL

Many applicants are unaware that they can use the Veterans Administration Hospital as a resource.

The Veterans Administration (VA) Hospital's relationship with Peace Corps is a resource for applicants to receive free physical exams when completing their Medical Kits; however, many applicants were unaware of this resource. Currently, only a few applicants use the VA Hospital to complete their physical exam requirement; from 2005 to June 2007, 125 applicants have utilized VA hospital to complete their medical screening exams.

This service is underutilized for multiple reasons:

- The tenuous nature and undefined purpose of the VA agreement with the Peace Corps. (Anecdotal understanding of the Peace Corps agreement with the VA Hospital is that the Hospital will provide screening resources as available.)
- The sparcity of VA hospitals nationwide.
- The widely-held assumption cited by applicants and Peace Corps staff that the VA Hospital is overwhelmed with demands from Veterans returning from Iraq.
- The fact that Peace Corps staff view the VA Hospital as a resource for applicants in need of financial assistance and therefore do not advertise the resource to all applicants.

One applicant who did not serve was unaware of the VA Hospital resource and wrote:

> *Provide a facility in order to do the medical clearance process much like the one that is done for the armed forces.*

An active Volunteer who answered our survey said:

> *After talking with a few volunteers about their experiences during Medical Clearance, I think that PC should send a list of veteran hospitals to the applicants along with the packet. I had all my exams done at the hospital and therefore did not have to pay anything. All the volunteers I talked to knew nothing about it and spent a lot of money out-of-pocket to finish the process.*

In addition to "saving" this resource for low-income applicants, several OMS staff said that they are reticent to advertise the VA Hospital to all applicants because they believe the physical exams provided by the VA Hospital are inferior to those provided by an applicant's family physician. In addition, OMS staff believe that the VA Hospital does not have the resources to screen significant numbers of Peace Corps applicants.

One OMS staff member provided us with this observation:

> *I don't think the VA hospital is a good option. They don't know the person's medical history. They just do a quick and dirty physical. And when there are gaps or voids on the physical form we will just have to ask for more information and that slows down the process here. The VA will just do the lab tests. But if the lab test is abnormal they have to go somewhere else to get more tests. Sometimes it is the doctor that gives the wrong test.*

Peace Corps needs to strengthen the agreement with VA Hospital in order to better define the VA Hospital's role as a resource to Peace Corps applicants.

Peace Corps' sole documentation on file referencing the agreement between the Peace Corps and the VA is a letter

dated May 2, 1961, from the Chief Medical Advisor at the Peace Corps to the Medical Director of the U.S. Veterans Administration Central Office. The letter states that Peace Corps is requesting the assistance of the Veterans Administration in order to screen the significant number of

applicants who have applied to the Peace Corps from all 50 states and Puerto Rico as follows:

> *Use of the Veterans Administration and the Uniformed Services facilities would make it possible to obtain these examinations without causing a significant impact on the workload of individual hospitals and clinics.*

Peace Corps has not systematically communicated or updated its agreement with the VA Hospital and has not updated the VA on Peace Corps' Medical Kit requirements. As a result, applicants and Peace Corps staff reported that VA Hospital staff are unaware that an agreement exists, are unprepared for Peace Corps applicants, and exhibit confusion and at times rudeness to applicants. OMS staff confirmed that they have heard this complaint from applicants and stated that some VA hospitals are known to be Peace Corps friendly whereas others will not accommodate Peace Corps applicants.

OMS staff shared testimonials from applicants who complained that their scheduled appointments were not honored by the VA Hospital and they were denied service. An active Volunteer provided the following feedback:

> *Misinformation about availability of using government/military medical facilities. I was denied this option when I tried. Also, unnecessary tests were required as follow-up for conditions or past procedures, which were not medically indicated and furthermore were not reimbursed by PC.*

Based on applicant and OMS staff feedback, Peace Corps' agreement with the VA needs to be assessed for effectiveness and efficiency. The nature of the agreements needs more clarity, strength and definition in order to determine the future of Peace Corps' relationship with VA Hospitals and its benefits for applicants. If it is determined that Peace Corps' relationship with VA Hospitals has been more problematic

than beneficial, Peace Corps should cease promoting this as an option to applicants.

<table>
<tr><td>RECOMMENDATIONS</td><td>

We recommend:

45. That the Peace Corps and the VA Hospitals more clearly define and update their agreement.

46. That OMS correspond with VA Hospitals on an annual basis to strengthen communication on new requirements to the Peace Corps Medical Kit.

47. That OMS develop and distribute a list of Veterans Administration Hospitals across the nation that are positively responding to screening Peace Corps applicants based on applicant feedback.

48. That the Pre-Service Unit post the VA Hospital Authorization Form online next to the list of applicant endorsed VA Hospitals.

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50+ APPLICANTS

In September 2006, the Director announced an agency initiative to increase the percentage of Volunteers 50 years and older serving in the Peace Corps. Based on feedback from Peace Corps headquarters offices that the 50+ initiative would place more demands on the Volunteer Delivery System (VDS), the Director chose to also establish the VDS Steering Committee, which includes the 50+ Initiative Working Group, with the mission to identify areas for improvement in the VDS and the MCS.

The agency has prioritized the Director's 50+ initiative and has enabled the 50+ Initiative Working Group to conduct activities that have provided valuable data and analysis on the special needs of 50+ applicants. The 50+ Initiative Working Group identified five major tenets for improving the MCS:

1. Develop a survey specifically for 50+ Volunteers to gain insight into their experience during the VDS and MCS process.
2. Institutionalize alliances with and evaluate healthcare management of government agencies, NGOs, and

corporations that support large numbers of 50+ Volunteers.
3. Improve the MCS process and marketing to attract Volunteers 50 years of age and older.
4. Ensure the application and online Health Status Review (HSR) are appropriate for the older American demographic.
5. Enhance the use of technology to offer a more individualized and customized application while shortening the application processing time.

On a departmental level, the Office of Medical Services (OMS) has identified the following six tenets to improve the MCS in response to the Director's Volunteer 50+ Initiative:

1. Improve the organization and streamline MCS processes in order to accommodate the influx of paperwork and labor in qualifying 50+ Volunteers.
2. Increase OMS staffing to meet the demand of more processing and paperwork.
3. Develop a strategy to reduce or maintain the current application response time when recruitment of 50+ Volunteers begins.
4. Coordinate the healthcare Peace Corps provides with the applicant's current insurance and determine how coverage coordinates with Medicare.
5. Provide training to OMS staff on how to communicate effectively and positively to a more sophisticated applicant profile.
6. Increase funding.

Applicants 50 years of age and older have a very different experience navigating through the Medical Clearance System.

Applicants 50 years and older have longer medical histories and typically have more health issues than their younger colleagues. It is acknowledged by the Office of Volunteer Recruitment and Selection and the Office of Medical Services that the Director's 50+ initiative to recruit older Volunteers will place an increased burden on the Volunteer Delivery System and the Medical Clearance System in particular.

Data gathered during this evaluation coupled with data from the 50+ Initiative Working group suggests that applicants 50 and older have a very different experience navigating through the Medical Clearance System than their under 50 colleagues.

Specifically, 50+ applicants:

- Cost more to screen. Our OIG evaluation conducted analysis and produced evidence that it costs significantly more to qualify an applicant over 50 years of age. We found that it costs $1,946 to qualify applicants 50 years and over and $821 to qualify applicants less than 50 years of age.
- Require more screening staff time. It takes approximately 35 days to medically qualify an applicant under the age of 50 and 69 - 84 days to medically qualify an applicant over the age of 50.
- 50+ applicant files take longer to review according to screening nurses for two reasons: (1) a higher incidence of chronic diseases and (2) the need for accommodations secondary to these chronic conditions.
- Require more medical accommodations.
- Expect more information, such as screening timeframes, reasons for additional screening requirements, etc. and higher quality and more timely customer service.
- Are more likely to be deemed medically not qualified and are more likely to appeal if they are deemed medically not qualified. The 50+ population comprises 5% of the total Volunteer population; however, they make up 25% of all appeals cases reviewed by the Medical Screening Review Board.
- May take longer to complete their Medical Kit and send it in to OMS. Screening nurses stated that the time it takes to complete the Medical Kit may be longer for older applicants because they may be required to track down documentation of past medical conditions, in some cases dating back as far as 40 years ago.

According to the OIG Medical Clearance System survey, 50+ respondents were generally less satisfied with the Medical Clearance System (see table below). The stratified number of 50+ applicants was too small to produce statistically significant results.

Were you satisfied with the Peace Corps MCS process?

	Volunteers Under 50	Volunteers 50+	Did Not Serve Under 50	Did not Serve 50+
Not at all to Minimally Satisfied	27%	41%	65%	68%
More or Less Satisfied	50%	38%	23%	24%
Very to Extremely Satisfied	24%	21%	12%	8%

If the 50+ Initiative is successful and Peace Corps receives an influx of 50+ applications, the impact on the agency, particularly the OMS' Pre-Service Unit, will be an increase in screening hours required to review the same number of applicant files. Also, because older Volunteers early terminate their service at a higher rate than younger Volunteers, additional applicant Medical Kits will need to be reviewed to maintain Volunteer levels. Further, the Pre-Service Unit will need to respond to the increased customer service demands of 50+ applicants.

It is clear that 50+ applicants have a different medical screening experience and demand greater resources in addition to other models of service. Therefore, it is critical for significant improvements to be made to the Medical Clearance System in order for the Director's laudable goal of significantly increasing the percentage of 50+ Volunteers to be achieved while improving the MCS for all applicants.

RECOMMENDATION

We recommend:

49. That OMS with consultation from the 50+ Initiative Working Group and the Office of Strategic Information, Research, and Planning analyze what screening resources may be required by the agency to ensure the success of the 50+ Initiative, such as additional screening nurses or screening assistants.

STREAMLINING THE MEDICAL CLEARANCE SYSTEM

The agency realizes the importance of transparency in the Volunteer Delivery System and has stated that it intends to use technology to improve transparency. Our evaluation found that the lack of transparency is correlated with lags in technological improvement.

In the 2004 and 2005 Performance Accountability Reports (PAR), the agency stated that consistent with the President's Management Agenda, it "plans to increase the use of information technology and e-government services to strengthen the quality, efficiency, and timeliness of recruiting, assessing, and selecting prospective Volunteers." According to the PAR:

> *The agency is planning a business process re-engineering of the Volunteer Delivery System to deliver services and information in a citizen-centric manner that promotes transparent customer service, security, and privacy. A fully citizen-centered Web presence has been completed. This includes Web-based outreach to attract new applicants; an extensive electronic information site for prospective Volunteers and their families and friends; an online application, medical history form, and reference submission; and an online tracking system so applicants can check their status at each step of the application process.*

In the 2006 PAR, the Peace Corps continued to emphasize the importance of the President's Management Agenda and specifically the e-government initiatives, which the agency is using "toward overcoming agency bureaucratic divisions and increasing productivity and the ease of electronic access for citizens, which facilitates program and operation transparency." Again, the agency highlighted the Volunteer Delivery System (VDS) as a target for e-government solutions as follows:

> *The Peace Corps has aligned the VDS to speed up the application process and to reach minority groups more effectively. Internal communication was streamlined and overall response times to applicants was reduced.*

The 2006 PAR reported on the effects of certain e-government initiatives implemented in FY 2004, heralding cost savings due to application packages (the skills assessment and the Health Status Review) being no longer printed, compiled, and mailed to applicants.

The Peace Corps application consists of two parts, the skills assessment portion and the Health Status Report (HSR) portion, which asks the applicant approximately 80 yes/no questions to make a cursory assessment of the applicant's health. In September 2004, an improved version of the online application was released and the HSR was posted online. As of FY 2006, 91% of applicants applied online. However, the Medical Kit remains in a paper format which currently is printed, copied, collated, and mailed to the applicant following their nomination to the Peace Corps. After completion of the forms, evaluations, and tests required by the Medical Kit, the applicant sends the medical packet back to OMS by mail.

If the applicant loses a form or a form is damaged, the applicant calls the forms request telephone number, leaves a voicemail, and waits for a replacement form to arrive by mail. Screening nurses reported that approximately 90% of the Medical Kits they receive are missing required documentation and this presents the major reason why medical screening is delayed. In addition, the waiting time between mailings delays the medical screening process. Contributing to the delay, the U.S. Postal Service, with assistance from FBI and national public health experts, continues to irradiate mail in attempt to kill potentially present anthrax spores. This irradiation process adds varied transit time and often damages documents making them illegible, in which case OMS is required to request the document a second time from the applicant.

In order to avoid these delays and unnecessary mailing cycles, the State Department switched from mailing to faxing all medical screening documents in and out of the screening unit. This decision was one of several improvements that enabled the State Department to significantly decrease the average amount of time it takes them to screen a potential employee.

ONLINE MEDICAL KIT

Placing the Medical Kit online is one example of the many ways Peace Corps can use technology in accordance with the President's Management Agenda to reduce screening time.

Although the Office of Medical Services has requested that the agency's Information Technology Group place the Medical Kit online more than two years ago, it had not occurred at the time of our evaluation. Past efforts to implement this project only resulted in individual Medical Kit forms placed online. The physical examination and dental examinations forms were placed online by the Office of the Chief Information Officer in 2005, but standards for collaboration between the two offices to update the online forms when changes were made to the paper versions were not established.

When changes were implemented to the paper versions of the Medical Kit forms, the obsolete versions of the online forms remained online, causing confusion. Several applicants downloaded the out-of-date forms, completed the outdated test requirements, and spent twice the screening cost to complete a second set of up-to-date medical forms to finish the medical screening process. OMS staff stated that they made numerous attempts to get the online forms updated or removed in order to prevent more applicants from gaining access to the outdated forms, but the forms remained online. In March 2007, the outdated online forms were taken offline.

In an effort to avoid mailing delays and streamline the Medical Clearance process, OMS has begun meetings with the OCIO to outline a preliminary scope for developing an Online Medical Kits Project. This project will enable applicants to access their Medical Kit packet from the internet rather than mail. OMS is also exploring the possibility of implementing an electronic medical records system.

The OMS computer programmer analyst met with OMS and OCIO management in September 2007 to gather additional requirements and determine priorities, time-frames, and costs. Following this meeting, the OIG has been informed that a more detailed design and requirements analysis will be conducted to determine estimated time-frames and costs.

MEDICAL CLEARANCE SYSTEM AT OTHER FEDERAL AGENCIES

To understand whether other federal agencies have similar medical clearance systems and how they maintain quality within those systems, our evaluation researched the medical clearance systems at AmeriCorps and the State Department.

AmeriCorps' and the State Department's medical clearance systems have significant differences to the Peace Corps; AmeriCorps Volunteers serve domestically and the State Department Foreign Service Officers are cleared for urban areas near healthcare facilities. Differences aside, the Peace Corps can gain valuable insight from studying their quality standards and controls to ensure efficient and effective screening timeframes and quality customer service.

AmeriCorps is the domestic equivalent to Peace Corps, providing technically skilled men and women to serve in U.S. communities who request their assistance. Only one of AmeriCorps' many programs, the National Civilian Community Corps (NCCC) program, medically screens its applicants (restricted in age from 18-24) prior to service. One screening nurse and one selection/placement officer recruit, medically screen, and place approximately 1,200 NCCC applicants a year.

In 2004, AmeriCorps' medical screening unit and their general counsel disability attorney received copies of Peace Corps Medical Screening Guidelines. They modified the medical screening guidelines for AmeriCorps and stated, "If I used the PC [Medical Screening] Guidelines as anything more than a reference, no one would get into our program." The three biggest differences between Peace Corps and AmeriCorps are:

1) The AmeriCorps screening nurse acknowledges that most 18 - 24 year olds have not requested documentation and particular tests from their doctors and need "hand-holding" during this phase. On the contrary, several OMS staff members described Peace Corps' medical screening process as an applicant rite of passage.

2) From the time they are invited, AmeriCorps applicants have 10 business days to return their medical clearance paperwork, 10 days to return their legal clearance paperwork, and 10 days to appeal a medical clearance rejection. If they do not return their paperwork within that time, they are told that their application status will change. The AmeriCorps screening nurse stated the following:

> *It is very important to tell them this is the deadline. It is important to be clear. We have to fill our class and we can't wait to*

the last minute but then we are also flexible.

On the contrary, the Peace Corps does not provide timeframes for when the applicant is expected to return medical clearance paperwork. Although stating and enforcing deadlines would most likely require an increase in retention activities, general timeframes would not and would provide more transparency to applicants regarding application timeframes and applicant responsibilities.

3.) Applicants receive a free physical exam at one of the three NCCC campuses after they have been medically screened and accepted into AmeriCorps. There is no dental exam. OMS states waiting for applicants to schedule, complete and mail their physical exams significantly lengthens the medical clearance timeframe. Dental clearance requirements increase applicant out of pocket expenses and that coupled with less than full reimbursement for medical expenses increase applicant dissatisfaction with the Peace Corps medical clearance process.

The AmeriCorps example demonstrates how standard timeframes, clarity in communications, and attention to customer service can improve the medical clearance process.

Our review of the U.S. State Department's medical screening division demonstrated the dramatic effect quality management standards and technological improvements can have on the time required to medically screen a person. The State Department's Medical Clearance Division reported they recently significantly reduced the average number of days it takes for a screening nurse to conduct the initial review of a medical kit of a potential Foreign Service Officer. The initial review may determine that the Foreign Service Officer is qualified for employment, not qualified for employment or that more information or medical testing is warranted. The Division Chief of Medical Clearances at the State Department explained the dramatic improvement was achieved by implementing four major changes:

1) Instituting ISO 9000 standards for quality management systems.
2) Requiring applicants to fax instead of mail medical screening documents.
3) Scanning all applicant medical documents upon

arrival to the State Department.

4) Developing and implementing an electronic medical document management system that enforces standardization of medical reviews and increases screening nurse accountability.

On August 6, 2007, OMS hired a new manager for the Pre-Service Unit. Her background includes ISO 9001 quality management experience and when interviewed, she expressed a keen interest in learning more about the State Department's medical screening division and recent improvements.

These examples demonstrate that Peace Corps can and must do better with regard to their medical screening efforts. The following recommendations provide mechanisms for improvements to occur.

SCANNING OF MEDICAL DOCUMENTS

An example of a technological improvement that has reduced screening time and increased efficiency at the State Department is the pre-scanning of all applicant medical documents.

Peace Corps scans documents at the end of the medical screening process: medical records contractors scan the applicant medical documents onto computer disks and mail them to the PCMO at the Peace Corps post two to three weeks before the staging. This is a fail-safe measure in case the paper medical records are lost in transit to the post.

The State Department Medical Records team scans all Pre-Service medical documents at the beginning of the medical screening process rather than at the end. The documents are entered into the State Department's custom software, eMed medical document management system, where they are accessed by the screening nurses and medical advisors. This procedure prevents staff from misplacing documents, facilitates management oversight, ensures safe storage of confidential medical documents, and requires less physical storage space than paper records.

The Pre-Service Unit and the Office of the Chief Information Officer at Peace Corps have explored the possibility of an electronic medical records system and reported that the cost was prohibitive.

OMS should consider meeting with the State Department's Director of Medical Screening to learn more about their medical screening tools and procedures.

A complete document management system similar to the State Department's may be the final goal for Peace Corps Pre-Service Unit; however, implementing a system to scan applicant medical records earlier in the medical screening process may help the department segue toward an electronic medical document management system and could remedy the current administrative problems of inadequate storage space, unsecured storage of confidential medical records, and the difficulty sometimes faced locating and processing paper files.

The status of an applicant's application as listed on the My Toolkit was incorrect approximately 20% of the time.

A technical problem that has been known by the VRS staff for several years are the errors in the My Toolkit Status check codes. VRS Staff reported the status of an applicant's application as listed on the My Toolkit was incorrect approximately 20% of the time. The misinformation of the status code causes confusion and unnecessary frantic applicant calls to Peace Corps staff.

The problem is that the computer code is not sophisticated enough to accurately handle all status updates and in the case of a complex case, the result is an inaccurate status code.

Once the status check problem is fixed, a second way to improve the transparency of the applicant's current status is to develop an automated email status messaging system. Each time an applicant's Medical Kit status is updated, an automatic e-mail could be sent to the applicant regarding the newly changed status of the applicant's file, with status codes explained in detail. Currently, applicants do not understand the difference between Defacto and Hold, nor do they understand their rights to put an application on hold.

Currently there is a subset of status codes that are made available to the applicant on the My Toolkit page. For transparency, this subset should be expanded and accompanied by a justification for the change in status. Screening assistants estimated that 40 - 50% of the calls they receive are status inquiries. Providing information online

would prevent unnecessary calls to screening assistants inquiring about the change in status.

VRS staff acknowledged that the My Toolkit program had many coding errors and that there was an initiative to redesign the My Toolkit. However, as of August 2007, the inaccurate status updates on My Toolkit had not been corrected.

Applicants have problems logging into the online application and My Toolkit.

There are two main issues with logging into the My Toolkit: 1) receiving the My Toolkit login username and password in a timely manner by mail and 2) confusion of whether the applicant is logging into the application portion or the My Toolkit portion of the website.

The Peace Corps application website was developed by an outside contractor, Apply Yourself, and is managed by the Office of Volunteer Recruitment Services. The My Toolkit portion that is integrated into the application website is a Peace Corps program and requires a different username and password. When an applicant creates an account on the application section of website, he/she receives a PIN and a temporary password which is to be changed at log-on. When the applicant completes his/her application, the applicant is told that a My Toolkit username and password will be sent in the mail to allow the applicant to log into the system and check the status of their application.

As a test case, one member of our evaluation team applied online to the Peace Corps. She submitted her application and Health Status Review on May 19, 2007 and received an automatic email stating she would receive her My Toolkit username and password in the mail in approximately 10 days. She did not receive the My Toolkit username and password until June 20, 2007.

When VRS staff was asked about this, they agreed that this was an inefficiency in the system that they addressed with the OCIO Chief Information Security Manager in May 2005. VRS indicated that it began talks with the OCIO Chief Information Security Manager to determine if Peace Corps could switch to a system of emailing instead of mailing the My Toolkit username and password. However, no decision

was made and the initiative to fix the inefficiency was never completed.

The current practice of mailing My Toolkit passwords to applicants involves: (1) the contractor sending information electronically to the Peace Corps Office of Administrative Services, (2) the Office of Administrative Services putting the information into a spreadsheet, (3) the information in the spreadsheet being used to create a mail merge file, and (4) a letter to the applicant with the My Toolkit username and password being sent using the mail merge file.

Currently, there is no system to verify whether new applicants receive this letter with the My Toolkit information and VRS continually receives complaints from applicants that did not receive their letters. Another reason why applicants may not be receiving this letter can be attributed to the following remark by a Peace Corps staff member:

> *We have so many college students that start the [application] process at school and put the school address in the application and then they move home and they never get the My Toolkit password that is sent in the mail to the college address.*

In the fall of 2006, VRS addressed the second issue of clarifying instructions for logging into the My Toolkit portion of the site. Labels were added to the log-in area of the site to designate whether the applicant was logging into the application portion or the My Toolkit. As a result of this change, VRS staff reported the number of support calls regarding login questions has decreased. It was suggested by applicants and staff that there should be a mechanism in place to ask applicants a security question if they forgot or misplaced their login information. However, VRS staff stated that this is not possible with the current software.

Another My Toolkit upgrade that OMS should consider is to enable medical screening assistants to update the My Tool Kit Medical Screening Checklist as an applicant's medical documentation is received. Similar to the way in which the Health Status Review is linked to the Expert System, if an applicant responds affirmatively to having a medical condition, a link will connect the Health Status Review to the My Toolkit. Each time the applicant responds affirmatively to

having a medical condition, the response flags in the Expert System and an expert letter corresponding to that medical condition is pulled from the system and assembled for the Medical Kit launch, which is then printed, collated and sent to the applicant. The checklist could contain a similar connection and each time an applicant responds positively to having a medical condition, the response flags in the My Toolkit and a checklist item corresponding to that medical condition will be added to the general requirements found in the Online Medical Screening Checklist.

Use of email will expedite the correspondence process of mailing medical documentation.

OMS staff reported that medical confidentiality prevents them from requesting or receiving medical documentation via email. Numerous prior studies, including our 2003 report Evaluation of the Volunteer Delivery System, stated that OMS's overly stringent interpretation of medical confidentiality prohibits them from communicating freely with their VDS delivery colleagues about applicants and with the applicants themselves over any medium other than telephone and physical mail.

The State Department's Medical Screening Division routinely uses email to communicate with the applicant. According to the State Department's interpretation of medical confidentiality, Screening Nurses can request documentation as long as they do not disclose the diagnosis or personal medical information. At the State Department, the Director of the Medical Screening Division stated that requests for "lab results" or "x-rays" are common. The State Department is transparent with the applicant and states that it is the applicant's decision whether they want to email medical documentation. As stated earlier in the Customer Service finding, per PCM section 268.5.3, **"**Medical information may be disclosed as authorized in writing by the individual whose medical information is involved." It is not a breach of medical confidentiality to accept emails with private medical information when sent by the applicant with the applicant's authorization.

Using email to communicate would expedite the correspondence process of mailing medical documentation back and forth while giving the applicant advance notice of outstanding requirements needed to complete their Medical

Kit. Email communication instead of phone conversations can use pre-determined templates for quality standardization which would save staff time and increase the quality and accountability of OMS screening staff.

In order to improve transparency and communication voids in the Medical Clearance System, Peace Corps should utilize its online presence to optimize communication tools with current online applications and post information online relevant to the medical screening process for applicants.

Several sources, including staff and applicants, suggested that a detailed description of the medical screening process, including definitions of all applicable terms, should be posted on the Peace Corps website and on My Toolkit. This description would help set applicant expectations for the amount of time the medical clearance will take during spike and non-spike periods and take into consideration the time needed for: scheduling doctors appointments, waiting for test results, completing follow-up tests and review of medical documentation by a screening nurse.

We also concur with providing more information to applicants on the medical dispositions that can result from the screening process and improving information regarding the implications of a failure to disclose medical information.

Peace Corps has identified but not implemented technological improvements to the MCS that would improve transparency and accessibility.

The agency has recognized the potential for e-government solutions to streamline the VDS; however, it is unclear why the agency has chosen to concentrate limited agency resources on the recruitment aspects of the VDS when the agency has repeatedly recognized the Medical Clearance System as the "bottleneck" of the entire VDS process.

The agency has not prioritized Pre-Service Unit technology projects; as a result the following projects have not been implemented:

1. Electronic Medical Records or Document Management System
2. Online Medical Kit
3. Posting of MCS Applicant Resources
4. Correction of serious Online My Toolkit errors

5. Improvements to the Telephone System to ensure a Live Person Answers (see customer service finding)

The majority of these technology projects would greatly improve MCS transparency to applicants.

RECOMMENDATIONS

We recommend:

50. That the Screening Unit Manager be mentored by the Division Chief of Medical Clearances at the State Department to provide expertise and assistance to the OMS Screening Unit and QI Unit for the purposes of the following:

    a. Streamlining the MCS.
    b. Developing performance measures.
    c. Developing and implementing staff feedback mechanisms.
    d. Developing and implementing applicant feedback mechanisms.
    e. Developing, updating, and enforcing guidelines, SOPs, and policies.
    f. Implementing improvements to the MCS.

51. That the OMS Screening Team meet with the State Department's Screening Division to learn how the State Department decreased medical screening time through a combination of technological improvements, systems streamlining, and quality management and to determine the following:

    a. The hardware required and communications methodology for requiring applicants to fax medical documentation instead of mailing,
    b. The hardware and system structure involved in transitioning to a system of scanning, accessing, reviewing and storing electronic medical files, and
    c. Whether the eMed document management system or a similar system would work for Peace Corps Medical Screening.

52. **That the OCIO implement improvements to the Medical Screening Process including the following:**
    - **Posting the Medical Kit online,**
    - **Instituting a new system in which applicant paper medical records will be scanned by the Medical Records Unit prior to review by screening nurses,**
    - **Fixing the identified applicant status problems with the My Toolkit and institute improvements to the My Toolkit code including:**
        - **Linking the HSR answers to requirements on the applicant's personalized Medical Screening Checklist,**
        - **Expanding and improving upon accuracy of online status checks and incorporating automated e-mail messaging to applicants explaining why the applicant's status was updated or changed,**
    - **Determining the parameters by which the Screening Unit can utilize email as an effective means of communication with the applicant as is currently being used by the State Department's Medical Screening Unit, and**
    - **Posting the following documents online:**
        - **The Comprehensive Medical and Dental Booklet**
        - **Detailed description of the Medical Screening process**
        - **The list and explanation of all medical disposition status codes.**

53. **That the agency establish a Volunteer Delivery System committee to meet on a monthly basis to discuss VDS system operations, performance measurement, impact of interoffice VDS decisions, and communication strategies for implementing VDS changes that ensure that all VDS offices are informed of changes to the system that effect multiple offices and changes are communicated consistently to regional recruitment offices and applicants.**

54. **That the agency prioritize long-standing recommendations for technological improvements to Pre-Service operations and provide OMS with the resources to carry out these improvements to the Medical Clearance System.**

PREVIOUS REPORTS

Several prior reports, dating back to 1992, made many excellent recommendations to improve the MCS, but were not implemented.

The agency's 2006 Performance and Accountability Report identified four tenets to enhance and strengthen the quality of the MCS and VDS:

1. Meeting the needs of applicants and Volunteers with efficient and effective support.
2. Providing comprehensive staff training.
3. Expanding E-government integration of medical screening processes.
4. Decreasing application response time.

In 2002 and again in 2006, a Volunteer Delivery System (VDS) task force was formed to identify ways to improve the system. The 2006 VDS task force has primarily focused on the effects the Director's 50+ initiative will have on the Peace Corps Volunteer Delivery System.

The agency has implemented the following recommendations based on prior evaluations. These improvements have sought to optimize and enhance the MCS:

- In 2003, OCIO hired a consulting firm, Mitre, to research, plan, and implement an Enterprise Architecture technology framework which would help streamline agency operations such as applicant processing and application timeframes.
- The Office of Communications worked closely with VRS and OMS to automate VDS and MCS processes, including an online application, applicant status checks, automated responses to frequently asked questions, online Health Status Review, online reference checks, and the Pre-Departure Online Training tool for Trainees. These efforts decreased the processing time; however, the agency did not meet its strategic performance goal in FY 2004 and FY 2005: *"Reduce overall response time to applicants by 2% from FY 2003 level of 223 days to 219 days by FY 2005."*
- OMS increased screening staff, reorganized staff into regional medical screening teams, redesigned the health status review form, and integrated scanning

technology into the medical records system in an effort to reduce applicant processing time.

Despite these improvements to the VDS and MCS, external and internal sources cited continuing problems with MCS transparency, OMS customer service, quality improvement, online presence, technological improvements, consistency in medical screening, outdated medical screening guidelines, exceedingly long timeframes, poor communication, and an inadequate reimbursement fee schedule.

Several of our recommendations for improvements to the Medical Clearance System were either suggested by Peace Corps staff verbatim and/or emerged from recommendations in prior reports dating back to 1992. These recommendations were accepted by the agency but were never implemented.

The GAO's report on Standards for Internal Control in the Federal Government states:

> *Monitoring of internal control should include policies and procedures for ensuring that the findings of audits and other reviews are promptly resolved. Managers are to*
> *(1) promptly evaluate findings from audits and other reviews...*
> *(2) determine proper actions in response to findings and recommendations from audits and reviews*
> *(3) complete, within established time frames, all actions that correct or otherwise resolve the matters brought to the management's attention.*

The following is a list of previous reports and other studies and their recommendations to improve the medical clearance system. In some cases, the agency pursued action and implemented recommendations but for many others, action was not taken by the agency and OMS.

1992 McManis Associates Report on the Screening and Medical Clearance Process
- Institutionalize and standardize procedures for updating and revising medical screening guidelines and medical screening policy.
- Improve the defacto letter sent to applicants.

1994 Peace Corps Volunteer Services and Office of Medical Services Report on Medical Screening Process Redesign

- Make medical dispositions on applicants as early in the process as possible.

- Make automated document handling a priority.

- Reduce work and rework and improve production speed by eliminating unnecessary work steps, scanning medical histories and records and automating document handling and generation of forms.

- Continue to use FIFO [first in – first out] as a general disposition priority tool, working to qualify the easiest cases first. When FIFO is impractical, work to give priority to those NOMs [nominations] with the earliest [accurate] COI [close of invitation].

- Use automation to eliminate all human rework during the delivery step of the medical screening process. Keep delivery to Staging within the screening process until it has been fully automated or until there is a change in workload distribution within the Office of Medical Services.

- In the short term, OMS should pursue outsourcing those screening functions that will have the greatest potential of reducing workload. These are Additions to existing contracts to cover the functions of boxing records for Staging and sending them to Staging sites and coordinating Staging sites and Outsourcing psych review cases, through the successful bidder for the MSIP [Medical Services Improvement Plan] or to a sole source contractor.

- Work to improve linkages between OMS and applicants and potential applicant clients.

- Work to reduce numbers of applicant complaints and Congressional inquiries regarding medical dispositions by improving the appeals process.

- Index the standard reimbursement rate for basic medical exams to 100% of a national UCR fee schedule.

- Index and increase the reimbursement rate for basic dental exam and x-rays to a national insurer's covered benefits rate.

1994 Joint Commission – PCVHS Evaluation Report

- Establish Quality Improvement Indicators.
- Establish Quality Improvement education and program implementation.
- Enhance and improve interoffice communication.

- Develop a protocol for systematic review of overseas health jackets for clinical appropriateness.

1997 Joint Commission- PCVHS Evaluation Report
- Maintain commitment to strategic planning.
- Continue measurement of important clinical processes.
- Complete implementation of the Health Information System Improvement Plan.

1999 Peace Corps- Review of the Volunteer Delivery System
- Communication to applicants regarding the medical screening component should be improved.

2000 VRS Committee Review of Recommendations from Volunteer Delivery System Report
- Employ information from the Health Status Review earlier in the process.
- Provide applicants with option to conduct automated status checks.
- Develop central customer service point of contact.
- Institute customer service standards to ensure timely, consistent, and quality communication with all applicants throughout the selection process.

2002 Office of Medical Services Pre-Service Unit- Medical Screening Redesign
- Continue with the re-engineering of functions, for efficiency and effectiveness. For example: applicants would be assigned to a team, not an individual nurse. Could a team member cover phones and be able to answer any questions from an applicant assigned to their team?
- Complete the changes and improvements to the management information system.

2002 Pugh, Ettinger and McCarthy Report External Review of OMS VHS
- The leadership of OMS should define the important dimensions of performance for the PCVHS and develop specific measures for each dimension. These measures should be tracked over time, displayed graphically and routinely communicated throughout OMS and the PCVHS. OMS leadership should utilize these measures to align organizational efforts by requiring each operating

unit of OMS to develop a set of performance measures for their key work processes that are aligned with the dimensions of performance. OMS leadership should utilize a dashboard/balanced scorecard to track and communicate progress.

- Customer knowledge should be improved at all levels of the PCVHS and customer feedback should be collected and used to improve performance.
- Create clear aims and performance measures for the Medical Screening Process.
- Improvement efforts are the work of leadership and leadership systems should be redesigned to achieve desired levels of PCVHS performance.
- Broaden the deployment of evidence-based medicine within the PCVHS.
- Improve the OMS field review process.

2003 Peace Corps Office of the Inspector General Evaluation of the Volunteer Delivery System

- That the agency establish customer service standards for the principal delivery system offices having direct communications with applicants and appoint representatives to respond to complaints and evaluate customer service.
- That the agency simplify and reform the unfriendly aspects of the application process.
- That the Office of Medical Services increase the number of screening nurses to further reduce the screening time, update the screening guidelines, and provide advisory services to support modification of the expert system.
- That OMS review the reimbursement schedule and reimbursement policies to reduce out-of-pocket costs for medical screening.

As of March 1, 2007, none of the recommendations listed above had been implemented.

We have determined that the agency has not prioritized Pre-Service issues and has not fixed the problems with the Medical Clearance System over the past 15 years. These recommendations are just as pertinent today, as shown in our findings, as they were when they were made, in certain cases, 15 years ago. The result of 15 years of inaction in key areas of the MCS is that criticisms and complaints have continued unabated.

55. That the Cross-Unit Board in collaboration with the Quality Improvement Unit review the recommendations in the above noted reports.

LIST OF RECOMMENDATIONS

WE RECOMMEND:

1. That the Pre-Service Unit develop Standard Operating Procedures for all aspects of the Pre-Service process.

2. That OMS enforce SOP 3.1 and 3.2 pertaining to confidential applicant medical records.

3. That the Pre-Service Unit with the assistance of the QI Unit and the Office of Strategic Information, Research, and Planning (OSIRP) determine whether the performance measures recommended in the Pugh Ettinger McCarthy Associates report would accurately capture Pre-Service performance. These performance indicators include but are not limited to the following:
   - Percentage of Volunteers with accommodations that complete 27 months of service.
   - Rate of non-injury related Medevac.
   - Rate of mental health early terminations.
   - Percentage of Peace Corps offices involved in the VDS that rate OMS performance as excellent.
   - Percentage of Pre-Service employees that rate their job satisfaction as excellent.
   - Average time to fill open positions.
   - Monthly turnover rate.
   - Cost per Federal Employees' Compensation Act claim.
   - Cost per screening.
   - Percentage of Volunteers with significant medical issues not identified in screening.
   - Percentage of screenings with decisions made within 90 days of receipt.
   - Percentage of incomplete medical records.

4. That OMS provide Quality Improvement training to their staff to enable the staff to develop meaningful performance indicators to measure the Pre-Service Unit's productivity and other related matters.

5. That OMS create policies and procedures to require PCMOs to complete the Country Health Resources Survey as information in their country changes in order to ensure that the headquarters data on the types of medical conditions the post can accommodate is accurate.

6. That OMS merge the two duplicative databases, the Country Health Resources database and the Medical Accommodations database, used by screening nurses to place applicants requiring a medical accommodation for efficiency and consistency in the medical accommodations process.

7. That OMS create policies and procedures to ensure that the Medical Screening Guidelines are updated at a minimum annually and as screening changes occur.

8. That OMS establish a required number of days that a post has to respond to a request from the Medical Accommodations Coordinator to minimize delays in the MCS process.

9. That OMS work with the Office of Strategic Information, Research and Planning (OSIRP) to accurately calculate the average time for a medical qualification for performance measurement and inclusion in the Performance Accountability Report.

10. That OMS work with OSIRP to identify the additional data fields that the Pre-Service Unit should collect to accurately measure the time it takes a screening nurse to review a Medical Kit, including stopping the clock for missing information.

11. That the Pre-Service Unit work with OSIRP to determine the data elements and data analysis required to implement performance indicators recommended in the 2002 PEM report for inclusion in the 2008 PAR.

12. That the Pre-Service Unit and VRS Placement Unit work with OSIRP to standardize application data across agency offices.

13. That OMS convert defactos to one of five medical dispositions by September 30th of a given year for performance tracking and measurement purposes.

14. That OMS and VRS work with OSIRP to devise a method for tracking applicants through the entire VDS process including the reconciliation of the number of nominations to medical kits sent and medical dispositions to final invitations.

15. That OMS work with OSIRP to determine how to accurately calculate the time and cost of a screening appeal and how to factor that time and cost into an average time and cost to screen an applicant.

16. That the OCIO correct the problem of applicant status and timeframes being overwritten in Peace Corps Volunteer Database Management System if an applicant applies to the Peace Corps more than once.

17. That the OCIO add data fields to the tables in PCVDBMS to capture additional information on the medical screening time frame and to capture when missing information is requested and when missing information is received.

18. That OMS designate responsibility and provide data collection and analysis training to a staff member to maintain and perform the data methodology, collection and analysis of Pre-Service data as defined by OSIRP.

19. That OMS establish a Cross-Unit Board consisting of managers from each of the

VS/MS Units: Medical Screening, Medical Field Support, Health Information Services, Programming and Training, Post-Service, Quality Improvement, Medical Records and Epidemiology.

20. That the Cross-Unit Board meet on a quarterly basis with VRS to discuss how screening requirements impact applicants, Volunteers, post management of Volunteer health conditions, medical evacuations, and FECA claims.

21. That OMS designate a staff member or hire an outside consultant to review the screening criteria and assess whether it is useful in the field. Possible questions to ask include:
   - Are posts receiving Volunteers with medical conditions that cannot be supported?
   - Do posts think Peace Corps should not accept applicants with these conditions?
   - Are there medical conditions that are screened for that are never a problem in the field and therefore should not be a screening requirement?

22. That the OMS Cross-Unit Board systematically collect feedback from posts via WebEx or a form of survey to measure the impact of screening requirements.

23. That OMS improve the Medical Clearance System customer service line so that the line always rolls to another phone until a live person is reached. This may be accomplished by instituting the following changes:
   - Coordinating screening nurse schedules to ensure full office coverage and that at least one screening nurse from each regional team is in the office every work day and available to accept applicant phone calls until 5:00pm EST.
   - Including the direct telephone extension of the screening assistant assigned to the applicant in the Medical Kit.
   - Adding an additional phone line.

24. That OMS identify, implement and monitor customer service standards.

25. That OMS and the Pre-Service Unit with the assistance of OSIRP systematically collect applicant feedback by developing and implementing an applicant feedback survey.

26. That the Pre-Service Unit manager meet with the Director of the Medical Screening Division at the State Department to learn about their medical screening survey to capture customer feedback.

27. That OMS establish and implement annual customer service training for all OMS staff that have direct communication with applicants. Customer service training should emphasize the importance of coaching applicants through the Medical Clearance System.

28. That the Pre-Service Unit develop a Nurse Line email address that can be checked by screening assistants and forwarded onto the proper screening nurse as an alternative to the Nurse Line.

29. That the Pre-Service Unit staff log and discuss applicant complaints.

30. That the Pre-Service Unit institute quality controls to ensure contact information is not missing from the letter in the Medical Kit.

31. That OMS conduct a staffing analysis to determine whether the number of screening nurses currently on staff is adequate.

32. That OMS conduct periodic staffing analyses to address new agency initiatives which impact the Pre-Service Unit workload.

33. That the OCIO designate a backup to the OMS computer programmer analyst with programming proficiency and ensure that he or she receives routine training on the Expert System.

34. That OMS routinely communicate changes in the Expert System to the backup programmer.

35. That OMS document the Expert System for succession planning.

36. Based upon screening productivity, quality performance, and compliance with policies and customer service standards, that the agency considers a pilot program to exempt screening nurses in the Office of Medical Services from the five-year rule with renewable 30-month tours.

37. That OMS define the purpose of the Plan One reimbursement schedule.

38. That OMS provide applicants with data from the survey they develop with the Office of Strategic Information, Research and Planning that shows average out-of-pocket costs that applicants have incurred in fulfilling the Peace Corps Medical Clearance requirements.

39. That the OMS Health Information Systems Unit establish criteria by which to assess the adequacy of the reimbursement fee schedule by 2008.

40. That immediately after establishing the assessment criteria, the OMS Health Information System Unit assess the adequacy of the current Plan One reimbursement fee schedule and adjust the schedule accordingly.

41. That the OMS Health Information Systems Unit establish a procedure by which they re-evaluate the adequacy of the reimbursement fee schedule biennially or as new screening requirements are implemented.

42. That OMS provide applicants with the estimated time it will take the Pre-Service Unit to screen a Medical Kit from an applicant under 50 years of age and to screen a Medical Kit from an applicant 50 years and older.

43. That OMS work with the Office of Communications to improve the Medical Kit instructions by eliminating contradictory and vague guidance and highlight the most critical information.

44. That OMS consolidate the location of instructions and medical forms for completion by applicant or a healthcare provider and ensure that they are accurately referenced on paper and online.

45. That the Peace Corps and the VA Hospitals more clearly define and update their agreement.

46. That OMS correspond with VA Hospitals on an annual basis to strengthen communication on new requirements to the Peace Corps Medical Kit.

47. That OMS develop and distribute a list of Veterans Administration Hospitals across the nation that are positively responding to screening Peace Corps applicants based on applicant feedback.

48. That the Pre-Service Unit post the VA Hospital Authorization Form online next to the list of applicant endorsed VA Hospitals.

49. That OMS with consultation from the 50+ Initiative Working Group and the Office of Strategic Information, Research, and Planning analyze what screening resources may be required by the agency to ensure the success of the 50+ Initiative, such as additional screening nurses or screening assistants.

50. That the Screening Unit Manager be mentored by the Division Chief of Medical Clearances at the State Department to provide expertise and assistance to the OMS Screening Unit and QI Unit for the purposes of the following:
    - Streamlining the MCS.
    - Developing performance measures.
    - Developing and implementing staff feedback mechanisms.
    - Developing and implementing applicant feedback mechanisms.
    - Developing, updating, and enforcing guidelines, SOPs, and policies.
    - Implementing improvements to the MCS.

51. That the OMS Screening Team meet with the State Department's Screening Division to learn how the State Department decreased medical screening time through a combination of technological improvements, systems streamlining, and quality management and to determine the following:
    - The hardware required and communications methodology for requiring

applicants to fax medical documentation instead of mailing,
- The hardware and system structure involved in transitioning to a system of scanning, accessing, reviewing and storing electronic medical files, and
- Whether the eMed document management system or a similar system would work for Peace Corps Medical Screening.

52. That the OCIO implement improvements to the Medical Screening Process including the following:
- Posting the Medical Kit online,
- Instituting a new system in which applicant paper medical records will be scanned by the Medical Records Unit prior to review by screening nurses,
- Fixing the identified applicant status problems with the My Toolkit and institute improvements to the My Toolkit code including:
- Linking the HSR answers to requirements on the applicant's personalized Medical Screening Checklist,
- Expanding and improving upon accuracy of online status checks and incorporating automated e-mail messaging to applicants explaining why the applicant's status was updated or changed,
- Determining the parameters by which the Screening Unit can utilize email as an effective means of communication with the applicant as is currently being used by the State Department's Medical Screening Unit, and
- Posting the following documents online:
  o The Comprehensive Medical and Dental Booklet
  o Detailed description of the Medical Screening process
  o The list and explanation of all medical disposition status codes.

53. That the agency establish a Volunteer Delivery System committee to meet on a monthly basis to discuss VDS system operations, performance measurement, impact of interoffice VDS decisions, and communication strategies for implementing VDS changes that ensure that all VDS offices are informed of changes to the system that effect multiple offices and changes are communicated consistently to regional recruitment offices and applicants.

54. That the agency prioritize long-standing recommendations for technological improvements to Pre-Service operations and provide OMS with the resources to carry out these improvements to the Medical Clearance System.

55. That the Cross-Unit Board in collaboration with the Quality Improvement Unit review the recommendations in the above noted reports.

OBJECTIVE, SCOPE, AND METHODOLOGY

The objective of this evaluation was to determine whether major components of Peace Corps' medical clearance system function efficiently and in accordance with established standards and performance goals. Specifically, we set out to determine whether the Medical Clearance System:

1. Is meeting Agency established internal controls, performance goals and standard operating procedures?

2. Is informative and transparent to applicants/Volunteers?
   - Provides applicants/Volunteers with accurate and relevant instructions on completing the Peace Corps medical clearance process.
   - Provides applicants/Volunteers with an estimated timeframe for the processing of their medical clearance; this includes providing information to applicants/Volunteers on certain medical conditions that may slow down the medical clearance process.
   - Has a transparent process and consistently applies standards and guidelines for reaching a determination on medical clearance, clearance with restrictions, deferral, or disqualification for each applicant.
   - Informs applicants/Volunteers regarding how Peace Corps medical benefits coordinate with their personal health insurance before, during and after Peace Corps service.
   - Provides applicants/Volunteers with explanation or justification of why additional tests are necessary.
   - Provides applicants/Volunteers with transparent and easily accessible information on submitting medical reimbursements and appeals requests.
   - Personnel consistently follow and convey MCS policies and standards.

3. Does it provide sufficient customer service and consistent guidance to applicants/Volunteers?
   - Recruiters set expectations during the applicant interview regarding the application timeframe, documentation, medical, and dental exams required, and reimbursement schedules outlining possible costs that an applicant may incur.
   - Customer service representatives, medical/dental screening assistants, screening nurses, dental consultants, and medical advisors provide cordial and informative customer service to applicants.
   - Customer service representatives, medical/dental screening assistants, screening nurses, dental consultants, and medical advisors return all phone messages and e-mail correspondence in a timely manner, providing helpful assistance.
   - Language in the paper and electronic documents provided to applicants/Volunteers is clear, appropriate and suitable for a diverse applicant audience.

- Provides customer service training to regional recruiting offices, customer service representatives, medical/dental screening assistants, dental consultant, and screening nurses.

4. Does it effectively coordinate with other offices involved in the Volunteer Delivery System?
   - Coordinates efficiently with Peace Corps regional recruiters in providing applicants with accurate and informative guidance for completing the medical clearance process and providing applicants with "Medical Information for Applicants."
   - Coordinates efficiently with placement officers to expedite the medical clearances of applicants with certain skill sets that are urgently needed in the field.
   - Coordinates efficiently with the Office of Communications to ensure that language and instructions containing medical clearance information located on the Peace Corps website and all collateral materials are current, accurate, accessible, and communicated effectively.
   - Coordinates efficiently with the Office of the Chief Information Officer to ensure that MCS processes are appropriately using technology available to ensure efficient processing of applicants.

5. Does it adequately reimburse applicants for required medical test and dental expenses?

6. Has mechanisms for receiving and appropriately responding to agency initiatives and recommendations for improvements to the medical clearance process made by internal or external evaluations?
   - Has mechanisms for receiving Volunteer feedback and incorporates Volunteer suggestions into improving the medical clearance process?
   - Has implemented the structural, technological, and staffing recommendations made in the OIG's 2003 Evaluation of the Volunteer Delivery Cycle (VDS), with which the Agency concurred with all recommendations, and all prior coverage reports with which the agency concurred?
   - Has implemented the structural, technological, and staffing recommendations made in all prior coverage reports (i.e. Joint Commission, Pugh Ettinger McCarthy, etc) with which the agency concurred?
   - Collaborates with the Volunteer Delivery System Steering committee to assess, plan and implement identified improvements to the medical clearance process?
   - Collaborates with the Volunteer Delivery System Steering committee- 50+ Initiative Working Group to assess, plan and implement identified improvements to the medical clearance process?
   - Has identified the impact and designed a plan for modifying the medical clearance system to accommodate more applicants and a greater percentage of baby boomer Volunteers?

APPENDIX A

SCOPE

This program evaluation will focus on the efficiency and performance of specific components of the medical clearance system and the medical clearance system as a whole. The scope of our document review covers years 1992 – 2007 as several reports that were commissioned by OMS during this period made recommendations that were not implemented and are still relevant today. The scope of our field work covers years 2002-2007 because the data collected through the surveys and interviews needed to be timely in order to accurately reflect the current medical clearance process.

METHODOLOGY

In order to maximize information and minimize cost, data was collected from applicants via survey and telephone interviews. There are six main components to the research methodology we used for this evaluation:

1. **Initial data analysis.** We evaluated a regionally representative sample of 1,157 OIG post surveys collected from 2002 to 2006 to determine areas of concern as voiced by active Volunteers. These surveys presented a unique resource for the OIG, serving as another source of data apart from that collected by the agency. We created a universal OIG Volunteer questionnaire data entry form using the analysis software, Epi-Info, based on all variations of the evaluation questions that appeared on the "A. Before Peace Corps Training" section of the questionnaire between 2002 and 2006. Upon entering the 1,157 Volunteer questionnaires from our representative sample, we conducted quantitative analysis and made findings that overall, Volunteers are generally satisfied with all aspects of the VDS. However, there was less satisfaction with the medical screening process and information provided to Volunteers from Peace Corps than in other areas of the Volunteer Delivery System. Following the quantitative analysis, we conducted qualitative analysis based on the open-ended section of the questionnaire in which Volunteers made comments. Sixty-one percent of the Volunteers wrote comments and the majority of those comments were of a negative nature regarding medical screening and information provided to Volunteers by Peace Corps.

2. **Document review.** We conducted an extensive literature review of past reports and documents pertaining to the VDS.[1] From the literature review and research of past

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[1] Thomas Tighe and VDS Review Team, Chief of Staff, *1999 Review of the Peace Corps Volunteer Delivery System;* Steve Buff, Alice Bunker, Jim O'Keefe, Office of the Inspector General for Evaluation and Inspections, *2003 Final Evaluation of the Volunteer Delivery System;* Headquarters Evaluation Q3 2002 [Volunteer Delivery System]; Office of Planning, Policy and Analysis, *FY2003-2008 The Peace Corps Strategic Plan: A Legacy of Service and Compassion;* Stephanie Saltzman, Office of Communications, *PC Accomplishments 2001-2004;* Project Management Office- Office of the CIO, All Agency IT Project Snapshot- January/2006; Ann Macdonald, Office of Planning, Policy and Analysis, FY 2005 Performance and Accountability Report; Erica McCaulley, Office of the Chief Information Officer, *IPBS Strategic Plan FY 2006-2008;* Office of Planning, Policy and Analysis, *2006 Fact Sheet;* Gaddi H. Vasquez, Director, *"Strategic Planning," email Memorandum from the Director, 7/19/06*

reports, we identified recommendations accepted and rejected by the agency as well as plans for implementation. The initial data analysis coupled with the document review of past reports on the VDS indicated that the area of most concern within the VDS was the Medical Clearance System.

3. **Data review.** We reviewed the Office of Medical Services' Pre-Service Unit's Expert System application used for collecting and documenting the work of the Pre-Service unit. Additionally, we reviewed the Pre-Service Executive Summary Report which summarizes the medical screening data collected in the Expert System and is the most frequently viewed report for tracking the number and types of medical dispositions processed by the Pre-Service unit by month. We determined that the Pre-Service Unit's Expert System has internal control problems and subsequently, the reports have data integrity issues. OMS staff are aware of these data issues and are working with the Office of the Chief Information Officer and the Data Working Group within the Office of Strategic Information, Research and Planning to resolve the problems.

The Office of Medical Services does not collect or analyze data on applicant financial obligations that may impact how much applicants can afford to spend to complete the Medical Clearance System. In order to analyze this information we requested screening and applicant data maintained by the OCIO within the Peace Corps Volunteer Database Mainframe System (PCVDBMS) be merged with reimbursement data from Seven Corners, the Peace Corps contractor for processing reimbursement claims. We did not review the internal controls of the Seven Corners database to ensure the integrity of the data. We reviewed some but not all of the internal controls of the PCVDBMS data and found some data problems. The data issues we identified in both the Expert System and in PCVDBMS are discussed in more detail in the Data Collection and Analysis section of this report. In the Executive Summary section of this evaluation report, we presented applicant processing reports that were originally produced by OMS and the Office of Volunteer Recruitment and have been widely distributed throughout the agency. The data presented in these reports may be inaccurate due to the aforementioned Expert System and PCVDBMS data problems; however, the statistics present the best estimate of agency screening performance available at this time. This evaluation report recommends measures the agency should take to address the identified data internal control and data integrity issues in the agency databases.

4. **Interviewing.** We conducted face-to-face and telephone follow-up interviews of Peace Corps staff and applicants. We conducted interviews with the following key Peace Corps offices and planning groups: Office of Medical Services, Volunteer Recruitment and Selection, Office of Communications, Congressional Relations, General Counsel, Regional recruitment offices, Office of Planning Policy and Analysis, Office of the Chief Information Officer, and the VDS Steering Committee-50+ Initiative. We also conducted interviews with the following organizations and federal agencies: The National Peace Corps Association, AmeriCorps, the Japan International Cooperation Agency (JICA), and the U.S. State Department. However, the scope of our evaluation focuses on Peace Corps' pre-service Medical Clearance

System, and therefore, the majority of our interviews were with the Office of Medical Services.

5. **Surveying.** We surveyed three subgroups of applicants: Active Volunteers, Returned Peace Corps Volunteers, and individuals who had applied to the Peace Corps but had not served. We generated random samples for each subgroup and verified that the demographics for the subgroup sample matched the demographics for the subgroup population in terms of gender, age, ethnicity, marital status, and education. In order to approve our request to collect information from the general public on the Peace Corps Medical Clearance System, the Office of Management and Budget required our survey sample be based on an anticipated response rate of 50% or higher. OMB approved the voluntary survey (OMB Control Number: 0420-0538) on June 11, 2007 and the survey was fielded from June 12, 2007 through August 20, 2007 (10 weeks). The online Zoomerang survey was emailed to the required number of people for each sample based on a targeted response rate of 50%, anticipated confidence rate of 95% and anticipated error rate of 4% which would reasonably ensure that the survey results were representative of the population. For those who could not complete the online survey, a paper survey backup system was used. Surveys from 1,114 applicants were collected worldwide. Surveys from 11 applicants were deleted because the applicants were contacted as part of one sample and their status had changed and they responded as part of a different sample. The remaining 1,103 surveys represent an overall response rate of 33%.

Applicant Type	Active Volunteers	Returned Peace Corps Volunteers	Did not Serve
Criteria	Currently serving at the end of FY 2006	Served but COS'd or SEP'd within FY 2005 or FY 2006	Applicants who applied but did not serve in FY 2005 or FY 2006
Population Size	7,749	8,190	7,662
Sample Size (emailed survey)	1,114	1,118	1,114
Anticipated Response Rate	50%	50%	50%
Anticipated Confidence Interval	95%	95%	95%
Anticipated Error Rate	4%	4%	4%
Anticipated Number of Responses	557	559	557
Actual Response Rate	46%	29%	24%
Actual Confidence Interval	95%	95%	95%
Actual Error Rate	4.2%	5.3%	5.9%
Actual Number of Responses	513	324	266

Based on the number of responses, we can say with 95% confidence that the survey data for each subgroup is representative of the larger population, with the following error rates per subgroup presented in the table above. However, as with any survey, there is the potential for non-response or self-selection bias which could create larger confidence intervals than presented in this table. In the absence of a non-response follow-up study to determine the extent to which there may have been a non-response

bias by the potential respondents, this information represents the best information from the research to date. We are looking forward to the implementation of the new Medical Screening applicant survey that will provide additional research to further investigate and understand applicant feedback on the medical clearance system.

This report primarily presents descriptive statistics, such as frequency of responses, averages, and cross tabulations. Many of the survey questions asked respondents to select one of five possible responses. The error rates provided above pertain to analysis of those Likert scale questions. Survey data included in this report presents the number of Volunteers who responded to a particular survey question. The number of respondents varies by question. Specific percentages in the figures and tables may not add to 100 because of rounding to the nearest whole number.

For multiple-response questions (i.e., "Please check all that apply"), each reported percentage was calculated from the number of individuals who selected that particular response divided by the total number of individuals who answered the question by selecting one or more responses. Since respondents may select more than one response to answer multiple response questions, the sum of the percents for all responses to any multiple response question will usually total more than 100.

Our sample demographics mirrored the applicant population demographics for all three subgroups. However, there were differences between our sample demographics and our resulting survey response demographics. The demographic category with the biggest difference was gender. In all three subgroups, more females responded to our voluntary survey than males. This impacts the reliability that the survey data is representative with respect to male applicants. In the category of education, 9% of the respondents to the OIG survey indicated that they were in their third year of graduate school and it could be argued that they applied to the Peace Corps before finishing college so that their graduation and entry into Peace Corps coincided. If this is the case, there may be no difference in education between applicant demographics and Volunteer Demographics.

Survey Demographics	IG Survey Respondent Demographics (valid %)	Peace Corps FY2006 Applicant Demographics (valid %)	Peace Corps FY2006 Volunteer Demographics
Gender	68% Female	59% Female	59% Female
Age	78% 20-29	82% 20-29	85% 20-29
Ethnicity	88% White	81% White	83% White
Education	89% College Degree or Higher	91% College Degree or Higher	96% College Degree or Higher
Marital Status	90% Single	92% Single	92% Single

6. **Case Study** – We conducted case studies that followed three 50+ applicants through the application process from their application online, applicant interview with a recruiter, completion of the Medical Kit, to their placement in a country (particularly

placement based on medical accommodation). The case study participants submitted two journal entries each month and participated in monthly teleconferences in order to share their experiences with the Peace Corps medical clearance system. Case study participants were applicants provided to the OIG by Peace Corps Chicago regional recruitment office.

INITIAL DATA ANALYSIS FOR JUSTIFYING NEED TO CONDUCT A REVIEW OF THE MEDICAL CLEARING SYSTEM

PAGE 1

Gender ____ Male
____ Female
Age _____
How many months have you been in country? _____

Project _____
Date Mo-Date-Year
Country _____
Region _____

PAGE 2

How satisfied were you with the following aspects of your Peace Corps recruitment experience:

1. the information sessions
2. understanding the application process?
3. the whole recruitment process?
4. your interview?
   process
   Telephone ___
   Face to Face ___

5. the medical clearance process?
6. the assignment selection?
7. How long the application process took?
8. How many months did the application
   take for you? _____ months

Answer Choices: *Not Satisfied/Satisfied/Very Satisfied/NA*

How useful was the information you received from Peace Corps about...

9. your country of assignment?
   behavior?
10. your primary work assignment?
11. your housing and possible living conditions?
12. about what to bring?
    to your work?
17. Specify other sources of information:

13. the need to change your dress or
14. your health?
15. your safety?
16. the need for flexibility in adapting

A _____

B _____

C _____

PEACE CORPS MEDICAL CLEARANCE SYSTEM SURVEY- PAPER VERSION

Peace Corps Medical Clearance System

Thank you for your time and assistance! We strongly prefer that you complete the survey online; the online survey is faster, should take you approximately **20 minutes** to complete and can be accessed using the following link:
http://www.zoomerang.com/survey.zgi?p=WEB226LCHW3TQU (Peace Corps Volunteers) or
http://www.zoomerang.com/survey.zgi?p=WEB226NA6K9G6S (RPCVs and DeFactos)
If you do not have access to the online survey, we still are very interested in your feedback and would appreciate your completion of this paper version of the survey. Please email electronic versions of the paper survey to selbert@peacecorps.gov, or mail paper versions of the survey to Shelley Elbert, Senior Evaluator Office of Inspector General, Peace Corps, 1111 20th Street, NW, L560, Washington, DC 20526.

Your response to this survey is voluntary. Any personal information you provide in response to this survey will be kept confidential, consistent with the provisions of the Privacy Act, 5 USC § 552 (a). Peace Corps will create a report summarizing all information collected. However, the report will not mention the names of respondents. We are requesting names below, because a small portion of respondents to this survey will be contacted to respond to a follow-up telephone interview.

1. Name

2. Telephone

3. Applicant Type
    (Please Select only ONE option)

    ☐   Applied but did not serve

APPENDIX A

☐ Invitee

☐ Trainee

☐ Peace Corps Volunteer

☐ Returned Peace Corps Volunteer

This survey addresses the stages of the Peace Corps application process shown below.
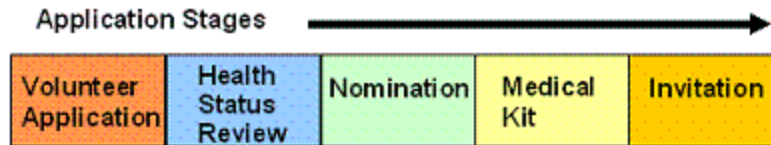
4. In the process of applying to the Peace Corps, was the application process (see diagram above) clear to you? (Please Select only ONE option)

☐ Not at all clear

☐ Minimally clear

☐ More or less clear

☐ Very clear

☐ Extremely clear

☐ No opinion

5. Would posting a diagram of the application stages, like the one above, have been helpful to your understanding of the application process?
(Please Select only ONE option)

☐ Not at all clear

☐ Minimally clear

☐ More or less clear

☐ Very clear

☐ Extremely clear

☐ No opinion

The following questions address these stages of the application process:

6. During the application process, did your Recruiting Officer discuss any of the following aspects of the Medical Clearance process with you?
   (Check all that apply)

☐ Medical exams required

☐ Dental exams required

☐ Estimated timeframe for processing a Medical Clearance

☐ Reimbursement of required exams

☐ How Peace Corps medical benefits would coordinate with your personal health insurance

☐ Office of Medical Services Nurse Line telephone number

☐ Office of Medical Services Main telephone number

☐ None of the above

7. Did you call the Nurse Line (1-800-424-8580, extension 4049)?

☐ Yes   ☐ No*

  *If No, skip to question #10.

8. How many times did you call the **Nurse Line** before you were able to speak with a nurse? (Please Select only ONE option)

☐ 1 time

☐ 2 times

☐ 3 times

☐ 4 times

☐ 5 times

☐ More than 5 times

☐ Never got through to a Nurse

9. Were you satisfied with the nurse's responses to your medical or dental related questions? (Please Select only ONE option)

☐ Not at all Satisfied

☐ Minimally Satisfied

☐ More or Less Satisfied

☐ Very Satisfied

☐ Extremely Satisfied

☐ No opinion

10. Were you satisfied with the information provided by the **recruiting officer** about the medical clearance process? (Please Select only ONE option)

☐ Not at all Satisfied

☐ Minimally Satisfied

☐ More or Less Satisfied

☐ Very Satisfied

☐ Extremely Satisfied

☐ No opinion

11. Were you made aware or provided the document, *Medical Information for Applicants*, which lists medical conditions that may delay or deter medical clearance?

☐ Yes   ☐ No*

 *If No, skip to question #15.

12. Where did you find or from whom did you receive this document?
    (Check all that apply)

☐ Recruiting Officer

☐ Online

☐ Screening Assistant

☐ Screening Nurse

☐ Other, please specify

13. Did you find this document useful? (Please Select only ONE option)

☐ Not at all useful*

☐ Minimally useful*

☐ More or less useful

☐ Very useful

☐ Extremely useful

☐ No opinion

14. *If you found this document, "Not at all useful" or "Minimally Useful" please tell us why and how it could be improved.

APPENDIX A

The following questions address these stages of the application process:
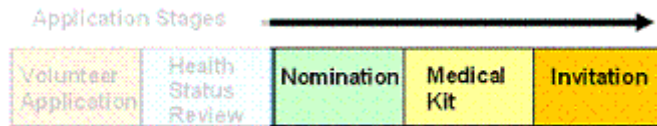
15. From the time you received your **Nomination Letter**, approximately how many business days (Mon-Fri) did it take for you to receive your **Medical Kit**? (Please Select only ONE option)

☐ 1-3 days

☐ 4-6 days

☐ 7-9 days

☐ 10-12 days

☐ 13-15 days

☐ 16-18 days

☐ More than 18 days

16. Was the **medical clearance information** provided by your Recruiting Officer and officials in the Office of Medical Services **consistent**?

☐ Yes   ☐ No*

*If no, please specify why

17. Were you made aware by your Recruiting Officer or online instructions, that if it took MORE than 14 days to receive your Medical Kit, you should call Office of Medical Services (OMS)?

☐ Yes- via recruiting officer   ☐ No

☐ Yes- via online

Medical Kit Instructions to the Applicant

18. Please rank the **clarity of instructions** provided to you on the following items:
      (Please Select only ONE option for each item)

1 Not at all clear	2 Minimally clear	3 More or less clear	4 Very clear	5 Extremely clear	6 Could not find	7 Did not read	8 No opinion

Medical Kit

☐ 1   ☐2   ☐3   ☐4   ☐5   ☐6   ☐7   ☐8

Physical exam forms

☐ 1   ☐2   ☐3   ☐4   ☐5   ☐6   ☐7   ☐8

Dental exam forms

☐ 1   ☐2   ☐3   ☐4   ☐5   ☐6   ☐7   ☐8

Eye exam forms

☐ 1   ☐2   ☐3   ☐4   ☐5   ☐6   ☐7   ☐8

Reimbursement for Medical Kit expenses

☐ 1   ☐2   ☐3   ☐4   ☐5   ☐6   ☐7   ☐8

Appeals process (if denied Medical Clearance)

☐ 1   ☐2   ☐3   ☐4   ☐5   ☐6   ☐7   ☐8

19. Did the Medical Kit instructions give **YOU** a better understanding about why Peace
      Corps required all the medical and dental examinations?
      (Please Select only ONE option)

☐ Yes

☐ No

☐ Somewhat

☐ Did not Read

20. How could Peace Corps improve the **Medical Kit guidance and instructions** in terms of tone, format, clarity, etc.?

Medical Kit Instructions to your Physician and Dentist

21. When you went to the doctor's office for your physical exam, who did you **show the "Instructions to the Examining Physician"** found in your Medical Kit?
    (Please check all that apply)

☐ Medical Clerk

☐ Attending Nurse

☐ Physician

☐ Other, please specify

22. Did your examining **physician read the instructions** provided by Peace Corps to better understand why Office of Medical Services (OMS) required all the medical tests and examinations listed in the Medical Kit? (Please Select only ONE option)

☐ Yes

☐ No

☐ Partially read

☐ Do not know

23. When you went to the dentist's office for your dental exam, who did you **show the "Instructions to the Examining Dentist"** found in your Medical Kit?
    (Please check all that apply)

☐ Dental Clerk
☐ Dental Hygienist
☐ Dentist
☐ Other, please specify

24. Did your examining **dentist read the instructions** provided by Peace Corps to better understand why OMS required all the dental examinations listed in the Medical Kit?

☐ Yes

☐ No

☐ Partially read

☐ Do not know

25. What kind of **response did you get from your physician or dentist** regarding the instructions or information required in the Medical Kit?

Medical Clearance Processing Time

26. Were you **satisfied with the length of time** of the Medical Clearance process?

☐ Yes   ☐ No*

 *If you were not satisfied, please explain why

27. In the process of completing your Medical Kit did you require **replacement or additional forms**?

☐ Yes   ☐ No

28. After you received your **Medical Kit**, how long did it take before you were able to send it back to Office of Medical Services (OMS)?
(Please Select only ONE option)

☐ 15 days or less

☐ 30 days (1 month)

☐ 45 days

☐ 60 days (2 months)

☐ more than 2 months*

☐ more than 6 months*

☐ more than 12 months*

☐ Did not submit the medical kit

29. *If it took you **more than 2 months** to submit your Medical Kit, please explain why.

30. Did Office of Medical Services (OMS) request any additional medical documentation or tests **not specified** in your original **Medical Kit**?

☐ Yes   ☐ No*

 *If No, skip to question #35.

31. Did OMS request additional information for past or present medical conditions that you **did not** disclose in the **Health Status Review (HSR)**?

☐ Yes   ☐ No*

 *If No, skip to question #33.

32. Please explain why you did not provide this information on the **Health Status Review (HSR)**?

33. How many times did Office of Medical Services (OMS) contact you to request additional medical information/tests **not specified** in your original **Medical Kit**?

☐ 1 time

☐ 2 times

☐ 3 times

☐ 4 times

☐ 5 times

☐ More than 5 times

34. What type(s) of additional **information/testing** were requested? (Please check all that apply; do not list medically confidential information)

☐ Test/Lab results

☐ Personal statements

☐ Doctor statements

☐ Specialist work

☐ Follow-up to previous medical conditions

☐ Other, please specify

35. In the process of completing your Medical Kit, was the meaning of the following terms clear to you:
    (Please Select only ONE option for each item)

1	2	3	4	5	6	7	8
Not at all clear	Minimally clear	More or less clear	Very clear	Extremely clear	Could not find	Did not read	No opinion

Medically qualified

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8

Deferred

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8

Medical accommodation/restrict

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8

Medically not qualified

☐ 1   ☐ 2   ☐ 3   ☐ 4   ☐ 5   ☐ 6   ☐ 7   ☐ 8

36. How many **additional months** did it take you to send in additional medical documentation to complete your Medical Kit? (Please Select only ONE option)

☐ Less than 1 month

☐ 1-3 months

☐ 4-6 months

☐ 7-9 months

☐ 10-12 months

☐ More than 1 year

☐ More than 2 years

☐ Did not submit medical kit to OMS

37. From the time you sent in your **Complete Medical Kit**, how long did it take to **hear back from OMS** whether you were qualified, deferred, medically accommodated, or not qualified? (Please Select only ONE option)

☐ Less than 1 month

☐ 1-3 months

☐ 4-6 months

☐ 7-9 months

☐ 10-12 months

☐ More than 1 year

☐ More than 2 years

☐ Did not submit medical kit to OMS

APPENDIX A

38. If you answered that you **did not submit your Medical Kit**, please check all reasons that accurately explain **why**:

☐ Medical costs

☐ Dental costs

☐ Medical Screening process took too much time

☐ Frustrated by lack of clarity in Medical Screening process

☐ Had condition listed on the *Medical Information for Applicants* document and I did not think Peace Corps would accept me

☐ Lack of Recruiting Officer Customer Service

☐ Lack of OMS Customer Service

☐ Returned to school

☐ Accepted a job offer

☐ Withdrew from entire application process

☐ Other, please specify

39. In total, how long did it take you to receive a **final medical decision from OMS**? This refers to the period of time from receiving your Medical Kit to receiving your final letter from OMS. (This includes any appeals, medical accommodations, deferment, etc.) (Please Select only ONE option)

☐ Less than 1 month

☐ 1-3 months

☐ 4-6 months

☐ 7-9 months

☐ 10-12 months

☐ More than 1 year

☐ More than 2 years

APPENDIX A

☐ Did not receive medical qualification

40. Did you **appeal** the Office of Medical Services' (OMS) decision regarding your medical suitability to serve as a Volunteer?

☐ Yes   ☐ No*

  *If No, skip to question #44.

41. How were you made aware of the **appeals process**?
   (Check all that apply)

☐ Screening Nurse

☐ Letter sent from OMS

☐ Was not made aware of appeals process

  Other, please specify

42. How were you made aware of **all possible outcomes** that could result from your appeal? (Check all that apply)

☐ Screening Nurse

☐ Letter sent from OMS

☐ Was not made aware of all possible outcomes

☐ Other, please specify

43. After submitting additional documentation, how long did it take for you to **hear back from OMS regarding the outcome of your appeal**?
   (Please Select only ONE option)

☐ 1 month or less

☐ 1-3 months

☐ 4-6 months

☐ 7-9 months

☐ 10-12 months

☐ More than 1 year

☐ Did not hear back from OMS

Correspondence with the Office of Medical Services (OMS) and the Placement Office

44. Throughout the medical screening process, did **OMS lose or misplace** any portion of your **Medical Kit** at any time? This includes lab results, personal statements, doctors' statements, medical forms, etc. (Please Select only ONE option)

☐ Yes

☐ No

☐ Do not know

45. How many times did you call the **Office of Medical Services Main telephone number** listed in the Medical Kit (1-800-424-8580, ext. 1500) before you were able to speak with a representative? (Please Select only ONE option)

☐ Did not call

☐ 1 time

☐ 2 times

☐ 3 times

☐ 4 times

☐ 5 times

☐ More than 5 times

☐ Never got through to a live person

APPENDIX A

46. Was the name of your **Screening Nurse left blank** in the letter addressed to you in your Medical Kit?

EXAMPLE: *Welcome to the medical screening process! My name is _____ R.N., and I am the Nurse Team Leader for the region to which you have been nominated...."*

☐ Yes   ☐ No

47. During the entire medical screening process, how many times did you contact your assigned **Medical Screening Assistant** to clarify instructions and requirements listed in the medical kit? (Please Select only ONE option)

☐ Did not contact the Medical Screening Assistant*

☐ 1 time

☐ 2 times

☐ 3 times

☐ 4 times

☐ 5 times

☐ More than 5 times

   *If did not contact, skip to question # 49.

48. How would you describe the customer service provided by your Medical Screening Assistant? (Please Select only ONE option for each item)

☐	☐	☐	☐	☐	☐
Not at all satisfactory	Minimally satisfactory	More or less satisfactory	Very satisfactory	Extremely satisfactory	No opinion

49. During the entire medical screening process, how many times did you contact the **Dental Screening Assistant** to clarify instructions and requirements listed in the medical kit? (Please Select only ONE option)

☐ Did not contact the Dental Screening Assistant *

☐ 1 time

☐ 2 times

☐ 3 times

☐ 4 times

☐ 5 times

☐ More than 5 times

 * If did not contact, skip to question # 51.

50. How would you describe the customer service provided by your **Dental Screening Assistant**? (Please Select only ONE option)

☐	☐	☐	☐	☐	☐
Not at all satisfactory	Minimally satisfactory	More or less satisfactory	Very satisfactory	Extremely satisfactory	No opinion

51. During the entire medical screening process, how many times did you contact a **Screening Nurse** to clarify instructions, requirements, or questions of a clinical nature? (Please Select only ONE option)

☐ Did not contact the Screening Nurse*

☐ 1 time

☐ 2 times

☐ 3 times

☐ 4 times

☐ 5 times

☐ More than 5 times

 * If did not contact, skip to question # 53.

52. How would you describe the customer service provided by your **Screening Nurse**? (Please Select only ONE option)

☐	☐	☐	☐	☐	☐
Not at all satisfactory	Minimally satisfactory	More or less satisfactory	Very satisfactory	Extremely satisfactory	No opinion

53. During the entire medical screening process, how many times did you contact your assigned **Placement Officer** to discuss a medical related issue?

☐ Did not contact a Placement Officer*

☐ 1 time

☐ 2 times

☐ 3 times

☐ 4 times

☐ 5 times

☐ More than 5 times

* If did not contact, skip to question # 57.

54. Did your Placement Officer inform you of the countries where you could serve in a timely manner?

☐ Yes   ☐ No

If you answered no, please explain

55. How would you describe the customer service provided by your **Placement Officer**? (Please Select only ONE option)

☐	☐	☐	☐	☐	☐
Not at all satisfactory	Minimally satisfactory	More or less satisfactory	Very satisfactory	Extremely satisfactory	No opinion

56. If you had a **"Not at all satisfactory" or "Minimally satisfactory"** customer service experience, please let us know. Please note the person you spoke with, whether the communication was by phone, email, fax or letter and details of the conversation so we can identify the problem areas and make improvements.

APPENDIX A

Medical and Dental Expenses

57. When you applied to the Peace Corps, did you have **health insurance**?

☐ Yes   ☐ No

58. What was the total cost for **medical exams and lab work** that you paid out-of-pocket, not including anything paid by your insurance?
(Please Select only ONE option)

☐ $0-$100

☐ $101-$500

☐ $501-$1,000

☐ $1,001-$2,000

☐ $2,001-$5,000

☐ $5,001-$8,000

☐ Do not recall cost

☐ Please specify if exceeded $8,000:

59. What was the total cost for **dental exams and treatment** that you paid out-of-pocket, not including anything paid by your insurance? (Please Select only ONE option)

☐ $0-$100

☐ $101-$500

☐ $501-$1,000

☐ $1,001-$2,000

☐ $2,001-$5,000

☐ $5,001-$8,000

☐ Do not recall cost

☐ Please specify if exceeded $8,000:

60. Did **you receive outside support** (i.e. family members, church, etc.) with any of the Medical Kit costs?

☐ Yes   ☐ No

61. Below is the **Peace Corps Reimbursement Schedule**. Please select the **amounts you were reimbursed**. (Check all that apply)

☐ $0 - **Did not submit a reimbursement claim**

☐ $165 - Medical exam & lab work for **females under 50**

☐ $290 - Medical exam & lab work for **females over 50**

☐ $125 - Medical exam & lab work for **males under 50**

☐ $175 - Medical exam & lab work for **males over 50**

☐ $60 - **Dental exam** and x-rays for **all applicants**

☐ $12 - Prescription for **Eyeglasses** for **all applicants**

☐ $0 - **Claim was denied**

62. Did you call the **Office of Medical Services (OMS) Main telephone number (1-800-424-8580 ext 1500)** for reimbursement information or assistance in submitting claims?

☐ Yes   ☐ No

63. How would you describe the customer service provided by the OMS representative on reimbursement information? (Please Select only ONE option)

☐	☐	☐	☐	☐	☐
Not at all satisfactory	Minimally satisfactory	More or less satisfactory	Very satisfactory	Extremely satisfactory	No opinion

64. Did you call Seven Corners (the Peace Corps contractor listed in the Medical Kit) for reimbursement information or assistance in submitting claims?

☐ Yes   ☐ No

65. How would you describe the customer service provided by Seven Corners? (Please Select only ONE option)

☐	☐	☐	☐	☐	☐
Not at all satisfactory	Minimally satisfactory	More or less satisfactory	Very satisfactory	Extremely satisfactory	No opinion

66. Was the reimbursement process clear to you?

☐ Yes   ☐ No*

*If you answered No, please explain what was unclear.

67. Did you complete the application process?

☐ Yes*   ☐ No

  *If yes, skip to question #71

68. At what stage did you withdraw? (Please Select only ONE option)

☐ Volunteer Application

☐ Health Status Review (HSR)

☐ Nomination

☐ Medical Kit (Before completion)

☐ Medical Kit (After completion)

☐ Invitation to serve as Volunteer

69. Why did you drop out at that stage?

APPENDIX A

70. Take a look at the list of categories below. Please check all categories that accurately explain why you withdrew from the application process:

☐ Returning to school

☐ Extended travel plans

☐ Personal/familial reasons

☐ Romantic involvement

☐ Work-related

☐ Military Issues

☐ Intelligence Activities

☐ Different Volunteer program found

☐ No longer interested in Peace Corps

☐ PC Program Cancelled

☐ Could not be assigned to desired country

☐ Medical Screening took too much time

☐ Medical condition would not permit service

☐ Burdensome medical costs

☐ Burdensome dental costs

☐ Other financial responsibilities

☐ Poor communication with Recruiting Officer

☐ Poor communication with Medical Screening

☐ Poor communication with Placement

Other, please specify

71. Were you satisfied with the Peace Corps Medical Clearance process?

☐	☐	☐	☐	☐	☐
Not at all satisfied	Minimally satisfied	More or less satisfied	Very satisfied	Extremely satisfied	No opinion

72. What one thing would you do to make the Medical Clearance process better?

73. Are there any other comments you would like to make regarding the Medical Clearance process?

Demographics

(Please answer these 6 demographic questions so we may determine whether the medical screening process is more burdensome to a particular type of applicant.)
** If you applied to the Peace Corps more than once, please provide information based on your first application.

74. Gender

☐ Male

☐ Female

75. Age (at the time you applied to the Peace Corps)

☐ 20-29

☐ 30-39

☐ 40-49

☐ 50-59

☐ 60-69

☐ 70-79

☐ 80 and over

APPENDIX A

76. Are you Hispanic or Latino?

☐ Yes   ☐ No

77. Racial Category (select one or more)

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Native Hawaiian or other Pacific Islander

☐ White

78. Highest Level of Education (at the time you applied to the Peace Corps)

☐ Did not complete High School

☐ High School Graduate/GED

☐ Technical School Graduate

☐ One or two years of College Completed

☐ A.A. Degree or Equivalent

☐ 3rd year of College Completed

☐ College Graduate

☐ Graduate Study

☐ Graduate Degree

☐ Doctorate Degree

☐ Other

APPENDIX A

79. Marital Status (at the time you applied to the Peace Corps)
    (Please Select only ONE option)

☐ Single (never married)

☐ Planning to Marry within One Year

☐ Married - Serving with Spouse

☐ Married - Serving without Spouse

☐ Widowed

☐ Divorced or Legally Separated

TESTING THE TRANSPARENCY AND TIMEFRAME OF THE MEDICAL CLEARANCE PROCESS: MEDICAL CLEARANCE SYSTEM PARTICIPANT CASE STUDY

Purpose:
The purpose of this initiative is to monitor three applicants as they progress through the Peace Corps application process and specifically the medical clearance portion of the system. Completion of the online application, including the Health Status Review (HSR) and medical kit will lend insight into the transparency, customer service and timeframe of the medical clearance system. Monitoring of the participants' experiences will provide our study with first hand information on the efficiency and the effectiveness of the Medical Clearance System (MCS), help the study identify areas in need of improvement and allow the study to issue informed programmatic recommendations.

Participants:
1) Male, Age 65, Serving Single
2) Female, Age 55, Serving Single
3) Couple, Age 65 and Age 67, Serving with Spouse (wife was point of contact and representative for the couple)

Methodology:
The MCS team leader will contact the Regional Manager in the Chicago Recruitment Office and the Acting Clinical Manager in the Office of Medical Services to inform them that the MCS study would like to involve a case study component and instruct them to not disclose the case study component to their staffs; the selection/identity of the case study subjects also will not be revealed. The MCS team leader will ask the Chicago Recruitment Office to provide a list of ten 50+ Volunteers who are currently in the pre-nomination stage of the application process. In order to better understand the application process and be able to ask participants informed questions, the MCS evaluation team will apprise the Regional Manager in the Rosslyn Office that the MCS team would like to complete an online application and Health Status Review. The MCS team will discuss with the Regional Manager in the Rosslyn Office the best process for completing a test application online that will not burden staff with a phony application and will not invalidate statistical reports on applications received.

PRIOR REPORTS

There have been multiple studies conducted by the General Accountability Office, Peace Corps Office of Inspector General, and various Peace Corps groups to evaluate the Volunteer Delivery System and components of the Volunteer Delivery System, such as the Medical Clearance System.

- ❖ **General Accountability Office (GAO), "Peace Corps: Long-Needed Improvements to Volunteers' Health Care System," issued July, 1991.**

This report found that most Volunteers and RPCVs contacted were satisfied with the health care that they received from Peace Corps. However, the GAO found that the quality of health care provided was not comparable to the level of care that they would receive in the United States. Medical officer capabilities and competencies were not evaluated, and training received by medical staff was insufficient. Furthermore, the GAO recommended that the Peace Corps healthcare system undergo an independent review by an accrediting organization that would assess the healthcare system against U.S. standards of healthcare. Other problems that they found included the Federal Employees' Compensation Act (FECA) system and post-service care. Upon receiving this report, the Peace Corps improved the FECA system and provided greater funding for medical officer orientation/training.

- ❖ **McManis Associates, "Quality Assurance Evaluation of the Peace Corps Medical Support Services, Report on the Screening and Medical Clearance Process," issued May 1, 1992.**

Information presented in this report derives from the work of the Screening and Medical Clearance Process Review Team, a cross-functional, permanent team established in 1992 by the OMS Quality Council. From their documentation and analysis, improvements and recommendations were made. The major issues that the Process Review Team monitored were: 1) Placement restrictions/medical accommodations, and 2) Screening Guidelines. The report stated that a process needs to be established to institutionalize and standardize the procedures for updating and revising medical screening guidelines and medical screening policy.

The report cited changes made to the medical screening process: defacto letter was changed to include more information, make it more user friendly, and sent to non-responsive applicants after 8 weeks instead of the previous 6. Applicant phone calls due to these letters were reduced; the number of phone calls reduced from 55% to 18%

APPENDIX B

Department of Volunteer Support & Office of Medical Services, "Report on Medical Screening Process Redesign," issued December 1, 1994.

This report was a result of the Department of Volunteer Support Associate Director and the OMS Director convening the Medical Screening Process Redesign Team. In order to be deemed efficient, the medical screening process had to be timely, conserve human and financial resources, not be unduly cumbersome to applicants, be automated to an optimal degree, improve communication and collaboration among OMS and VRS, use existing resources to maximum efficiency, reconfigure staff to perform screening functions efficiently, designate a manager to improve and troubleshoot the medical screening process, and enable collection of data to make more informed decisions on process improvements.

The report made the following findings:
- The time frame allotted for applicant medical screening was too short.
- There were serious communications and information gaps between OMS and other VDS offices that produced inefficiency [these involve human and technology fixes].
- More immediate and more accurate health information was needed from the applicant.
- The health status report did not encourage detailed, accurate responses regarding the applicant's medical history.
- Most administrative complaints were that requests for additional medical evaluations were made in a series of letters, and applicant phone calls were not returned.

The report found that approximately 50% of Peace Corps health care services expenditures are reimbursements to FECA claimants. The report recommended that a screening manager be hired, customer service be improved, more linkages be made between OMS and the VDS, new performance measures be practiced, structured process be written for the appeals process, the health status report (HSR) be improved, streamline existing screening process, automate screening processes, automate medical records, index standard reimbursement rate to 100% of a national UCR fee schedule, and implement a scannable medical history.

❖ **Joint Commission on Accreditation of Healthcare Organizations (JCAHO), "Peace Corps Volunteer Health System Evaluation Report," issued December 28, 1994.**

This report was requested by the Department of Volunteer Support as the second of three external assessments of the Peace Corps Volunteer Health System. The report cites that the MCS has improved with respect to the following: medical records management and contracting with registered records administrator, new initiatives to improve the PCMO recruitment and contracting process, better assignment of OMS staff dedicated to quality improvement activities, redesign of the medical screening process regarding psychosocial issues and mental health. However, the report also identified areas for improvement with

respect to high-management level issues and guidance from staff on which areas of improvement to prioritize. According to the report, the following improvements need to be addressed by the agency: recruitment and hiring of PCMOs needs review due to lack of direct interviewing before hire, and lack of input by the country director and regional PCMOs, continued improvement of quality improvement activities, currently there is no single individual responsible for developing or improving the information system, and more development of management information systems technology to monitor, track and trend.

❖ **Joint Commission on Accreditation of Healthcare Organizations, "Peace Corps Volunteer Health System Evaluation Report," issued February 28, 1997.**

The report was very commendable of efforts, initiatives, and improvements implemented by OMS and VS to the VHS. The report found the progress of Health Information Systems, Quality Improvement and re-engineering of the medical clearance process to be the major improvements since the 1994 Evaluation.

While, the report stated that the medical clearance guidelines were in the process of revision, almost all the medical screening guidelines that are being revised in 2007 have not been revised since 1993, which questions the validity of this finding. A recommendation was made in the report to consolidate medical confidentiality procedure for electronic and paper medical records. This recommendation is still pertinent in 2007 and according to the findings of this report, has not been established.

❖ **Peace Corps groups, "Review of the Peace Corps Volunteer Delivery System," issued 1999.**

In 1999, a committee led by Senior Staff and organized by Peace Corps offices and consultants released a *Review of the Peace Corps Volunteer Delivery System*. This report evaluated the strength, quality, and efficiency of the VDS, established before the spread of telecommunications and information technology. The recommendations from this report that focused on the medical clearance system were themed around centralizing information, increasing staff, and incorporating technology. More specifically, the recommendations called for an increase in Office of Medical Services (OMS) staff, a decrease in the response time of OMS to Volunteers, and the establishment of customer service standards to provide greater transparency and Volunteer satisfaction. However, the agency did not endorse these recommendations and no action was taken.

❖ **Volunteer, Recruitment and Selection Committee, "Recommendations from the Review of the Volunteer Delivery System," issued 2000.**

In 2000, VRS organized a committee to refine the recommendations of the 1999 Report, which culminated into the 2000 *Recommendations from the Review of the Volunteer Delivery System*. Recommendations were action-oriented and emphasized the need to incorporate technology and the Internet in the VDS as a whole. Regarding the medical

clearance system, the report's recommendations urged utilizing the Health Status Review earlier in the application process, providing applicants tools to conduct automated status checks, developing a customer service point of contact, instituting customer service standards, and ensuring better integration of medical assessment and the matching process. However, the agency did not endorse these refined recommendations and no action was taken.

❖ **Office of Medical Services, "Screening Redesign," issued February, 2002**

This document was a re-design of the work unit within the Screening Unit with the goal of improving the process, customer service of medical screening of Peace Corps applicants, screening nurse work load, and to maximize placement options.

- Reorganizing the screening staff to work according to the three regions aligned the unit with VRS, OMS Field Support, and the country desk regions**.** A fourth team was created to address other screening tasks and was called the Support Team, which comprised of an OMS/Placement Coordinator (currently MAC Coordinator) and additional staff if available.
- Screening Team responsibilities were designated to review medical files on a FIFO basis with COI dates, review and send all kits for applicants recruited in a region, review and prepare all files for stagings to their region, respond to VRS medical requests on a daily basis for the applicants in their region, provide a cross-trained team member to conduct medical reviews for UNVs, CCVs, and OMS/Placement Coordination, and to manage telephone calls and communication with applicants.
- Other self directed work groups were created to improve the applicant screening process, improve customer service, and to simplify the knowledge that external customers require on who to contact in OMS.

❖ **Pugh Ettinger McCarthy Associates, "OMS External Evaluation of the Volunteer Health System," issued August 8, 2002.**

The report's recommendations focus on Peace Corps Volunteer Health System's (PCVHS) compliance with standards developed by JCAHO, which OMS was found to be in compliance with, and also to identify improvements and recommendations that will improve the system of care supporting Volunteers. The report found that: there were no processes for monitoring quality control, a two-tiered quality improvement model needs to be implemented focusing on process and strategy, the 5-year rule negatively affects the culture of Peace Corps by distracting employees and limiting the agency's institutional memory, OMS and related units need to communicate and document processes better, OMS is too conservative in observing medical confidentiality, data and statistical analysis is underutilized, feedback from Volunteers and returned Volunteers was not collected and used systematically to improve the PCVHS.

The report made the following recommendations: customer service feedback should be systematically collected using a feedback survey that measures overall satisfaction, clear

aims and performance measures of the medical screening process should be established, OMS leadership should prioritize quality improvement initiatives, and leadership of OMS should define performance measures and track performance standards.

❖ **Office of the Inspector General, Final Report on Evaluation of the Volunteer Delivery System, issued April 18, 2003.**

In 2003, the Office of the Inspector General conducted an evaluation of the whole VDS and made 24 recommendations for all offices (VRS, OCIO, OMS, Office of Communications, regional recruitment offices, overseas posts, PPA, and the Center) and stages involved in the VDS. Recommendations mirrored several made in 1999 and 2000 but also called for the renovation and improvement of leadership, organizational operations, information flow and sharing, information technology, medical screening, and customer service.

1. Regarding the medical clearance system, recommendations called for an increase in OMS screening nurses, an update of the Technical Guidelines and the expert system, reduction of screening time, the establishment of customer service standards to improve communication and relations, better efficiency in OMS, reevaluation of the reimbursement schedule and policies, and agency review of the system's coverage under the American Rehabilitation Act. The agency concurred with all 24 recommendations and issued plans to implement these recommendations.

MANAGEMENT'S RESPONSE TO THE PRELIMINARY REPORT

THE PEACE CORPS
OFFICE OF MEDICAL SERVICES RESPONSE
TO

THE PEACE CORPS
OFFICE OF THE INSPECTOR GENERAL
PRELIMINARY PROGRAM EVALUATION REPORT
ON

THE PEACE CORPS' MEDICAL CLEARANCE SYSTEM

In its preliminary audit report, the Peace Corps Office of the Inspector General (PC IG) identifies a number of audit conditions concerning the Peace Corps' Medical Evaluation System. The Office of Medical Services (OMS) appreciates the thoroughness with which the PC IG performed this evaluation. As discussed in this response, OMS has already taken decisive action to address many of the issues reflected in the draft report. OMS appreciates the PC IG commendation that the OMS Screening unit achieved recent improvements to the Medical Evaluation System, continually meets the annual request for Trainees, and fulfills their core functions.

As well noted in this report, the OMS Pre-Service Unit is responsible for operating the Medical Evaluation System which ensures that the medical eligibility standard for Peace Corps applicants is consistently met, and that an adequate medical history is compiled so that the Peace Corps Medical Officers can provide high-quality care to the Volunteer. The medical eligibility standard for Peace Corps service, as set out in the Peace Corps regulations at 22 C.F.R. 305.2(c), is that the applicant must, with reasonable accommodation, have the physical and mental capacity required of a Volunteer to perform the essential functions of the Peace Corps assignment for which he or she is otherwise eligible, and be able to complete a 27-month tour without unreasonable disruption due to health problems. The Medical Evaluation System is one component of the Volunteer Delivery System (VDS), a continuous cycle of Volunteer recruitment, medical evaluation, and placement that allows the Peace Corps to fulfill its mission of providing Volunteers to serve in developing countries.

OMS responses to the specific OIG recommendations are as follows:

OIG Recommendation 1:   That the Pre-Service Unit develop Standard Operating Procedures for all aspects of the Pre-Service process.

OMS Response: OMS Concurs with OIG Recommendation 1

Prior to issuance of this report, the Pre-Service Unit began developing Standard Operating Procedures (SOPs) for the crucial aspects of the screening process. Currently there are 16 that have been completed.

OIG Recommendation 2:   That OMS enforce SOP 3.1 and 3.2 pertaining to confidential applicant medical records.

OMS Response: OMS Concurs with OIG Recommendation 2

OMS SOP 3.1 and SOP 3.2 were reviewed and revised October 2007.

Enforcement of current SOPs and assessment of the medical records process has been and is continued priority for all of OMS. Maintaining medical confidentiality, compliance, and screening efficiency as referenced in policies:
>   3.1:   Health Records Protection
>   3.2:   Health Records Location

"Health records are confidential and therefore are housed in physically secured areas under immediate control and limited to access to authorized personnel."

The office of OMS is locked during non-work hours and requires authorization for entry onto the unit. All medical records are housed in the Medical Records Office. This office is also locked after work hours from 5PM to 7 AM. When a medical record is requested by authorized personnel, the medical records staff assistant assigned to retrieving the record manually enters the "location" of the record in the OMS database.

Managers of each Unit in OMS, who have staff that require use of the medical record, are responsible for enforcement of SOP 3.1 and 3.2.

Further efficiency in maintaining health records could be achieved by eliminating the need for manual entry of the location of the medical record. One such system is the Bar Code Recognition application which is capable of recognizing bar code labels or codes on pre-printed forms to identify document type and/or patient identification to allow automatic electronic indexing. In essence, each folder would be given a strip, placed in an electronic location and updated weekly by inventorying each office. This modification would require additional funding from the agency.

OIG Recommendation 3:   That the Pre-Service Unit with the assistance of the QI Unit and the Office of Strategic Information, Research, and Planning (OSIRP) determine whether the performance measures recommended in the Pugh Ettinger McCarthy Associates report would accurately capture Pre-Service performance. These performance indicators include but are not limited to the following:

OMS Response: OMS Concurs with OIG recommendation 3

OMS and OSIRP have met and reviewed the performance measures. The following performance measures were determined to capture pertinent information. These indicators will be tracked and reported in the OMS quality council report:

1.   Percentage of Volunteers with accommodations that complete 27 months of service.

2.   Percentage of Pre-Service employees that rate their job satisfaction as excellent.

3.   Cost per Federal Employees' Compensation Act claim.

4.   Percentage of screenings with decisions made within 90 days of receipt of completed medical application.

OIG Recommendation 4:   That OMS provide Quality Improvement training to their staff to enable the staff to develop meaningful performance indicators to measure the Pre-Service Unit's productivity and other related matters.

OMS Response: OMS Concurs with OIG Recommendation 4

Initiatives have been implemented for capturing the actual work done in the Pre-Service Unit; and then responding to trends noted to improve the screening process. In September of 2007 all Pre-Service nurses began reporting on their work loads. This includes charts distributed as well as those in the review process. These figures are posted and are transparent to the team which has increased motivation in the pre-screen nurses and between regions. If one nurse, or region has an influx in applications while another has a lighter load, human resources are redistributed as necessary. There are measurable improvements in qualifications in relation to the close of invitation (COI) as well as time from physical examination received to disposition.

OIG Recommendation 5:   That OMS create policies and procedures to require PCMOs to complete the Country Health Resources Survey as information in their country changes in order to ensure that the headquarters data on the types of medical conditions the post can accommodate is accurate.

OMS Response: OMS Concurs with OIG Recommendation 5

The policy and procedure for annual certification of the Country Health Resource survey have been provided to the PCMOs. There will be a quarterly review of the certifications and feedback provided to PCMOs at their designated annual medical conference (CME Conferences).

OIG Recommendation 6:   That OMS merge the two duplicative databases, the Country Health Resources database and the Medical Accommodations database, used by screening nurses to place applicants requiring a medical accommodation for efficiency and consistency in the medical accommodations process**.**

OMS Response: OMS Concurs in Part with OIG Recommendation 6

OMS does not consider the databases to be duplicative as they contain different information related to the medical accommodations process and use different platforms. It is not clear at this time that the databases could be merged because they use different software platforms, however there may be efficiencies in either expanding one of the databases to include all of the information or reconstructing the medical accommodations information on a new platform. OMS will examine the following possibilities (listed in order of complexity), although implementation would require assistance and resources from the agency.

- **Approach 1**: Incorporate textual information from the Country Health Resource Survey (CHRS) into the Microsoft Access Accommodation (MS Accomm) database.

  Tasks: Gather and analyze the business and technical requirements, modify the MS Accomm database and program, create the task to automatically update the MS Accomm database with data from the CHRS.

  Estimated staffing requirements: If this method is viable, then the OMS staff can perform the majority of work required to complete this task.

  Estimated schedule and cost requirements: 1-2 months for the analysis, development, testing, training and implementation. No budget costs are expected.

- **Approach 2:** Modify the existing CHRS to allow the PCMOs the ability to identify those conditions that can be accommodated.

  Tasks: Gather and analyze the business and technical requirements, modify the CHRS database and program, develop standards and SOPs for the PCMOs to follow, develop and implement oversight procedures.

Estimated staffing requirements: If this method is viable, then the OMS staff will have to relay on the office of the CIO to provide the technical expertise needed to modify the existing CHRS database and application.

Estimated schedule and cost requirements: 3-4 months for the analysis, development, testing, training and implementation. Budget costs may include CIO technical assistance

- **Approach 3:** Redesign the CHRS to act as an "Expert" system and have it available on the .net platform.

  Tasks: Gather and analyze the business and technical requirements, design and develop the new the CHRS database and program, develop standards and SOPs for the PCMOs to follow, develop and implement oversight procedures. Testing, training, and implementation steps

  Estimated staffing requirements: If this method is viable, then the OMS staff will have to relay on the office of the CIO to provide the technical expertise needed to design, develop, and implement the new CHRS database and application.

  Estimated schedule and cost requirements: 8-10 months for the analysis, development, testing, training and implementation. Budget costs may include: CIO technical assistance, technical training for development staff, staff training.

OIG Recommendation 7:   That OMS create policies and procedures to ensure that the Medical Screening guidelines are updated at a minimum annually and as screening changes occur.

OMS Response: OMS Concurs with OIG Recommendation 7

A complete review and update of the medical screening guidelines was completed in November 2007. Policies are in place to insure that the screening guidelines are reviewed at least annually, and modified as new medical information becomes available.

OIG Recommendation 8:   That OMS establish a required number of days that a post has to respond to a request from the Medical Accommodations Coordinator to minimize delays in the MCS process**.**

OMS Response: OMS Concurs with OIG Recommendation 8

OMS has established that a Post must respond to a request from the Medical Accommodations Coordinator within 7 business days.

OIG Recommendation 9: That OMS work with the Office of Strategic Information, Research and Planning (OSIRP) to accurately calculate the average time for a medical qualification for performance measurement and inclusion in the Performance Accountability Report.

OMS Response: OMS Concurs with OIG Recommendation 9

A systems application has been designed to capture the timing of the medical qualification process from the moment a physical exam is received from an Applicant to the final outcome. This new tracking system has been operative since October 1, 2007 and will measure or track the length of time for several major steps in the process, including average time for medical qualifications.

OIG Recommendation 10: That OMS work with OSIRP to identify the additional data fields that the Pre-Service Unit should collect to accurately measure the time it takes a screening nurse to review a Medical Kit, including stopping the clock for missing information.

OMS Response: OMS Concurs with OIG Recommendation 10

As described in recommendation nine, with the creation of a new application that will track steps and timing in the medical qualification process, it is now possible to measure the time it takes to review medical kits. The measurement will also capture timing for complete and incomplete forms and records.

OIG Recommendation 11: That the Pre-Service Unit work with OSIRP to determine the data elements and data analysis required to implement performance indicators recommended in the 2002 PughEttinger McCarthy Associates (PEM) report for inclusion in the 2008 PAR.

OMS Response: OMS Concurs in Part with OIG Recommendation 11

OSIRP has advised that it is too late for inclusion of new performance indicators in the 2008 PAR. As outlined in the response in recommendation number three, OMS will capture the specific performance measures identified in the PEM report which would accurately capture Pre-Service performance and include them in the Office of Medical Service performance indicators report.

OIG Recommendation 13: That OMS convert defactos to one of five medical dispositions by September 30th of a given year or performance tracking and measurement purposes.

OMS Response: **OMS Does Not Concur with OIG Recommendation 13**

A defacto is driven by the length of time of inactivity of an application. The status of defacto cannot be resolved by an arbitrary date. OMS will develop an SOP that will standardize this length of time.

OIG Recommendation 15: That OMS work with OSIRP to determine how to accurately calculate the time and cost of a screening appeal and how to factor that time and cost into an average time and cost to screen an applicant.

OMS Response: OMS Concurs in Part with OIG Recommendation 15

OMS will measure and report as a performance indicator the average time for screening appeals, starting from the time that the appeal letter is received and ending at the formal decision by the Pre-Service Review Board. This report will break out the period of time that it takes applicants to submit their appeal and the time interval from submission of this information to the Pre-Service Review Board's review and decision.

OMS does not collect data regarding the cost of a screening appeal, as cost is extraordinarily variable and dependent on an applicant's overall health status, health insurance coverage, medical tests or reports needed and geographic location. In addition, the cost of medical tests, procedures or care does not necessarily correlate with the actual charges for these services. The difference between the two will depend upon the type and amount of available insurance coverage. Because each applicant's situation is unique, this information would not be useful for a specific applicant to apply to their own circumstance and would be confusing and misleading.

OIG Recommendation 18: That OMS designate responsibility and provide data collection and analysis training to a staff member to maintain and perform the data methodology, collection and analysis of Pre-Service data.

OMS Response: OMS Concurs with OIG Recommendation 18

OMS has designated responsibility to provide data collection and analysis training to a staff member of the Pre-Service Unit to maintain and perform the data methodology, collection and analysis of Pre-Service data as defined by OSIRP.

OIG Recommendation 19: That OMS establish a Cross-Unit Board consisting of managers from each of the VS/MS Units: Medical Screening, Medical Field Support, Health Information Services, Programming and Training, Post-Service, Quality Improvement, Medical Records and Epidemiology.

OMS Response: OMS Concurs with OIG Recommendation 19

This constitutes the Senior Staff of the Office of Medical Services. This group currently meets bimonthly.

OIG Recommendation 20: That the Cross Unit Board meet on a quarterly basis with VRS to discuss how screening requirements impact applicants, Volunteers, post management of Volunteers health conditions, medical evaluations and FECA claims.

OMS Response: OMS Concurs with OIG Recommendation 20

Currently the OMS Pre-Service staff meets with the staff of VRS on a weekly basis to discuss issues related to screening and placement. The Senior Staff of the Office of Medical Services will meet on a quarterly basis with the designated Senior Staff in VRS.

OIG Recommendation 21:   That OMS designate a staff member or hire an outside consultant to review the screening criteria and assess whether it is useful in the field. Possible questions to ask include:

- Are posts receiving Volunteers with medical conditions that cannot be supported?
- Do posts think Peace Corps should not accept applicants with these conditions?
- Are there medical conditions that are screened for that are never a problem in the field and therefore should not be a screening requirement?

OMS Response: OMS Concurs with OIG Recommendation 21

OMS has designated the Health Systems Specialist to review the screening criteria and assess whether it is useful in the field.   .

OIG Recommendation 22:   That the OMS Cross-Unit Board systematically collect feedback from posts via WebEx or a form of survey to measure the impact of screening requirements.

OMS Response: OMS Concurs with OIG recommendation 22

OMS utilizes an annual PCMO evaluation tool to assess key areas of services provided by Volunteer Support. OMS has completed a review of the past two years of PCMOs evaluation of Volunteer Support services and a recent survey assessing the screening process by the Pre-Service manager.   Key focus areas included:

- Number and type of accommodations sent to posts
- Medical records completion prior to forwarding to post

OMS plans to expand the current PCMO evaluation of Volunteer Support services tool to incorporate the question: Are posts receiving Volunteers with medical conditions that cannot be supported?

OMS will continue to measure the impact of screening requirements through the PCMO evaluation of Volunteer Support services tool and implement necessary improvements as they are identified.

OIG Recommendation 23: That OMS improve the Medical Clearance System customer service line so that the line always rolls to another phone until a live person is reached. This may be accomplished by instituting the following changes:

> • Coordinating screening nurse schedules to ensure full office coverage and that at least one screening nurse from each regional team is in the office every work day and available to accept applicant phone calls until 5:00pm EST.
> • Including the direct telephone extension of the screening assistant assigned to the applicant in the Medical Kit.
> • Adding an additional phone line

OMS Response: OMS Concurs with OIG Recommendation 23

This system was put into place prior to the OIG report. One nurse is assigned to do phone duty. This ensures continuity and that there is appropriate time to take the calls. The hours of nurse line coverage have been extended, and a tracking system implemented to capture the number of calls that come in. Preliminary feedback from VRS indicates that there has been an increase in satisfaction among applicants due to this change.

OIG Recommendation 24: That OMS identify, implement and monitor customer service standards.

OMS Response: OMS Concurs with OIG Recommendation 24

Customer service training was completed for all of OMS staff. Customer service training will be provided on a yearly basis for all OMS staff.

OMS *is* dedicated and committed to enhancing the quality of customer service by providing premium services in response to the needs of every customer including but not limited to all Peace Corps Applicants, Peace Corps Volunteers, and Returned Peace Corps Volunteers.

OMS will develop a system to monitor the implementation and continued use of the customer service standards in coordination with the OMS Program & Training Manager.

Standards currently in place include but are not limited to:

> ▪ Courtesy, Respect, Honesty and Professionalism
> ▪ Timeliness, Responsiveness, Accessibility and Efficiency
> ▪ All calls and e-mails are addressed in a timely manner
> ▪ All incoming calls from external sources will be answered with a consistent message.

OIG Recommendation 25: That OMS and the Pre-Service Unit with the assistance of OSIRP systematically collect applicant feedback by developing and implementing an applicant feedback survey.

OMS Response: OMS Concurs with OIG Recommendation 25

OMS health system specialist in collaboration with the Pre-Service manager has discussed with OSIRP the possibility of developing and implementing an applicant feedback survey. The question forwarded by OSIRP to the OIG in response to this recommendation is: "What is it the survey needs to answer? A survey can be done but would need OMB clearance."

In addition, the planning, performance and evaluation chief commented on the need to first confirm that the applicant status is accurately recorded in the database (see responses to recommendations 12-14) in an effort to properly determine applicant samples ("dropout", "not medically qualified" and "medically qualified"). Once the Warehouse (Magellan) project is completed, Pre-Service will be able to track and provide data regarding applicants at each step of the application process.

Ongoing planning meetings will occur between OMS and OSIRP managers.

OIG Recommendation 26: That the Pre-Service Unit manager meet with the Director of the Medical Screening Division at the State Department to learn about their medical screening survey to capture customer feedback**.**

OMS Response: OMS Concurs with OIG Recommendation 26

The OMS Medical Director, Pre-Service Unit Manager, Health Information Systems Manager, IT Programmer and the Acting Deputy Director of OMS met with the Director of the Medical Screening Division at the State Department to learn about their medical screening survey to capture customer feedback on January 23, 2007.

OIG Recommendation 27: That OMS establish and implement annual customer service training for all OMS staff that have direct communication with applicants. Customer service training should emphasize the importance of coaching applicants through the Medical Clearance System**.**

OMS Response: OMS Concurs with OIG Recommendation 27

Customer Service training by an outside consultant was provided to all employees in Volunteer Support in September 2007. OMS will request funds for continuing annual customer service training.

OIG Recommendation 28:   That the Pre-Service Unit develop a Nurse Line e-mail address that can be checked by screening assistants and forwarded onto the proper screening nurse as an alternative to the Nurse Line.

OMS Response: OMS Concurs with OIG recommendation 28

As of January 2008 two e-mail boxes have been set up as recommended by the OIG to supplement the Nurse Line and the calls to the screening assistants.

OIG Recommendation 29:   That the Pre-Service Unit staff log and discuss applicant complaints.

OMS Response: OMS Concurs with OIG Recommendation 29

All complaints are addressed at the appropriate agency level. For complaints within Pre-Service, these are brought to the Pre-Service Manager who responds to these complaints. There has been staff training on this process and it has been implemented

OIG Recommendation 30:   That the Pre-Service Unit institute quality controls to ensure contact information is not missing from the letter in the Medical Kit.

OMS Response: OMS Concurs with OIG Recommendation 30

The Pre-Service Unit instituted quality controls to ensure contact information is not missing from the letter in the Medical Kit with those who put together the medical kits.

OIG Recommendation 31:   That OMS conduct a staffing analysis to determine whether the number of Pre-Service nurses currently on staff is adequate.

OMS Response: OMS Concurs with OIG Recommendation 31

Each manager in OMS is responsible for the staffing analysis of his/her unit.

Pre-Service staffing analysis has concluded that there is a need for three additional screening assistants, one for each region. These additional positions would provide two screening assistants for each PC Region. This staffing pattern will reduce the administrative burden of the nurses, improve efficiency of medical reviews, and reduce time to disposition of an application.

Post Service Unit staffing analysis identifies the need for two additional case management positions in order to continue and to increase the productivity and savings to the Federal Employee Compensation Administration (FECA) chargeback. Additional staff in this position will also allow oversight of most, if not all, of the existing PC FECA claims. In addition, it would also provide available staff (Call Center) time to assist former Volunteers filing new claims to sort out complex issues and deal with Department of Labor.

OIG Recommendation 32: That OMS conduct periodic staffing analyses to address new agency initiatives which impact the Pre-Service Unit workload.

OMS Response: OMS Concurs with OIG Recommendation 32

OMS will conduct periodic staffing analyses as new agency initiatives are implemented which impact the Pre-Service Unit workload.

OIG Recommendation 33: That the OMS designate a backup to the OMS computer programmer analyst with programming proficiency and training on the Expert System.

OMS Response: OMS Concurs with OIG Recommendation 33

Currently back-ups exist for normal operations of all Pre-Service applications, including the expert system. These back-ups are located in the office of the Chief Information Officer (CIO) and OMS.

OIG recommendation 34: That OMS routinely communicate changes in the Expert System to the backup programmer.

OMS Response: OMS Concurs with OIG Recommendation 34

Changes are available to the CIO back-up through the Change Review Board and the Configuration Management System.

OIG Recommendation 35: That OMS document the Expert System for succession planning.

OMS Response: OMS Concurs with OIG Recommendation 35

The process of documenting the expert system has been initiated with current staff and is expected to be complete within six months.

OIG Recommendation 37: That OMS define the purpose of the Plan One reimbursement schedule.

OMS Response: OMS Concurs with OIG Recommendation 37

Applicants are informed of the purpose of the Plan One reimbursement schedule in both the "Guide to Completing Your Peace Corps Medical and Dental Forms" and in the "Instructions and Reimbursement Information for the Examining Physician." Both documents are sent

directly to the Applicant during the application process. The full fee schedule is also included along with the toll free number to contact the Pre-Service Unit with any questions.

All Applicants are informed that they are responsible for all medical expenses not covered by their insurance and that the Peace Corps provides a small contribution or stipend to help offset some of the costs that the Applicant may incur.

OIG Recommendation 38:   That OMS provide applicants with data from the survey they develop with the Office of Strategic Information, Research And Planning that shows average out-of-pocket costs that applicants have incurred in fulfilling the Peace Corps Medical Clearance requirements.

OIG Recommendation 39:   That the OMS Health Information Systems Unit establish criteria by which to assess the adequacy of the reimbursement fee schedule by 2008.

OIG Recommendation 40:   That immediately after establishing the assessment criteria, the OMS Health Information System Unit assess the adequacy of the current Plan One reimbursement fee schedule and adjust the schedule accordingly.

OIG Recommendation 41:   That the OMS Health Information Systems Unit establish a procedure by which they re-evaluate the adequacy of the reimbursement fee schedule biennially or as new screening requirements are implemented.

OMS Response: OMS Does Not Concur with OIG Recommendations 38- 41

The purpose of the Plan One fee schedule is to provide a small contribution or stipend to help offset some of the costs that may not be covered by insurance. It is not, nor has it ever been intended to be a full reimbursement for the out-of-pocket expenses that an applicant may have incurred during the medical clearance process. Thus the suggestion that OMS determine the "adequacy of the current Plan One reimbursement fee" is not consistent with the intent of the stipend.

The Plan One fee schedule is not based on nor part of an insurance program, and as such there is no existing mechanism to capture or track total charges or total costs to the Applicant. OMS would be pleased to increase the stipend for applicants; this however would require that the organization increase the budget for this specific account.

The costs that an applicant may incur during the medical clearance process is highly variable and depends on many factors including type of insurance (if any), extent and type of prior medical history, need for follow-up evaluation or treatment, geographic location, etc. While the OIG recommendation suggests that applicants be surveyed, we do not believe that this would provide accurate information that would be useful to another individual applicant because of the method of reporting and all of the variables described above. In fact, this would be much more likely to result in misconceptions and confusion on the part of other

applicants. The Peace Corps recommends that applicants consult with their doctor and insurance provider about the cost of medical exams, labs and blood tests before they begin their medical evaluation and as necessary during the medical evaluation process. This is clearly stated in the redesigned "Guide to Completing your Peace Corps Medical and Dental Forms."

OIG Recommendation 42: That OMS provide applicants with the estimated time it will take the Pre-Service Unit to screen a Medical Kit from an applicant under 50 years of age and to screen a Medical Kit from an applicant 50 years and older.

OMS Response: OMS Concurs with OIG Recommendation 42

Once data is available from the new Pre-Service tracking system, OMS will make information available regarding the average time it takes to evaluate a medical packet from applicants less than 50 years of age and a medical packet from applicants 50 years and older.

OIG Recommendation 43: That OMS work with the Office of Communications to improve the Medical Kit instructions by eliminating contradictory and vague guidance and highlight the most critical information.

OMS Response: OMS Concurs with OIG Recommendation 43

The forms and instructions for the Medical Kit have been updated and improved. These will be sent out as part of the kit as soon as they are printed. There is now a user friendly checklist, and a list of FAQs that will aid the applicant in the medical screening process.

OIG Recommendation 44: That OMS consolidate the location of instructions and medical forms for completion by applicant or a healthcare provider and ensure that they are accurately referenced on paper and online.

OMS Response: OMS concurs with OIG Recommendation 44

All medical information forms have been updated and are available on the Internet and in the Medical Kits. The proposal to put forms as a downloadable option is being evaluated by the CIO. This change, if made, would allow for the medical forms to be available for download after the applicant was nominated.

OIG Recommendation 45: That the Peace Corps and the VA Hospitals more clearly define and update their agreement.

OIG Recommendation 46:   That OMS correspond with VA Hospitals on an annual basis to strengthen communication on new requirements to the Peace Corps Medical Kit.

OIG Recommendation 47:   That OMS develop and distribute a list of Veterans Administration Hospitals across the nation that are positively responding to screening Peace Corps applicants based on applicant feedback.

OIG Recommendation 48:   That the Pre-Service Unit post the VA Hospital Authorization Form online next to the list of applicant endorsed VA Hospitals.

OMS Response: OMS Concurs in Part with OIG Recommendations 45-48

Section 2504 of the Peace Corps Act states the following:

"Volunteers shall receive such health care during their service, applicants for enrollment shall receive such health examinations preparatory to their service, applicants for enrollment who have accepted an invitation to begin a period of training under section 8(a) [22 U.S.C. 2507(a)] of this Act shall receive such immunization and dental care preparatory to their service, and former volunteers shall receive such health examinations within six months after termination of their service, as the President may deem necessary or appropriate. Subject to such conditions as the President may prescribe, such health care may be provided in any facility of any agency of the United States Government, and in such cases the appropriation for maintaining and operating such facility shall be reimbursed from appropriations available under this Act. Health care may not be provided under this subsection in a manner inconsistent with the Assisted Suicide Funding Act of 1997."

This section of the Peace Corps Act allows, but does not require, other health care agencies of the U.S. Government to provide health examinations for Peace Corps applicants. To our knowledge there has never been a formal agreement between the Peace Corps and the Department of Veterans Affairs regarding the use of VA medical facilities for Peace Corps Applicants.

Currently there are approximately 157 hospitals and 650 outpatient clinics run by the Department of Veteran's Affairs. There is a central governing body; however each hospital or clinic functions independently in terms of clinic structure, organization and availability of appointments and medical personnel. As stated in the OIG report, the Peace Corps Office of Medical Services informs applicants of this resource but cannot provide any assurance that appointments will be available in a timely fashion (or at all) for any particular facility.

Mr. Verle Lanier, Associate Director for Volunteer Support, and Dr. Scott Saxman, Director, Office of Medical Services met on February 19, 2008, with representatives from the

Department of Veterans Affairs to discuss an agreement. During this meeting it was reiterated that the primary responsibility of the Veterans Administration is to the Veterans that are eligible for care, and while Peace Corps applicants may on occasion be accommodated this would be on an "as space available" basis and would be completely at the discretion of each individual facility. They noted that nearly all VA facilities are currently operating beyond their capacity and waits can be long—even for the Veterans who are eligible for care. They also noted that appointments for dental evaluations are even more difficult to obtain, and waits can be extremely long. Other possibilities were considered such as whether Peace Corps applicants could obtain part of their medical needs routinely from VA facilities (for example laboratory tests and vaccinations) and it was determined that this was not a practical option. The representatives from the VA did agree to distribute guidance to the Office of Patient Care Services so they can let personnel in the field know that this opportunity exists. It was felt that this might be helpful in reminding the facilities that Peace Corps Applicants could be seen if space is available.

As a result of this meeting it was concluded that a formal agreement that would assure facilitation of medical evaluation of Peace Corps applicants could not be executed, and that the use of VA facilities for the medical evaluation of Peace Corps applicants will continue to be unpredictable and inconsistent.

Given these limitations, providing the Department of Veterans Affairs with updates on the medical kit would not be constructive. Similarly, attempts to develop and distribute a list of Veteran Administration Hospitals across the nation that are positively responding to screening Peace Corps applicants based on applicant feedback would not have meaning, as even a specific institution may have a space available on one day and not again for an indeterminate period of time. OMS will continue to provide the required authorization forms to applicants when requested, but will cease actively promoting this option to applicants. OMS will also communicate to applicants the high likelihood that the VA will not be able to accommodate them, that the applicant will be entirely responsible for contacting the facility and determining whether appointments are available, and that obtaining their medical evaluation at a VA facility could significantly prolong the medical evaluation process because of long wait times for both the initial examination as well as any necessary follow-up evaluations.

OIG Recommendation 49: That OMS with consultation from the 50+ Initiative Working Group and the Office of Strategic Information, Research, and Planning analyze what screening resources may be required by the agency to ensure the success of the 50+ Initiative, such as additional screening nurses or screening assistants.

OMS Response: OMS Concurs with OIG Recommendation 49

Currently OMS has 2 dedicated screening nurses for the 50+ Initiative. Having one additional nurse would allow dedication of one nurse for each PC Region. This will be a proactive approach to the

projected increase in 50+ applicants as a recent workflow analysis has determined that it takes a longer period of time to medically evaluate 50+ applicants.

OIG Recommendation 50: That the Screening Unit Manager be mentored by the Division Chief of Medical Clearances at the State Department to provide expertise and assistance to the OMS Screening Unit and QI Unit for the purposes of the following:

> a. Streamlining the MCS.
> b. Developing performance measures.
> c. Developing and implementing staff feedback
>   mechanisms.
> d. Developing and implementing applicant feedback
>   mechanisms.
> e. Developing, updating, and enforcing guidelines,
>   SOPs, and policies.
> f. Implementing improvements to the MCS.

OMS Response: OMS Concurs in Part with the OIG Recommendation 50

OMS staff have met with the State Department's screening division and have reviewed their processes. It cannot be determined whether the final clearance determinations occur more rapidly at the State Department because they do not collect this data. While the afternoon visit to the State Department was highly informative, due to the fact that the systems and processes are extremely different it was not felt by either team that further formal "mentoring" of the Pre-Service manager by the Division Chief of Medical Clearances would have value. A relationship and communication has been established however and we will continue to share ideas and improvements.

OIG Recommendation 51: That the OMS Screening Team meet with the State Department's Screening Division to learn how the State Department decreased medical screening time through a combination of technological improvements, systems streamlining, and quality management and to determine the following:

> a. The hardware required and communications methodology for requiring applicants to fax medical documentation instead of mailing,
>
> b. The hardware and system structure involved in transitioning to a system of scanning, accessing, reviewing and storing electronic medical files, and
>
> c. Whether the eMed document management system or a similar system would work for Peace Corps Medical Screening.

OMS Response: OMS Concurs in Part with OIG Recommendation 51

OMS has met with the State Department's screening division and reviewed their process and their information regarding the timelines for screening of applicants. Currently, the State Department's data accounts for the time from which the medical information is received and scanned to the time that an initial determination is made. The Peace Corps however measures the length of the screening process from the time the medical kit is sent to the applicant to the time that a final medical determination is made. This time period extends well before and well after the time period that the State Department uses in its calculation, and includes a significant period of time during which the medical packet is within the applicant's control and not under OMS. Therefore it cannot be determined whether the State Department's clearance process requires more or less time on average than the Peace Corps.

In the new tracking system process that OMS implemented prior to the IG report, each particular time period will be tracked separately so that it can be accurately determined how much of the clearance time is related to OMS processes and how much is related to the time it takes an applicant to obtain and submit the requisite information. It will require approximately three quarters of tracking to have data that OMS can report.

OMS agrees that the eMed document management system described in the report is efficient and effective and would function equally well for the Peace Corps medical evaluation process.   An assessment of the hardware and system structure involved in transitioning to a system of scanning, accessing, reviewing and storing electronic medical files would have to be conducted by the CIO office as OMS does not have this expertise. OMS was informed by the State Department that the start-up and maintenance costs of this system have been approximately 14 million dollars.

While not having nearly the functionality as eMed, it would offer some improvement in efficiency to have scanners at each of the Pre-Service screening nurse's and assistant's workstations so that documents could be scanned and sent to applicants in a password protected e-mail rather than having to use the postal service or FedEx. This would require additional funding and assistance from the agency.

OIG Recommendation 55:   That the Cross-Unit Board in collaboration with the Quality Improvement Unit review the recommendations in the above noted reports.

OMS Response: OMS Concurs with the OIG Recommendation 55

The OMS Quality Council will review the recommendations in the above noted reports. Following are the tentative timelines for review:

Feb 08: 2003 PC office of IG evaluation of the volunteer delivery system
Mar 08: PEM Report
May 08: 2002 OMS Pre-Service Unit – Medical Screening Redesign
Jun 08: 1999 PC – Review of the Volunteer Delivery System

Jul 08: 1997 JCAHO – PCVHS Evaluation Report
Sep 08: 1994 JCAHO – PCVHS Evaluation Report
Nov 08: PC Volunteer Service and OMS report on Medical Screening Process Redesign
Dec 08: McManis Associates Report on the Screening and Medical Clearance Process

To: Geoffrey Johnson, Acting Inspector General

From: Rosie Mauk, Associate Director for Volunteer Recruitment and Selection

Cc: David Liner, Chief of Staff
                Michelle Brooks, Deputy Chief of Staff
                John Dimos, Chief Compliance Officer
                Verle Lanier, Associate Director for Volunteer Support
                Ed Anderson, Chief Information Officer
                Scott Saxman, Director, Office of Medical Services

Re: Response to the Inspector General's Preliminary Report on the Peace
                Corps' Medical Clearance System

Date: March 5, 2008
_____

The office of Volunteer Recruitment and Selection (VRS) is pleased to respond to
Recommendations 12 and 14 of the Inspector General's (IG) Preliminary Report on the
Peace Corps' Medical Clearance System. VRS is additionally pleased that the IG
recommends a continuation of cooperation between VRS and the Office of Medical
Services (OMS).

**Recommendation 12: That the Pre-Service Unit and VRS Placement Unit work with
OSIRP to standardize application data across agency offices.**

VRS concurs with this recommendation. VRS will work with the Pre-Service Unit and
OSIRP to create a task force to analysis and resolve this problem. The task force will be
composed of those members of the Placement Unit, the Pre-Service Unit, and OSIRP
who are familiar with the data systems of both the Placement Unit and the Pre-Service
Unit. Work will begin on or before March 31, 2008, and the issue is expected to be
resolved by July 31, 2008.

**Recommendation 14: That OMS and VRS work with OSIRP to devise a method for
tracking applicants through the entire VDS process including the reconciliation of
the number of nominations to medical kits sent and medical dispositions to final
invitations.**

VRS concurs with this recommendation. VRS will work with the same task force
developed to address Recommendation 12 to analyze and resolve this problem. Work
will begin on or before March 31, 2008, and the issue is expected to be resolved by July
31, 2008.

To:	Geoffrey Johnson, Acting Inspector General
From:	Ed Anderson, Chief Information Officer
Cc:	David Liner, Chief of Staff
	Michelle Brooks, Deputy Chief of Staff
	John Dimos, Chief Compliance Officer
	Verle Lanier, Associate Director for Volunteer Support
	Scott Saxman, Director, Office of Medical Services
	Rosie Mauk, Associate Director for Volunteer Recruitment and Selection
Re:	Response to the Inspector General's Preliminary Report on the Peace Corps' Medical Clearance System
Date:	March 31, 2008

The Office of the Chief Information Officer (OCIO) is responding to recommendations 16, 17 and 52 of the Inspector General's (IG) Preliminary Report on the Peace Corps' Medical Clearance System.

Recommendation 16: That the OCIO correct the problem of applicant status and timeframes being overwritten in Peace Corps Volunteer Database Management System if an applicant applies to the Peace Corps more than once.

Response: The OCIO concurs with the underlying findings which generated recommendations within item 16 and is working with OMS and other departments within the agency to meet needs as identified by the IG. It is recognized that accurate applicant status and appropriate metrics are required to meet organizational control and reporting needs. In addition, we concur that overall there is a need to improve the electronic flow, capture and presentation of information associated with the medical screening process.

It is the OCIO view that the specific recommendations delineated need to be predicated upon an overall process review and system architecture analysis. The goal of this analysis is to meet the overall goal of improving the mission capability of the Medical Screening Group and medical screening process by reducing the time required to clear applicants. The OCIO, in concert with the agency through the IRB, has already initiated work activities to address this issue and the underlying recommendations captured within item 16.

- The overall architecture for which OMS is a part, the VDS Program, is the number 1 rated priority as set by the IRB.
- Within the VDS Program, the analysis of the OMS business and information processes has and is currently an on-going project with the mapping of current

and proposed processes. This effort is actively being worked on by staffs of both OMS and OCIO Enterprise Architecture.

- The issues addressed within the recommendations will be used as input for requirements and recommendations for subsequent development proposals.

Recommendation 17: That the OCIO add data fields to the tables in PCVDBMS to capture additional information on the medical screening time frame and to capture when missing information is requested and when missing information is received.

Response: The OCIO concurs with the underlying findings which generated recommendations within item 17 and is working with OMS and other departments within the agency to meet needs as identified by the IG. It is recognized that accurate applicant status and appropriate metrics are required to meet organizational control and reporting needs. In addition, we concur that overall there is a need to improve the electronic flow, capture and presentation of information associated with the medical screening process.

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Recommendation 52: That the OCIO implement improvements to the Medical Screening Process including the following: Posting the Medical Kits online; instituting a new system in which applicant paper medical records will be scanned by the Medical Records Unit prior to review by screening nurses; Fixing the identified applicant status problems with the My Toolkit and institute improvements to My Toolkit code.

Response: The OCIO concurs with the underlying findings which generated recommendations within item 52 and is working with OMS and other departments within the agency to meet needs as identified by the IG. It is recognized that accurate applicant

status and appropriate metrics are required to meet organizational control and reporting needs. In addition, we concur that overall there is a need to improve the electronic flow, capture and presentation of information associated with the medical screening process.

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Date: March 5, 2008

To: Geoffrey Johnson, Acting Inspector General

From: Verle Lanier, Associate Director for Volunteer Support

Subject: Response to the Inspector General's Preliminary Report on the Audit of Peace Corps' Medical Clearance System

The office of Volunteer Support is pleased to respond to Recommendations 36, 53, and 54 of the Inspector General's Preliminary Report on the Audit of Peace Corps' Medical Clearance System. We appreciate the understanding and cooperation provided by you and your staff during this process.

OIG Recommendation 36: Based upon screening productivity, quality performance, and compliance with policies and customer service standards, that the agency considers a pilot program to exempt screening nurses in the Office of Medical Services from the five-year rule with renewable 30-month tours.

Agency Response: Agency Does Not Concur with OIG Recommendation 36.

Exempting only a certain number of nurses would cause morale problems among the other nurses in the OMS Pre-service Unit who do not get the exemption. This was shown when the previous Peace Corps Director exempted only one of the four doctors serving in OMS. We do not want to exempt all 18 nurses, as that goes against the spirit of the Peace Corps Act setting out the 5 year rule.

OIG Recommendation 53: That the agency establish a Volunteer Delivery System committee to meet on a monthly basis to discuss VDS systems operations, performance measurement, impact of interoffice VDS decisions, and communication strategies for implementing VDS changes that ensure that all VDS offices are informed of changes to the system that effect multiple offices and changes are communicated consistently to regional recruitment offices and applicants.

Agency Response: Agency Concurs with OIG Recommendation 53.

A Volunteer Delivery System Steering Committee has been established and meets weekly to perform what the OIG has recommended.

OIG Recommendation 54: That the agency prioritize long-standing recommendations for technological improvements to Pre-Screening operations and provide OMS with the resources to carry out these improvements to the Medical Clearance System.

Agency Response: Agency Concurs with OIG Recommendation 54.

The OMS Quality Council will prioritize the recommendations, some of which will be satisfied with the results from the actions taken in connection with this evaluation.

cc: David Liner, Chief of Staff
      Michelle Brooks, Deputy Chief of Staff
      Ed Anderson, Chief Information Officer
      Rosie Mauk, Associate Director, VRS
      Scott Saxman, Director, OMS
      Ruben Hernandez, Director, OSIRP
      John Dimos, Chief Compliance Officer

OIG COMMENTS

Management concurred with 40 recommendations, partially concurred with recommendation numbers 6, 11, 15, 45 – 48, 50, and 51, and did not concur with recommendation numbers 13, 36, and 38 – 41.

We closed recommendations numbers 1 – 4, 7 – 11, 19, 23, 24, 26 – 28, 31, 32, 34, 36 – 41, 45 – 51, and 55. Recommendation numbers 5, 6, 12 – 18, 20 – 22, 25, 29, 30, 33, 35, 42 – 44, and 52 – 54 remain open pending confirmation from the chief compliance officer that the following has been received:

- For recommendation number 5, a copy of a quarterly review of the certifications and a copy of the feedback provided to the PCMOs.

- For recommendation numbers 6 and 54, documentation that resources have been provided to OMS to improve the Medical Clearance System.

- For recommendation numbers 12 and 14, documentation that a task force has resolved the issues.

- For recommendation number 13, a copy of the standard operating procedure.

- For recommendation number 15, a copy of the report showing the average reporting time for a screening appeal.

- For recommendation number 16, documentation that applicant status and timeframes are not being overwritten in the Peace Corps Volunteer Data Management System (PCVDMS).

- For recommendation number 17, documentation that data fields for medical screening timeframe have been added to the PCVDMS.

- For recommendation number 18, documentation that a staff member has received data collection and analysis training.

- For recommendation number 20, a copy of the agenda of the first meeting between the Cross Unit Board and the Office of Volunteer Selection and Recruitment.

- For recommendation number 21, a copy of the Health Systems Specialist's assessment.

- For recommendation number 22, a copy of the revised PCMO evaluation of Volunteer Support services tool.

APPENDIX D

- For recommendation number 25, a copy of the customer service survey.

- For recommendation number 29, a copy of the staff training curriculum covering the process of logging complaints.

- For recommendation number 30, documentation verifying that quality controls are in place.

- For recommendation number 33, documentation that the backup programmers have been trained to address the identified knowledge gaps.

- For recommendation number 35, documentation showing the Expert System succession plan.

- For recommendation number 42, a copy of the information provided to applicants that provides the average time it takes to evaluate a medical packet.

- For recommendation number 43 and 44, a copy of the revised Medical Kit instructions.

- For recommendation number 52, documentation that the OCIO has implemented improvements to the Medical Screening Process.

- For recommendation number 53, a copy of the Volunteer Delivery system committee meeting minutes.

In their response, the management describes actions they are taking or intend to take to address the issues that prompted each of our recommendations. We wish to note that in closing recommendations, we are not certifying that they have taken these actions nor 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.

OIG CONTACTS AND STAFF ACKNOWLEDGEMENTS

OIG CONTACTS

If you wish to comment on the quality or usefulness of this report to help us improve our products, please e-mail Shelley Elbert, Assistant Inspector General for Evaluation, at selbert@peacecorps.gov, or call (202) 692-2904.

STAFF ACKNOWLEDGEMENTS

Assistant Inspector General for Evaluation Shelley Elbert, Assistant Evaluator Sarah Magallanes, and Senior Auditor Elizabeth Palmer managed all aspects of this assignment.

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