



# Peace Corps Office of Inspector General



## Peace Corps/Morocco Assessment of Medical Care

February 2010

---

---

## EXECUTIVE SUMMARY

---

---

On November 19, 2009, Peace Corps Director Aaron Williams requested that the Peace Corps Office of Inspector General (OIG) conduct an independent inquiry into the facts and circumstances related to the illness and death of Peace Corps Volunteer [REDACTED] [REDACTED] and to identify, assess, and evaluate the specific health care provided to [REDACTED]. The Director also asked the OIG to review the organization and provision of care that is given to Peace Corps Volunteers in Morocco. In particular, he requested we assess the following areas: accountability and reporting lines; quality assurance procedures; funding and staffing levels; and professional skill levels and qualifications. This report will focus on the OIG review of the organizational structure and provision of care to Peace Corps Volunteers in Morocco. Information concerning the facts and circumstances relating to the death of PCV [REDACTED] and the health care provided to [REDACTED] will be addressed in a separate report.

The OIG determined that the way in which PC/Morocco organizes its medical services and provides health care to Volunteers in Morocco had an impact on PCV [REDACTED] medical care. The PC/Morocco health unit staff failed to identify the condition causing [REDACTED] symptoms. Two main factors led to this breakdown. The first was a failure to effectively communicate, including transferring the case from one Peace Corps Medical Officer (PCMO) to another and relaying pertinent information to Moroccan medical facilities. The second is the questionable professional judgment of the PCMOs involved in PCV [REDACTED]'s care during the last month of [REDACTED] life. We have identified possible contributing factors including PC/Morocco medical unit's sizeable workload, questionable organization of case management and dissemination of duties, and the lack of an effective mechanism to ensure that a PCMO is practicing within his or [REDACTED] scope of practice.

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

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

This assessment specifically looked at PC/Morocco and PCV [REDACTED] healthcare, but the question of whether this was a one-time failure or an indication of a larger systemic problem throughout Peace Corps operations remains. The facts and circumstances surrounding this case call into question the efficacy of Peace Corps' structure, execution, and oversight of overseas health units.

## Table of Contents

EXECUTIVE SUMMARY .....	i
BACKGROUND .....	1
OBJECTIVES, SCOPE, AND METHODOLOGY .....	2
ORGANIZATION AND PROVISION OF .....	3
HEALTH CARE TO VOLUNTEERS .....	3
LIST OF RECOMMENDATIONS .....	14

---

---

## BACKGROUND

---

---

The Peace Corps program in Morocco (PC/Morocco) is the second largest Peace Corps program in the world. Since 1963, over 4,000 Volunteers have served in Morocco. As of November 17, 2009, the agency reported that 254 Volunteers were serving in Morocco. There are two incoming training cohorts of Volunteers each year. Volunteers are assigned to projects in four primary areas: youth development, health, environment, and small business development.

Volunteer sites are broadly dispersed within Morocco's mountainous and sometimes hard-to-access terrain. Although placing Volunteers in remote locations is standard throughout Peace Corps, it underscores the importance of the professional judgment of the PCMO to determine when a Volunteer needs to be seen in person by a PCMO or can be cared for locally. It also underscores the importance of site visits by PCMOs, which are critical to 1) assess the medical resources available in proximity to a Volunteers site, 2) build relationships with providers, and 3) assess a Volunteer's environment and get a first hand view of the environment in which they live.

PC/Morocco has three full time PCMOs. Two are medical doctors and one is a registered nurse. There is one administrative medical assistant for the PC/Morocco health unit. All are host country personal services contractors. Only six hospitals in major cities have been pre-approved for Volunteer health care by the health unit. Volunteers must receive PCMO approval to receive health care at one of these facilities and they are not allowed to visit unapproved local providers except in emergencies.

In June 2009, the OIG conducted a program evaluation of PC/Morocco.<sup>1</sup> The OIG interviewed 42 Volunteers (approximately 20% of the Volunteer population) and 15 in-country staff. Eighteen of the 42 Volunteers (43%) reported concerns with the quality of medical support at the post. With regard to health findings, the OIG evaluation found that both PCMOs and Volunteers reported that the quality of medical support was impacted by the health unit's large volume of work. Volunteers reported that PCMOs were frequently too busy to fully investigate their medical complaints. In interviews with two of the three PCMOs in the health unit, both reported a need for additional staff because they did not have enough time to conduct all their duties, including site visits.<sup>2</sup> The evaluation also disclosed that Volunteers lacked confidence in medical opinions and feared being misdiagnosed.

---

<sup>1</sup> The OIG briefed the PC/Morocco country director of its program evaluation findings on June 24, 2009 and the Europe, Mediterranean, and Asia (EMA) regional management on July 8, 2009.

<sup>2</sup> According to PC Technical Guideline 200, there are no fixed staffing ratios of PCMOs to Volunteers due to a variety of mitigating factors; however, as a general guideline, a post with good medical support should not have more than 80 Volunteers per PCMO. At the onset of this evaluation there were 86 Volunteers per PCMO.

The Office of Medical Services conducted an assessment of PC/Morocco in June 2009, which coincided with the fieldwork portion of the OIG evaluation. OMS determined that an additional part-time PCMO is needed to meet the current physical and mental health care demands at the post and recommended an additional part-time PCMO when the year-round number of Volunteers exceeds 240. The OIG concurred that such a hire would address the concerns raised during the OIG evaluation.

---

## **OBJECTIVES, SCOPE, AND METHODOLOGY**

---

The purpose of the Office of Inspector General is to prevent and detect fraud, waste, abuse, and mismanagement and to promote effectiveness and efficiency in government. In February 1989, the Peace Corps/OIG was established under the Inspector General Act of 1978, as amended, and is an independent entity within the Peace Corps. The Inspector General (IG) is under the general supervision of the Peace Corps Director and reports both to the Director and Congress.

To address Director Williams' request, the Inspector General assembled a multi-disciplinary team consisting of members from the OIG's evaluation and investigation units. The Inspector General also contracted the services of two independent medical experts who reviewed PCV [REDACTED]'s medical records and assessed medical operations at the post. An OIG investigator and one of the expert physicians conducted interviews of PCV [REDACTED]'s host family and colleagues in Tamegroute the doctors who evaluated and treated [REDACTED] at hospitals in [REDACTED] [REDACTED] [REDACTED] all three Peace Corps Medical Officers (PCMOs). At no time during this assessment did the two consultant physicians communicate with each other; however, both physicians came to similar conclusions about the circumstances and causes related to the illness and death of PCV [REDACTED]. The OIG issued a separate report detailing these conclusions.

The OIG conducted over 30 interviews at PC/Headquarters, PC/Morocco, and Moroccan health facilities. We also interviewed numerous Volunteers, spoke to the Volunteer Action Committee (VAC) and Volunteer Support Network (VSN), and addressed the Youth Development and Small Business Development Volunteers who were in Rabat for their mid-service medical exams.

We conducted in-country fieldwork between December 5 and December 19, 2009. Site visits included Peace Corps operations in Rabat, PCV [REDACTED]'s site and youth development center in [REDACTED], the [REDACTED] in [REDACTED] the [REDACTED] [REDACTED] in [REDACTED], and the [REDACTED] in [REDACTED].

The OIG reviewed applicable policies and technical guidelines, handbooks, medical records, personnel files, and other pertinent documentation. As part of this assessment we examined the skills and experience requirements of the PCMO position, the PCMO hiring process, the PCMO reporting structure, and the PCMO performance evaluation process. We also examined various functions within the Office of Medical Services and the way in which the quality of health care provided to Volunteers monitored.

---

## **ORGANIZATION AND PROVISION OF HEALTH CARE TO VOLUNTEERS**

---

Peace Corps trainees' and Volunteers' health needs are addressed through the in-country Volunteer Health Program. Medical Technical Guideline 110 (TG 110) defines the purpose of the in-country Volunteer health program and outlines the roles and responsibilities of the in-country staff toward the program. It states that the provision of health care services to Volunteers should conform to U.S. medical standards and norms within the limitations imposed by local conditions.

The core functions of the in-country Volunteer Health Program are to:

- Support Volunteers in assuming responsibility for their own health.
- Promote the health of Volunteers and prevent disease.
- Provide health services to Volunteers overseas in as safe, efficient, and timely a manner as possible within the particular host-country environment.
- Provide medical evacuation (medevac) to Volunteers who require medical care beyond the care available in-country.

The roles and responsibilities of Peace Corps overseas staff in the in-country Volunteer Health Program are outlined as follows:

The Country Director oversees all in-country programs, including the in-country Volunteer Health program, and is ultimately responsible for the safety and well-being of Volunteers.

The PCMO, as delegated by the CD [country director] and OMS, is responsible for establishing and managing the in-country Volunteer health program. The PCMO acts as both a program manager and clinician. The program management responsibilities of the PCMO are similar in all countries but clinical responsibilities vary depending on the country and on the PCMO's training and expertise. CDs and PCMOs should be familiar with the duties and responsibilities as outlined in their individual personal services contracts.

Area Peace Corps Medical Officers (APCMOs) are assigned to the Africa region to provide clinical and programmatic support to the in-country Volunteer health programs. APCMOs are based in a host country and are responsible for providing assistance to the Volunteer Health program in each country of their sub-regional area.

PCMOs are personal services contractors. Per Peace Corps Manual (PCM) section 261, each post will have a PCMO, who may be a physician, nurse practitioner, registered nurse or a physician's assistant. The health professional skill level needed at post is designated by the Office of Medical Services. The regional director, in consultation with

the country director, selects the post's PCMO after OMS determines that the individual has the professional qualifications necessary to meet the health needs of the post.<sup>3</sup>

PC/Morocco has three full-time PCMOs. Two are physicians and one is a registered nurse.

### **Accountability and Reporting Lines**

While OMS is responsible for providing in-service health care to Volunteers and trainees (V/Ts) by developing and managing a comprehensive health care program, including the delivery of medical care and health services and medical evacuation and providing clinical oversight of and training and consultation for PCMOs, OMS must coordinate responsibility and oversight of the health care system with the Regions. Health budgets for posts, including PCMO positions, as well as APCMO positions are not managed by OMS. OMS and region staff report that when conflicts arise, OMS generally makes the "medical" decisions, but that the region will make the decisions concerning "operations." In interviews, OMS staff raised concerns about conflicting funding priorities, the skill levels of local medical officers, whether more U.S. hired medical officers are needed, and the lack of OMS clinical supervision of PCMOs.

Throughout Peace Corps worldwide, the country director, the APCMO, and OMS have shared authority and professional oversight responsibilities for the PCMO position.<sup>4</sup> According to Peace Corps policy and guidelines, all parties are involved in the PCMO hiring process. OMS determines the health professional skill level needed at a post, but country directors must recruit and select candidates and justify contracting with non-host country nationals. OMS, the country director, and the APCMO, when present, are involved in the annual PCMO performance management process. While the APCMO's oversight responsibilities for the PCMO are defined in PCM section 261, for those posts without an APCMO, it is unclear how OMS performs the clinical oversight function for PCMOs.

### ***Peace Corps did not provide sufficient oversight of the PC/Morocco in-country health program.***

Per TG 110, PCMOs must seek prompt consultation with OMS for all health conditions that may place a Volunteer at high risk of morbidity or mortality.<sup>5</sup>

---

<sup>3</sup> The Peace Corps Manual refers to both the country director and regional director regarding the hiring of PCMOs. The country director selects and enters into contracts with host country PCMOs. The regional director approves staffing levels and hires U.S. direct hire employees.

<sup>4</sup> Africa is the only region that currently uses the APCMO model. However, there have been on-going discussions between OMS, EMA, and Africa since the June 2009 OMS visit about making PC/Morocco a medical evacuation site and placing an APCMO in Rabat. Organizationally, PC/Morocco falls in the EMA region which does not follow the APCMO model. The proposal for the APCMO in Morocco involves shared funding.

<sup>5</sup> Peace Corps does not have a standard definition of morbidity.



Per TG 370, a field consultation inquiry should be sent to OMS if a Volunteer has a significant illness or any clinical situation that requires information, resources, or expertise that exceeds the training, skills, or qualifications of the PCMO and local consultants. The field consultation process makes it possible for posts to contact headquarters to utilize medical resources and specialists in the U.S. to inform and respond to urgent medical situations.

An OMS Medical Duty officer is available 24 hours a day, seven days a week and is expected to respond to field consultation calls within 20 minutes. Both of these situations require that the PCMO make the determination about when and if to involve OMS for guidance.

The PCMOs responsible for PCV/█████'s care did not contact OMS for a field consultation. In fact, OMS was notified about PCV █████'s medical condition less than one hour before █████ died. OMS staff and OIG medical experts have put forth that it is not clear that the outcome would have been any different had OMS been contacted on the morning of November 15, 2009 when █████ presented with █████ at █████ . OIG medical experts have put forth that an earlier diagnosis and intervention identifying the █████ █████ may have prevented █████ from evolving into █████ According to International Guidelines █████ timeframe to from initial diagnosis to hospital-based treatment is important to reduce the mortality rate. Had OMS been contacted earlier, a dialogue could have occurred about the best course of action for █████ situation, including whether or not to medically evacuate █████ . There was no request to OMS to medically evacuate PCV █████.

As demonstrated in PC/Morocco, substantial responsibility is placed on the professional judgment of the individual PCMO. If a PCMO fails to recognize that a volunteer is at a high risk of morbidity, mortality or has a significant illness, there appears to be no mechanism to ensure the case is escalated and receives the appropriate attention. Peace Corps lacks effective mechanisms to prevent or mitigate failures of this magnitude.

**We recommend:**

- 1. That the agency assess whether resources and expertise are aligned to provide sufficient oversight to overseas health units.**
- 2. That OMS develop an effective mechanism for closer clinical oversight for PC/Morocco.**
- 3. That OMS develop standard definitions of morbidity and significant illness.**
- 4. That PC/Morocco develop a medical escalation policy.**

*PC/Morocco does not have a clear policy on transferring patient information when there is a transfer in care.*

The PC/Morocco medical unit operates the in-country Volunteer health program in Morocco and provides health care services to Volunteers 24 hours a day, seven days a week. The primary means for casework collaboration in the PC/Morocco health unit is through a rotating medical duty officer system that transfers on-call responsibility between the PCMOs on a weekly basis, from Monday to the following Monday. According to information received in interviews with the PCMO staff, a meeting is held each Monday during which the PCMO that is transferring his/her duty shares new or pending case information with the PCMO beginning duty. However, there are no formal requirements for transfer and documentation of patient information if there is a transition of care. The PCMOs in Morocco do not have regular team meetings to discuss medical cases other than the Monday work transition meeting.

The OIG found a lack of clear policies about when and what the PCMOs should communicate with each other. Additionally, PCMOs reported that their chart documentation was not fully complete. PCMOs also reported that they were not always able to review patient charts before attending to them because of incomplete information or if a duty call was received when they were not onsite at the medical office. One PCMO reported that he carries a duty handbook with pertinent information for all Volunteers, should he receive a duty call offsite. The OIG reviewed the information in his duty handbook pertaining to PCV [REDACTED] and determined that it did not contain current information. These factors adversely impacted the quality of health care provided to PCV [REDACTED] and were the source of many complaints received from other Volunteers serving in Morocco during the June 2009 OIG evaluation and as part of this assessment.

During interviews with the OIG, several Volunteers voiced concerns about information not being shared between PCMOs. They stated that they would call the medical unit to discuss their symptoms but if their next contact was not with the same PCMO, they would be required to rehash their symptoms. Volunteers also raised communication concerns with the medical unit including language barriers, as English is not the PCMOs' first or primary language, and that being diagnosed over the phone limited Volunteers' ability to communicate their symptoms or health care concerns. Both the PCMOs and Volunteers recognized limitations with "telephone medicine." While telephone medicine is typical throughout Peace Corps worldwide because of the remote locations in which Volunteers are placed, the OIG found no telephone triage policy to standardize this approach to medical care. The OIG also found no standard requirement for Volunteers to be placed within a defined distance from medical care.

**We recommend:**

- 5. That OMS and PC/Morocco develop a telephone triage policy for PC/Morocco.**

- 6. That OMS and PC/Morocco develop a clear policy and procedures to ensure that patient information is documented and transferred appropriately if there is a transition in care.**

**PCMO Skills and Experience Requirements**

According to PCM section 261, each post has at least one PCMO, who may be a physician, nurse practitioner, registered nurse or a physician's assistant. OMS determines the PCMO professional skill levels and qualifications necessary to meet the health needs of the post. Following approval from OMS, the regional director selects each PCMO in consultation with the country director.

Further explanation is given in Technical Guideline 200, which states that when in-country medical services are limited or unavailable, "an advanced practice PCMO, e.g., a physician's assistant, nurse practitioner or physician is generally required." PCM section 743.11 further directs that "it is Peace Corps policy that contracts for medical services be Personal Services Contracts and that host country medical practitioners be utilized unless it can be shown that no suitable candidates can be found in the host country or that special conditions exist that require a US or TCN [Third Country National] medical professional." It also states that the country director will solicit PSC candidates only after consulting with the Director of OMS regarding selection criteria and that country directors review the medical qualifications of all prospective medical services contractors with and obtain written concurrence from the Director of OMS prior to awarding the contract.

***The current oversight structure does not ensure that clinicians are practicing within their scope.***

PC/Morocco has three full-time PCMOs who are locally hired PCSs. Two are physicians and one is a registered nurse. The PC/Morocco PCMO Statements of Work (SOWs) reviewed by the OIG state that acceptable skill levels for this post include nurse practitioners, physician assistants, registered nurses (RNs), or physicians. The SOWs state that PCMO activities are subject to the ultimate responsibility and authority of the country director in conjunction with medical supervision and guidance from OMS. Their responsibilities, as reflected in the SOWs, do not differ. The PCMOs report that the registered nurse does not conduct [REDACTED] or [REDACTED]; however, these areas are not restricted in his statement of work. Additionally, all of the PCMOs reported that the medical doctors are available to help should the registered nurse determine he needs assistance.

OMS staff reported that there are very successful PCMOs who are registered nurses but recognized that in the United States, RNs do not provide direct healthcare. OMS staff stated that they have been trying to address this limitation by placing RN PCMOs with medical doctors within a medical unit. While this may be the case, the OIG found no

agency guidance for delineation of duties or an oversight structure for PCMOs with different skill sets.

Because clinical oversight in the field is minimal, it is especially important during the PCMO hiring process to assess a practitioner's professional judgment. Prior to February 2007, OMS' involvement in the PCMO hiring process was to perform a credentials check to vet a candidate that was selected by a country director. OMS staff stated that most country directors do not have the medical expertise to evaluate potential PCMOs. In February 2007, the PCMO hiring process changed to include an OMS assessment of English skills and a few clinical questions before a final PCMO selection is made. OMS further refined this process in October 2009 to include a behavioral interview of common clinical scenarios. All current PCMOs in Morocco were hired prior to the February 2007.

Even though current policy and guidelines dictate that OMS determines the skill set or mix of skill sets required for a medical unit and state that "...clinical responsibilities [of the PCMO] vary depending on the country and on the PCMO's training and expertise..." current clinical oversight mechanisms do not address areas like the medical unit structure and medical case management or ensure that providers are practicing within their professional scope.

**We recommend:**

- 7. That OMS develop a policy on scope of practice.**
- 8. That OMS develop an oversight mechanism to ensure sufficient clinical oversight of scope of practice.**
- 9. That Global Operations, OMS, and OACM ensure personal services contracts specify and delineate PCMO clinical responsibilities, particularly when they differ based on level of training or experience.**

***Recommended actions to address current PCMO skill and requirements needs in the PC/Morocco Health Unit have not been resolved.***

In June 2009, the OIG conducted a program evaluation in Morocco Eighteen of the 42 Volunteers (43%) interviewed reported concerns with the quality of medical support at post. With regard to health findings, the OIG evaluation found that both PCMOs and Volunteers reported that the quality of medical support was impacted by the health unit's large volume of work. Volunteers reported that PCMOs were too busy to fully investigate their medical complaints. In interviews with two of the three PCMOs in the health unit, both reported a need for additional staff because they do not have enough time to conduct all their duties, including site visits. The evaluation also disclosed that Volunteers lacked confidence with medical opinions and feared being misdiagnosed.

OMS conducted an assessment of PC/Morocco in June 2009, which coincided with the fieldwork portion of the OIG evaluation. OMS determined that an additional part-time PCMO is needed to meet the current physical and mental health care demands at the post and recommended an additional part-time PCMO if the year-round number of Volunteers exceeds 240. The OIG concurred that such a hire would address the concerns raised during the OIG evaluation.

More specifically, the Director of OMS did not find any issues of malpractice or inappropriate conduct, but found that Volunteers in Morocco had insufficient emotional support and expressed a strong desire to talk to an Anglophone healthcare provider from a western background. Subsequently, he recommended the post hire an additional .5 full-time equivalent (FTE) PCMO, and that this person be a female U.S. nurse practitioner or U.S. physician to assist with communications, cultural adaptations, and mental health support. Additionally he recommended making PC/Morocco a medical evacuation site and placing an APCMO in Rabat. Per his report, “the APCMO would be an OMS staff member who would work with current PCMOs to ensure the highest quality of care is offered to PCVs.” Though it is not explicitly stated in his report, the OIG recognizes that placing an APCMO in Morocco would provide closer clinical oversight by OMS to PCMOs in Morocco.

At present, the recommended .5 FTE PCMO position has not been filled, although in a memo dated December 17, 2009, the EMA Chief Administrative Officer certified that funds were approved for the position. Since November 29, 2009, a temporary duty U.S. hire Peace Corps Medical Contractor has been working in Rabat to provide the medical unit with extra support.

Additionally, discussions have been ongoing between OMS and the EMA region regarding placing an APCMO in Rabat. The OIG team medical experts recommend that the agency give serious consideration to hiring more American physicians to serve as APCMOs overseas so that all PCMOs would be more closely clinically supervised by an American-trained physician.

**We recommend:**

- 10. That PC/Morocco hire a U.S. or third country national PCMO or APCMO to provide closer clinical oversight to PC/Morocco’s health unit.**
- 11. That OMS assess ways to increase clinical supervision of PCMOs, in accordance with American standards, and work with Global Operations to implement the needed changes.**

**PCMO Performance Management**

Overall, the performance evaluations for all three PCMOs in Morocco indicated that they met or exceeded all the requirements and included positive comments from OMS staff and the former and current country directors.

PCMOs are evaluated annually following the Continuing Medical Education conferences. The performance evaluation is a multi-part process involving the country director, OMS, and the PCMO. In the Africa region, the APCMO plays a role in the performance evaluation process. The PCMO Performance Evaluation process, as outlined in Technical Guideline 112, suggests data sources for assessing components of PCMO performance. It does not require that “customer” or Volunteer feedback be gathered or used as part of the evaluation process. OMS staff reported that a major evaluative challenge is the lack of close clinical supervision.

Additionally, the performance evaluation for PC/Morocco’s RN PCMO includes a reference to a mentoring report from the unit’s senior medical doctor PCMO, the unofficial “boss” of the unit, which includes the following comment: "Understands the importance of following TG [technical guideline] and seeking prompt consultation with OMS for all health conditions that may place a Volunteer at high risk of morbidity." It also includes a suggestion to "continue on-the-job training in Mental Health and GYN."

***PCMO concerns about their workload and the growing Volunteer population have not been addressed.***

In their self assessments since 2007, the PCMOs in Morocco have repeatedly stated the challenges that the growing Volunteer population has presented to the Health unit. Since 2007, the PCMOs set forth goals to carry out site visits to Volunteers to identify and evaluate local health care resources and build local provider networks, especially in remote areas, as well as to build relationships with Volunteers. In interviews with the OIG, each PCMO stated that they did not have sufficient time to conduct all of the work that was required. With a finite amount of resources and a scope of work that goes beyond that, it is left to the PCMO to prioritize his or her activities.

The OIG assesses that despite the issue of insufficient staffing having been raised in a standard agency process that includes all parties responsible for oversight since 2007, the issue was not addressed by agency or post management. In fact, Volunteer population in Morocco has continued to increase.

### **Quality Assurance and Quality Management**

Per the FY2009 Performance and Accountability Report, “The health of Volunteers is one of the agency’s top priorities, with individuals serving around the world in a variety of challenging environments. Volunteer satisfaction is just one of many components of health that the agency monitors and evaluates...” However, the agency-level performance indicators for performance goal 5.1.2 a-c to “provide quality medical and

mental health services to trainees and Volunteers” are measured only by Volunteer satisfaction.

The standard assessments currently conducted by OMS did not, and would not identify the issues raised with PCV medical care. The current assessments do not assess work environments, reliability, communication failures, lapses in patient transitions, ineffective teamwork and collaboration, or ensure that a clinician is practicing within his or her scope of practice. Regardless of whether these areas are “programmatic,” overseen by the country director, or “clinical,” overseen by OMS, they are critical to the success of a health unit. Additionally, as noted in the previous section above, even if the overseeing parties are aware that all required work for the health unit is not being completed, no action has been taken to remediate the situation.

One of OMS’s charges is to monitor health care provided to Volunteers in order to assure quality and accountability of clinical processes. This large task is carried out by multiple parties in OMS, but primarily by the Clinical Programs Unit and the Quality Improvement Unit. Per OMS staff, the overall quality of medical care at posts is primarily assessed by the following: the Biennial Volunteer Survey (BVS) on satisfaction with medical care; OMS site visits, which occur approximately every three years and include a meeting with Volunteers to assess their satisfaction and comfort level with medical care; and annual chart documentation reviews. While Volunteer survey information on satisfaction is used by the Quality Improvement Unit at an aggregate level as an overall indicator, it is not an indicator of the quality of health care provided.

Additionally, there is no standard mechanism for country directors to request assistance from OMS if there are questions or concerns about the quality of care provided by a PCMO. Issues raised by country directors are addressed on an ad-hoc basis; however, it is left to the country director to determine whether and how to contact OMS for assistance. Volunteers do not have an avenue for a “second opinion.”

Standard OMS assessments did not indicate problems with health care in Morocco. In fact, the February 2008 OMS site visit noted PC/Morocco as having an “efficient and comprehensive health program.” The overall summary stated:

The [OMS] evaluator noted that PCMO staff has done an excellent job of providing health care to Volunteers at the Morocco post. Care is organized and delivered by three PCMOs, two MDs and RN. They have been proactive in identifying areas of improvement and taking the necessary action for implementation. The health suite is capable of serving as a model for Peace Corps.

Annual documentation reviews of a post-selected sample of charts did not reveal any problems.

However, starting in the fall of 2008, multiple Volunteer concerns regarding health care were forwarded by the country director in Morocco to OMS’ Quality Improvement Unit.

Concerns were raised in October 2008, November 2008, and March 2009.<sup>6</sup> On May 4, 2009, the Chief of Quality Improvement informed the OMS Director by memo of concerns raised by Volunteers serving in Morocco with the quality of health care.

The OMS Director visited Morocco in June 2009 to obtain further information and to observe PCMO performances. He “did not find any issues of malpractice or inappropriate conduct,” but noted Volunteer perceptions that “PCMOs are ‘too busy’ and that [Volunteers] do not call them with questions so as not to ‘bother them’ because they ‘work too hard.’ In his report, he found that Volunteers had insufficient emotional support and that they expressed a strong desire to talk to an Anglophone health care provider from a western background.

OMS staff reported concerns with the agency’s lack of a medical audit function and no medical auditors on staff. While OMS makes the determination of the skills and experience requirements for PCMOs in any given country, there is no standard process that assesses whether the providers’ skills are being appropriately put to use and whether the work of the medical unit is being conducted in an efficient manner. Other than TG200, which discusses a general guideline for staffing ratios of PCMOs to Volunteers, the OIG found no agency mechanism to determine staffing requirements.

**We recommend:**

- 12. That Volunteer Support, Global Operations, and OSIRP determine appropriate indicators of quality of medical and mental health services provided to Volunteers.**
- 13. That Global Operations and OMS determine a system for sufficient oversight of PCMOs to ensure quality and accountability of clinical processes.**
- 14. That OMS evaluate its current assessments and modify, as necessary, to ensure quality and accountability of clinical processes.**

---

<sup>6</sup> The current PC/Morocco country director started at the post in September 2008.



***Peace Corps does not have a sentinel event policy.***

Though standard in the healthcare field as a practice for improving quality, neither OMS nor PC/Morocco has a requirement to analyze or follow-up on sentinel events. Furthermore, PCM section 265 on the “Overseas Death of a Volunteer/Trainee” and Technical Guideline 165 on “Volunteer Death” do not outline a role for OMS.

By the onset of our assessment, Peace Corps had not performed a sentinel event analysis of PCV/█ death, though it was discussed with the OMS staff as a standard response in the healthcare field. The OIG questions why Peace Corps does not systematically employ this standard practice for learning from critical situations and improving quality.

The primary intent of these reviews are to learn from and identify contributory factors and root causes, identify systems and processes that require improvement, and identify strategies to prevent or minimize risks of future recurrence of serious and sentinel events. In support of its mission to improve the quality of health care provided to the public, The Joint Commission<sup>7</sup> includes the review of organizations' activities in response to sentinel events in its accreditation process. It defines a sentinel event as follows: “a sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.

**We recommend:**

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

---

<sup>7</sup> The Joint Commission, an independent not-for-profit organization, accredits and certifies more than 17,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization’s commitment to meeting certain performance standards.

---

---

## LIST OF RECOMMENDATIONS

---

---

We recommend:

1. That the agency assess whether resources and expertise are aligned to provide sufficient oversight to overseas health units.
2. That OMS develop an effective mechanism for closer clinical oversight for PC/Morocco.
3. That OMS develop standard definitions of morbidity and significant illness and define an escalation policy.
4. That PC/Morocco define a medical escalation policy.
5. That OMS and PC/Morocco develop a telephone triage policy for PC/Morocco.
6. That OMS and PC/Morocco develop a clear policy and procedures to ensure that patient information is documented and transferred appropriately if there is a transition in care.
7. That OMS develop a policy on scope of practice.
8. That OMS develop an oversight mechanism to ensure sufficient clinical oversight of scope of practice.
9. That Global Operations, OMS, and OACM ensure personal services contracts specify and delineate PCMO clinical responsibilities, particularly when they differ based on level of training or experience.
10. That PC/Morocco hire a U.S. or third country national PCMO or APCMO to provide closer clinical oversight to PC/Morocco's health unit.
11. That OMS assess ways to increase clinical supervision of PCMOs, in accordance with American standards, and work with Global Operations to implement the needed changes.
12. That Volunteer Support, Global Operations, and OSIRP determine appropriate indicators of quality of medical and mental health services provided to Volunteers.

13. That Global Operations and OMS determine a system for sufficient oversight of PCMOs to ensure quality and accountability of clinical processes.
14. That OMS, evaluate its current assessments, and modify as necessary, to ensure quality and accountability of clinical processes.
15. That the agency develop a sentinel event policy.

## ***REPORT FRAUD, WASTE, ABUSE, AND MISMANAGEMENT***

**Fraud, waste, abuse, and mismanagement in government affect everyone from Peace Corps Volunteers to agency employees to the general public. We actively solicit allegations of inefficient and wasteful practices, fraud, abuse, and mismanagement related to Peace Corps operations domestically or abroad. You can report allegations to us in several ways, and you may remain anonymous.**

***Mail:***

**Peace Corps  
Office of Inspector General  
P.O. Box 57129  
Washington, DC 20037-7129**

***Phone:***

**24-Hour Toll-Free: 800.233.5874  
Washington Metro Area: 202.692.2915**

***Fax:***

**202.692.2901**

***Email:***

**oig@peacecorps.gov**

