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United States Department of State  
and the Broadcasting Board of Governors  
Office of Inspector General

# Report of Inspection

## Office of Medical Services

Report Number ISP-I-06-34, June 2006

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# TABLE OF CONTENTS

KEY JUDGMENTS .....	1
CONTEXT .....	3
EXECUTIVE DIRECTION .....	5
POLICY AND PROGRAM IMPLEMENTATION .....	7
Emergency Preparedness and Avian Influenza .....	7
Quality of Care and Customer Satisfaction .....	8
Medical Clearances .....	10
Oversight/Supervision of Overseas Staff .....	12
Privacy and Confidentiality of Medical Information .....	15
Eligibility for Services .....	17
RESOURCE MANAGEMENT .....	19
Medical Services Worldwide Resources .....	19
Office of the Executive Director .....	21
Reengineering for Future Cost Savings .....	22
Human Resources .....	25
Financial Management .....	28
Information Management and Information Systems Security .....	30
MANAGEMENT CONTROLS .....	35
ISO 9001: A System of Quality Care .....	35
Risk Assessments .....	35
FORMAL RECOMMENDATIONS .....	37
INFORMAL RECOMMENDATIONS .....	41
PRINCIPAL OFFICIALS .....	43
ABBREVIATIONS .....	45

## KEY JUDGMENTS

- The Office of Medical Services (MED) does a commendable job of fulfilling its mission of safeguarding the physical and mental health of official Americans and their families at U.S. missions abroad and of the Department of State's (Department) domestic workforce. To do this, MED provides suitable services to missions, regardless of the host nation's stage of development.
- Current MED leadership is committed to systematizing MED's operations and improving quality control. To this end, MED has clarified who is entitled to its health services abroad, is arranging a formal agreement with the Peace Corps to provide for cooperation in locations where it and the Department are both present, and is in the final phases of drafting a Quality Systems Manual based on the International Standards Organization's (ISO) ISO 9001-2000 quality standards.
- MED takes very seriously its role of protecting against the threat of avian influenza and works cooperatively with the Department's Senior Coordinator for Avian Influenza and with other relevant federal agencies, notably the Department of Defense.
- MED does not have a formal program to objectively evaluate the consistency and quality of care provided by clinical staff to overseas posts. Such a program should include a formal peer review process for all health care providers engaged in direct patient care. It should also include formal practice guidelines and require that a supervisory MED clinician contribute a written assessment to each clinician's employee evaluation report.
- MED does not fully comply with certain administrative provisions of the Health Insurance Portability and Accountability Act of 1996 and the Privacy Act of 1974, which protect the security and confidentiality of health information. Written policies and procedures for the use and disclosure of protected health information are needed, and all files and notes on patients must be included in the patient's official medical records.
- A challenge for MED has been the development and implementation of a global medical records system to improve patient care. The process is inherently difficult and has been hampered by the lack of consistent information technology management and project documentation. There are alternative commercially available records systems in the health care industry that could be reviewed for use by MED in this regard.

- The President's Management Agenda requires federal agencies to explore ways to minimize costs while enhancing performance and service. MED can realize savings by outsourcing specific, discrete functions such as laboratory services, occupational health services, the examination clinic, and medical informatics. Another potentially significant cost savings would arise from implementing a fee-for-service program that would pass the cost of outpatient care to an employee's insurance company instead of the U.S. government.

The inspection took place in Washington, DC, between January 23 and March 30, 2006.

## CONTEXT

MED's mission is to safeguard and promote the health and well being of America's global diplomatic community, providing the Department and other U.S. government foreign affairs agencies with a healthy workforce. Section 904 of the Foreign Service Act of 1980, as amended (22 U.S.C. § 4084), requires the Secretary of State to establish a health care program to promote and maintain the physical and mental health of Department employees, other eligible U.S. government employees, and their family members.

An important component of the health care program is the overseas health care unit. There are currently 192 health units in embassies and consulates abroad. MED's direct-hire overseas staffing includes 45 regional medical officers (RMO), who are physicians, 16 regional psychiatrists, 72 health practitioners, 10 laboratory technicians, and three regional medical managers, supplemented by 250 locally employed staff. The health units, depending on their size, location, and capabilities, provide primary health care services, such as examinations and immunizations, and assist employees and family members with access to local health care facilities.

Overseas, MED serves patients from 51 U.S. government agencies. This patient population includes approximately 50,000 direct-hire employees and family members who are full beneficiaries of the program and about 70,000 locally employed staff, for whom MED provides treatment for on-the-job injury and illness. In 2004, there were 230,000 health unit visits and MED facilitated 635 medical evacuations to the United States and 350 medical evacuations to overseas centers.

The Washington-based MED staff has 122 Civil Service and Foreign Service employees. In addition to the examination clinic and activities related to clearances, MED promotes a wellness program that includes on-the-job injury and illness evaluation, first aid treatment, vaccination for overseas travel, health education, health fairs, and counseling on life style changes, including dieting and education for persons with ongoing health concerns.

In its FY 2007 Bureau Performance Plan, MED notes that direct patient care is the foundation for all that MED does. However, the changing world situation has recently moved MED to offer more preventive and protective measures and has

guided its recent training towards responding to emergencies, treating the effects of weapons of mass destruction, and preparing for the outbreak of potential pandemic infections, such as might occur with avian influenza.

## EXECUTIVE DIRECTION

MED's medical director and deputy director lead a bureau that is staffed almost entirely by medical professionals, and they employ a collegial approach to leadership. They hold a weekly management team meeting where the senior staff discusses a wide range of issues and all participants may express their views. During the inspection, the management team conducted a detailed review of the draft ISO 9001 Quality Systems Manual, producing a fully vetted document. Following a discussion of the merits of draft language for the Foreign Affairs Manual (FAM) covering lines of authority abroad, MED decided the first attempt was unworkable and started anew. The management team has reviewed even such delicate issues as whether to extend for another term a very senior employee. On rare occasions where consensus is not obtainable, the front office makes the final call. The weekly, extended management team meeting, meanwhile, is open to all MED employees, and attendees are welcome to express their thoughts.

MED assignments are made through the open assignments process under which a qualified person bids on his or her choice of jobs. After reviewing these bids, the medical director and deputy make the assignments in a collegial fashion. They do so with help from the director of mental health services, when filling psychiatrist positions; the director of Foreign Service health practitioners (FSHP) programs, when filling FSHP positions (nurses and physician's assistants), and the chief of laboratory services, when filling medical technologist positions.

MED's overseas staff can readily access MED/Washington for advice, consultation, or assistance via telephone or e-mail. Each year, continuing medical education seminars are held for doctors and FSHPs serving abroad. Each seminar includes a day devoted to administrative matters, providing an occasion for the medical director or his deputy to go over new policies and procedures and answer questions. To deal with patients' cases abroad that have not gone according to expectation, MED holds periodic risk-management sessions that are attended by a wide range of doctors and nurses. These cases are discussed with the goal of avoiding similar problems in the future.



## POLICY AND PROGRAM IMPLEMENTATION

### EMERGENCY PREPAREDNESS AND AVIAN INFLUENZA

An important component in safeguarding the health of America's global diplomatic community is preparing for emergencies and disasters overseas. In an emergency, MED's onsite medical personnel would provide immediate patient care. To meet this requirement, MED has reorganized its emergency response and occupational medicine offices to respond quickly to emergency needs. It has also ensured that all posts have up-to-date chemical antidotes and antibiotics to counter biological weapon threats and trained overseas medical staff in community life support, cardio-pulmonary resuscitation, and the community emergency response team concept.

#### Avian Influenza

In light of the continuing spread of avian influenza globally, the Department is preparing for a possible pandemic. MED has been a key participant in this effort and recently completed the Department's Pandemic Influenza Plan, which outlines the Department's response to the next influenza pandemic, focusing primarily on measures to protect those who rely on MED's services. The plan emphasizes mitigation of the impact of disease and maintaining continuity of operations. The plan is available on the Internet and is intended to be an evolving document that can be easily updated.

To help the Department prepare for a pandemic, the medical director and other senior managers in MED meet regularly with Department officials, including those of the regional bureaus and the Senior Coordinator for Avian Influenza, and with their counterparts at other federal agencies, particularly the Department of Defense. MED has positioned the antiviral medication Tamiflu at all overseas posts. MED also ensures that appropriate planning and education are taking place overseas, including coordination with host country officials and posts' emergency action committees.

## QUALITY OF CARE AND CUSTOMER SATISFACTION

### Domestic Health Units

MED operates four domestic health units. They are located in the Harry S Truman Building (HST), the Columbia Plaza (SA-1) Building, the former headquarters of the U.S. Information Agency (SA-44), and at the Foreign Service Institute (FSI). The health units provide first aid, on-the-job injury and illness evaluation, immunizations, health education, cardio-pulmonary resuscitation training, and health fairs. MED hopes to develop and expand the program into a comprehensive employee health promotion program that contributes to improving employee fitness and productivity.

The health units provide certain routine health screenings, including blood pressure monitoring and weight measurement. Employees who visit a health unit with a common illness such as an upper respiratory infection or minor laceration may receive first aid, illness education, and health promotion counseling. Patients having nonemergent conditions that require additional evaluation and treatment, such as cellulitis (a skin infection requiring antibiotic treatment), are referred to their primary care physicians for further evaluation and management. When employees visit a health unit and have emergent conditions such as chest pain, an ambulance is called and the employee is transported to the George Washington University Medical Center.

The FSI health unit is staffed with two nurses and mainly provides immunizations for Foreign Service personnel. FSI's health unit provides the largest share of immunizations given by MED. It therefore tends to be fairly busy for the half of the year that precedes employees' travel to post in the late spring--early summer and less busy the other six months of the year. The health unit at SA-44 is staffed by one nurse and is lightly used, although use is increasing. The health unit at the HST building is in a corner on the basement level, although it had been located on the second floor. Signs for the unit do not accurately reflect the new location. Given the vast size of the HST building and the number of personnel employed there, this health unit has the largest potential clientele. The unit is staffed by one nurse and provides similar services to MED's other health units except for immunizations. The unit at SA-1 is diagonally across the street from the HST building and provides services similar to those provided by the HST building's health unit. Immunizations can be obtained at a separate clinic for travelers located elsewhere in SA-1. The close proximity between the HST and SA-1 health units is a duplication of services.

**Recommendation 1:** The Office of Medical Services should conduct a utilization review to determine whether all four health units in the Washington, DC, area are needed and if they are appropriately located. (Action: MED)

## Quality Improvement Office

MED's Office of Quality Improvement has embarked on praiseworthy initiatives to establish and promote quality improvement in the processes and culture of MED. The medical director has also been receptive to developing and advancing quality improvement projects within MED. (An important quality improvement initiative, the implementation of ISO 9001 is discussed elsewhere in this inspection report.) The Quality Improvement Office is responsible for risk management and credentialing and privileging of clinical providers. Credentialing is the process by which the training, expertise, and licensure of a health care provider are reviewed and verified. Privileging is the process of determining a clinician's current skill and competence to perform specific diagnostic and therapeutic procedures and interventions that the clinician wants to perform. The office conducts credentialing and privileging after the clinician's initial hire and subsequently every two years. The office has a formal process for the credentialing, privileging, and risk management functions, a process designed to comply with ISO 9001 standards, and has converted into formalized procedures and work instructions the tasks involved in the credentialing and privileging process.

The Quality Improvement Office compiles a monthly report on the incidence of common diagnoses at overseas posts. The office obtains the data from a spreadsheet that is filled out and sent from each post, and it analyzes the spreadsheet for trends. Although the quality improvement program does not perform root-cause analysis or failure-mode-effects analysis, the office does conduct quarterly risk management meetings to discuss adverse events that are brought to the office's attention. MED management and clinicians participate in the meetings, where clinical events are presented and applicable policies and processes are reviewed. The minutes of these meetings are redacted to remove or modify specific details that would indicate a patient's identity or a post's location and are then distributed electronically to alert health unit clinicians at posts worldwide. Because MED was implementing the ISO 9001 standard at the time of the inspection, the Office of Inspector General (OIG) made no recommendations regarding the need for additional quality improvement measures.

## MEDICAL CLEARANCES

### Effective Staff Utilization

MED performs on average of 2,020 health clearances per month. The process largely involves documentation review, rather than an in-person medical evaluation. Because initial employment in the Foreign Service is contingent on receiving a Level 1 medical clearance, a significant portion of the documentation review pertains to clearances for prospective Foreign Service hires. (A Level 1 clearance indicates worldwide availability for deployment to foreign posts.) After the initial determination, subsequent medical clearances are updated every two years or at the end of a tour, unless the individual requires a medical evacuation to the United States or a change occurs in an individual's medical condition that could affect the status of his or her medical clearance. Foreign Service personnel update their medical clearance status by completing a Medical Clearance Update form (DS-3057) and, if they wish, may then undergo a physical examination at the examination clinic. In recent years, few have taken advantage of this opportunity.

The clearance process begins when an applicant is provisionally accepted for employment and receives a Medical History and Examination for Foreign Service form (DS-1843) and an Authorization for Medical Examination form (DS-3069). A prospective employee who lives more than 50 miles from MED completes the form and visits his or her primary care physician, who gives the employee a physical examination, a set of required screenings including blood work, and a chest X-ray and/or mammogram. The results are then given to the employee to return to the Medical Clearance Division in Rosslyn, VA. Prospective employees who live within 50 miles of MED complete the DS-1843 and receive physical examinations and screenings at the MED examination clinic in SA-1.

Physical examination and screening test results are sent to MED's Medical Records Branch, which creates an electronic medical record, scans the data into the record, and alerts staff in Medical Clearances that the record is ready for review. The population of prospective hires tends to be relatively young and in good health. If the requisite information is available and unremarkable, a Medical Clearance nurse can recommend a Level 1 clearance. If information from the history form, physical examination, or screening tests indicates a potential concern, Medical Clearance nurses may confer with a MED physician and notify prospective hires of any need for additional testing, documentation, or consultation with a medical specialist.

Some prospective employees have complained about the timeliness of the clearance process, and MED's clearance staff has reported significant delays associated with the creation of electronic medical records by the Medical Records Branch. MED blamed the delays on delays by the Bureau of Human Resources (DGHR) in creating the electronic personnel records that the medical records depend upon. No data was available at the time of the inspection regarding the average time required to complete this process.

The clearance staff said its location in Rosslyn, when the consultative physicians are at SA-1, contributes to delays in the clearance process for new employees, delaying their entry on duty date. This requires the clearance staff to contact the physicians by telephone, which is often difficult because of the physicians' clinical duties. Many staff members said that, when the clearance office was colocated with the consultative physicians, as it had been, they could contact physicians more quickly and obtain consultations more efficiently.

**Recommendation 2:** The Office of Medical Services, in coordination the Bureau of Human Resources, should evaluate the timeliness of the clearance process, specifically the time required to create electronic personnel and medical records and the additional staff hours required as a result of the geographic separation of the clearance staff and the consultative physicians, and develop and implement a plan to improve timeliness. (Action: MED, in coordination with DGHR)

## Data Integrity

The clearance process for most new hires does not include verification of the data on an employee's DS-1843, where the disclosure of information depends on a new hire's forthrightness. Because most prospective employees hand-carry their DS-1843 and screening test results from their physicians to MED, the integrity of this information is vulnerable to compromise. MED provided OIG with data indicating that 11 of 48 mental health medical evacuations carried out during the past year involved employees or family members who, it was subsequently determined, had not been forthright in completing their DS-1843s. The DS-1843 states that "intentional omission of any crucial medical information is a criminal offense" and that "[p]re-employment applicants who intentionally omit information which would make them ineligible for appointment will be subject to disciplinary action, including separation for cause." However, OIG was not provided with evidence

that the Department referred these matters to OIG for investigation or DGHR for disciplinary action or had held those involved financially or administratively accountable for the medical costs incurred as a result of these omissions.

**Recommendation 3:** The Office of Medical Services should inform Department employees of the disciplinary actions that can be taken when there is an intentional omission or falsification of critical medical clearance data. (Action: MED)

**Recommendation 4:** The Bureau of Human Resources should establish procedures to ensure that employees who intentionally omit crucial medical information on form DS-1843 are subject to the appropriate referrals and disciplinary action, including reimbursement for medical costs. (Action: DGHR)

## OVERSIGHT/SUPERVISION OF OVERSEAS STAFF

MED clinicians report that the population they serve is relatively healthy. Although MED clinicians occasionally treat maladies that would be uncommon in the United States, such as malaria, the majority of visits to overseas health units are for common conditions such as nasal congestion, diarrhea, and anxiety. The significant differences from providing care in the United States are the local logistics and level of health care resources available in each country where MED has a health unit. At some posts in Western Europe, RMOs and FSHPs largely provide triage and referral. Conversely, at posts in remote or undeveloped nations, RMOs, FSHPs, and locally hired nurses serve as primary care providers and may be the only health care professionals in the area. There may also be a need to transport the patient to one of MED's medical evacuation sites (Pretoria, Singapore, Florida, and London) due to a patient's condition or the unavailability of local resources (e.g., an orthopedic specialist to set a broken arm or the safety of the hospital blood supply).

### Clinician Employee Evaluation Reports

The regional medical manager is a newly established MED position, and there is some confusion among the RMOs and FSHPs regarding the oversight duties of regional medical managers. The position description for the regional medical

managers says they have responsibility for quality improvement activities in their regions and are expected to evaluate and document the performance of RMOs and FSHPs.

In practice, the regional medical manager performs an informal evaluation of these employees because, at most posts, the clinician's employee evaluation report is written by the post management officer or deputy chief of mission. (The exception involves posts where an RMO and FSHP are colocated; there, the RMO becomes the rating officer for the FSHP for both medical and administrative matters.) Regional medical managers are not required to serve as the rating officer and to write part of the report that evaluates an RMO, and RMOs are not required to serve as the rating officer and to write part of the report that evaluates an FSHP or locally hired nurse.

Since a considerable portion of MED's provider activities are clinical, and nonclinical administrators do not have the qualifications needed to adequately assess clinical skills, the employee evaluation reports are limited to a review of administrative matters and do not serve as a comprehensive assessment of clinician performance. In addition, because a supervisory clinician is not required to contribute to the employee evaluation report, MED has diminished capability to promote collaboration and accountability, sustain an advisory function, or promote communication between Washington, DC, and the regional bureaus and remote posts.

RMOs are responsible for providing guidance, assistance, and advice to the health units in their regions, including assessing medical care and reviewing local medical and health conditions. However, when RMOs, including RMO psychiatrists (RMO/P), visit posts, they have no consistent guidelines regarding what indicators of health unit operations should be examined. (For instance, are they supposed to examine supplies, environment of care issues, delivery of care issues, or conduct a clinical chart review or use a combination of these factors?) As a result, MED may not always get the most benefit from the visit of a regional medical manager, RMO, or RMO/P.

**Recommendation 5:** The Office of Medical Services, in coordination with the Bureau of Human Resources, should revise the clinician employee evaluation reports to include a critical element on the employee's clinical skills to be rated by the appropriate regional medical officer or regional medical manager. (Action: MED, in coordination with DGHR)

**Recommendation 6:** The Office of Medical Services should establish guidelines for the site visits of the regional medical manager, regional medical officer, and regional psychiatrist to ensure consistent evaluation of health unit functions and should include in the guidelines specific indicators regarding the quality and environment of care being provided. (Action: MED)

## Peer Review

MED does not have a formal peer review process. According to the American Academy of Family Physicians, an effective peer review mechanism is an essential part of quality health care delivery. For meaningful peer review to occur there must be adherence to certain basic concepts. Peer review should also assess the quality of care rendered. Peer review does not aim to single out and discipline clinicians for human error but to shift the curve of overall clinical practice to a higher level of quality. Peer review should result in improved patient care by improving the physician and health practitioner's education and health system. Although standards of care should be uniform within a health care system, policies for reviewing patient care should be established that account for local needs, circumstances, and considerations. Sustained participation in the peer review process would provide MED with objective data to better assess care and make changes that affect practice patterns across the range of settings where MED clinicians provide care. Peer review results could be incorporated into the periodic re-credentialing and re-privileging process. Without a formal peer review process, MED has limited ability to objectively evaluate the delivery of care to overseas posts.

**Recommendation 7:** The Office of Medical Services should institute a formal peer review process for all health care providers engaged in direct patient care. (Action: MED)

## Practice Guidelines

MED does not have formal practice guidelines for assessing and managing common conditions found in its patient population. Practice guidelines make specific recommendations to clinicians on how to diagnose and treat such conditions as diabetes, osteoporosis, and hypertension. Practice guidelines attempt to replace potentially idiosyncratic or dated practice patterns with evidence-based clinical decisionmaking processes. Well-designed guidelines are a starting point for

improvement, not a definitive formula, and can help establish treatment consistency across a system of care, although they may need to be adapted to posts' resources. MED's implementation of formal practice guidelines would reinforce consistent use of evidence-based practices, augment the peer review process by providing independent criteria for review, and ensure that disease-specific management is consistent across posts that have similar resources.

**Recommendation 8:** The Office of Medical Services should implement formal practice guidelines to ensure consistency in the quality of health care delivery system-wide. (Action: MED)

## PRIVACY AND CONFIDENTIALITY OF MEDICAL INFORMATION

### The Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), which took effect in April 2003, encourages electronic transactions and requires new safeguards to protect the security and confidentiality of health information. However, MED does not fully comply with HIPAA standards regarding mandatory employee training and the requirement for a written employee privacy procedure. The Department's Notice of Privacy Practices is available on the MED website, and MED employees are asked to sign a receipt for the notice. In addition to providing privacy protections for patients, such as the Notice of Privacy Practices, HIPAA mandates that covered entities must take additional administrative steps to protect privacy. For instance, these entities must have written privacy procedures for staff, designate a privacy officer responsible for ensuring that procedures are followed, take disciplinary action when procedures are not followed, and train employees in privacy procedures.

MED has a designated privacy officer, and potential breaches in the privacy of protected health information are addressed in meetings of its risk management committee. However, although some informal employee training sessions have been offered at health units, MED does not conduct uniform, scheduled, mandatory HIPAA training sessions for new and existing employees. In addition, although MED provides verbal and informal training, MED was unable to provide OIG with

any written policies and procedures for MED employees on the proper handling and securing of medical records. As a result, MED cannot ensure that all MED employees have received formal training on the procedures for the use and disclosure of protected health information.

**Recommendation 9:** The Office of Medical Services should establish mandatory Health Insurance Portability and Accountability Act training sessions for new and existing employees. (Action: MED)

**Recommendation 10:** The Office of Medical Services should develop written policies and procedures for the use and disclosure of protected health information. (Action: MED)

## Maintaining Separate Patient Files

MED's management and the director of Mental Health Services said there were instances where RMO/Ps at posts have kept separate files or notes on their patients that were not included in the medical record. Medical records of employees are protected under the Privacy Act of 1974, as amended (5 U.S.C. § 552a). The records must be maintained in the State-24 records system. According to the Department Notice for that system, "all records containing personal information are maintained in secured file cabinets or in restricted areas, access to which is limited to authorized personnel." If these records are maintained in a physician's desk or personal work area, they are not being maintained properly.

The Privacy Act, at 5 U.S.C. §552a(d)(1-2), gives the patient the right to access his or her records and to make copies and request that the record be amended. Individuals whose records are maintained in a physician's personal space, and not in the official medical record, may be denied these rights because the Department may not know that the records exist or where they are maintained. In addition, by not having control over the records, the Department cannot monitor the release of the records, as required under Section 552a (c), and problems with retention and disposal of the records could arise.

**Recommendation 11:** The Office of Medical Services should require that all records containing patients' personal information are properly maintained in the State-24 records system. (Action: MED)

## Mental Health Examinations

OIG received allegations that MED improperly shields information that is used to make recommendations to the Bureau of Diplomatic Security (DS) on security clearance eligibility. In reviewing the process, OIG found that adjudicators in DS may refer cases to MED, asking for an opinion as to whether an employee is eligible for a security clearance under the provisions of Executive Order 10450. Some of these provisions require medical review and DS's authority to make such referrals is delineated in 12 FAM 232.3-3. When a case is referred, one or more clinicians from MED will review the information provided by DS, request additional information or testing as needed, and perform an independent medical evaluation for the Department. Information gathered during this process is kept separate from the official medical record. Under this process, no protected health information from either file (the official record and the separate file for this review) should be shared with DS. MED makes its recommendations by checking the appropriate box on a standard form that contains no protected health information. The documents generated as part of this independent medical examination are appropriately maintained in a secured area in MED and are available to employees through the Privacy Act or Freedom of Information Act in the same way regulated medical records are. OIG informally recommended that MED clearly define the processes under which patients obtain copies of their medical records and make that information easily accessible to all employees.

## ELIGIBILITY FOR SERVICES

The Department has issued a number of instruction cables on the policy and regulations regarding eligibility for the overseas medical program. The cables have explained the authorities under which the medical program operates (04 State 036783), emphasized post management's responsibilities for ascertaining employment status and eligibility for overseas medical services (04 State 158214), and described the eligibility requirements and limitations for U.S. citizen contractors (04 State 201464).

In emergencies and exceptional circumstances, the chief of mission has the authority to determine that a person in need can receive medical treatment at the embassy health unit. Exercise of this authority is limited to a one-time basis and must be reported to the medical director, who reports the exception to the Under

Secretary for Management. This standard applies to persons who would not normally be eligible for treatment in a U.S. government facility, as detailed in 05 State 002398.

A memorandum of understanding between the Department and the Peace Corps will allow short-term or emergency medical care to be provided through implementing instruments at individual posts. In the case of the Department, the staff of embassy health units will serve Peace Corp volunteers and trainees. In the case of the Peace Corps, Peace Corps medical officers will serve those eligible to use the embassy health unit. The memorandum is being discussed, and a final agreement was expected before the summer of 2006. Individual posts are expected to implement the memorandum in those situations where reciprocal coverage is needed on a short-term or emergency basis.

The memorandum will be implemented only where the chief of mission and the Peace Corps country director determine implementation is necessary to provide adequate coverage of embassy and Peace Corps personnel; the memorandum will not adversely affect the ability of each agency to adequately serve its own community. Any reimbursement of costs under the memorandum will be determined on a post-by-post basis and specified in the post's implementing instruments.

**Recommendation 12:** The Office of Medical Services should implement the memorandum of understanding between the Department and the Peace Corps at all posts where reciprocal medical coverage is appropriate. (Action: MED)

# RESOURCE MANAGEMENT

## MEDICAL SERVICES WORLDWIDE RESOURCES

Providing worldwide medical services is a unique, complex, and costly operation for the Department and involves 343 employees and total medical-related costs of almost \$130 million. Table 1 summarizes the worldwide cost and staff

<b>Table 1: FY 2005 Activities and Funding</b>	
<b>Major Activities by Account</b>	<b>Funding</b>
ICASS funds, Washington based medical service <sup>1</sup>	\$20,439,000
Diplomatic & consular program funds, <sup>2</sup> Washington based	\$23,797,000
American salary costs, <sup>3</sup> Washington based	\$10,548,000
IRM funds for electronic medical records, Washington based	\$3,675,000
Worldwide security upgrades <sup>4</sup>	\$2,170,000
Iraq operations	\$55,000
<b>Subtotal, Washington based</b>	<b>\$60,684,000</b>
Salary costs for Foreign Service officers, overseas <sup>5</sup>	\$24,850,475
Overseas health units (includes ICASS costs)	\$44,291,139
<b>TOTAL Worldwide Cost</b>	<b><u>\$129,825,614</u></b>

allocations for the Department's medical program. No one central point manages all the resources, and funding comes from the Bureau of Resource Management (RM), the International Cooperative Administrative Support Services (ICASS) system, the regional bureaus, and MED. The budget for MED in Washington is \$60.7 million, and its staffing totals 197. Costs for the 192 overseas health units include \$24.9 million for 146 American salaries that are centrally held in RM and \$44.3 million funded for health units at posts involving ICASS funds.

<sup>1</sup> Includes funding of \$4.8 million for a nonrecurring purchase of Tamiflu.

<sup>2</sup> Includes \$14.6 million for medevacs/hospitalizations/clearance exams.

<sup>3</sup> Civil Service and Foreign Service

<sup>4</sup> Provides funds for emergency medical preparedness at overseas posts, such as chemical/biological antidotes and alternate medical site kits.

<sup>5</sup> The salary cost for Foreign Service medical personnel based overseas with 15 percent estimated for allowances that include cost of living adjustment, post differential, and danger pay.

RM budgets for the costs of all American Foreign Service employees, RMOs, psychiatrists, nurse practitioners, physician's assistants, and medical technologists who are posted overseas, including their salaries and benefits. Additional support costs, such as those for housing and utilities, are paid by each post's ICASS budget. An ICASS council at a post may decide to hire additional staff locally for the medical unit. In such cases, MED approves the credentials of the proposed new-hire, but the position is funded by the post's ICASS budget. As part of its continuing medical education program, MED provides training funds for one locally employed staff member per post.

Requests for new American Foreign Service overseas positions that are centrally funded are initiated by posts and forwarded to MED for consideration. After consultation with the regional bureau, MED submits the position requirement as part of its budget request to RM. Once approved, the position and its funding is transferred by RM to the regional bureau involved and the position becomes a bureau position not a MED position. Only domestic positions are counted against MED's domestic full-time equivalency staffing count. This process of managing medical personnel is cumbersome, and MED is reviewing changes to make it more efficient.

In previous years, MED secured supplemental funding for the MED emergency preparedness program, including funding to prepare for a possible avian influenza pandemic. In addition, over the last five fiscal years more than \$27.5 million has been obligated to establish an electronic medical records system in MED. Funding for these programs has not been made a part of MED's recurring budget, however.

## Funding Regional Medical Positions

A recurring ICASS issue is how to distribute the costs for regional medical positions, which may cover one post or as many as six posts. Post ICASS councils, seeking ways to reduce their ICASS costs, continue to question why individual agencies must pay full support costs for these regional medical positions, since their service is spread between the post of assignment and constituent posts. This issue has been brought to the attention of the ICASS Working Group, which believes there is insufficient benefit derived from the cost of tracking workload, billing agencies at numerous posts in a given region, and allotting funds to a regional post. The cost of changing the software and setting up new procedures is also not cost effective, and doing so would not address the real concern of regional posts because the RMO still travels and is not full time at the home post. The ICASS Service Center also believes that agencies located at the regional hub generally are also located at the posts serviced by the hub's RMO.

## OFFICE OF THE EXECUTIVE DIRECTOR

There are four branches in MED’s Office of the Executive Director: human resources, financial management, logistics management, and medical informatics. The positions are overseen by the executive director and the deputy executive director. The executive office has 56 full-time employees and 35 contractors and a budget of \$60 million for Washington-based medical services. The responses of MED staff to OIG’s management operations questionnaire indicated that the office does very well in responding to customer requests, but that improvements could be made in the expendable supply program and the employee awards program. The executive office is reviewing both programs to determine what improvements should be made.

The office’s executive director, a Foreign Service officer who has been in the position for six months, is well versed in the nuances of the job and dedicated to customer service but is also looking for ways to reduce costs. She brings a fresh look to management operations as well as the ideas and energy to make positive changes. The deputy director is a Civil Service employee who has over 30 years of experience in administrative positions in the Department. Her corporate memory and personal commitment to the office are a good match with the executive officer, making for a strong management team. The office’s sections are well managed. The office’s chief challenge is medical informatics and its role in the development and implementation of an electronic medical records system. The director and deputy are committed to resolving the problems in this area and are hiring a new branch chief for the Medical Informatics Branch.

**Table 2: FY 2005 Staffing, Authorized and Actual**

<i>Staffing</i>	<i>Author-ized</i>	<i>Actual</i>
Civil Service	89	95 including eight part-time Civil Service employees
Foreign Service, Washington based	29	27, including three regional medical manager positions (Brussels, Fort Lauderdale, Johannesburg) and a “Y tour” position (usually a Foreign Service Officer on a one-year tour)
<b>Subtotal for full-time staff, Washington</b>	<b>118</b>	<b>122</b>
Contractors		49
Contractors (part-time)		4
Temporary, while actually employed		22 (but only about six are active in any given year)
<b>Total Washington Staff</b>	<b>118</b>	<b>197</b>
Foreign Service overseas	150	146 (part of regional bureaus’ staffing, not that of MED)
<b>TOTAL Staff</b>	<b>268</b>	<b>343</b>

## REENGINEERING FOR FUTURE COST SAVINGS

The President's Management Agenda requires federal agencies to explore ways to minimize costs while enhancing performance and service. The Bureau of Administration's Office of Global Support Services and Innovation provides guidance to the Department on developing cost savings and reengineering business processes. MED is using this guidance to review costs in two areas. One area is to use a Department of Defense contract to purchase pharmaceuticals and medical supplies. The second is to identify savings that could derive from outsourcing, under which a function is provided by a commercial source, and competitive sourcing, which defines the most efficient organization.

### Use of an Alternative Supply Source

MED is reducing costs by developing a contracting source to purchase pharmaceuticals and medical supplies, the Defense Supply Center Philadelphia's Prime Vendor Program. MED began using Prime Vendor in April 2005 and to date has saved \$63,525, a 20-percent savings. Individual savings on items may go as high as 50 percent. For example, Tetanus vaccine costs \$137 per vial from Prime Vendor, compared to \$352, and surgical gloves cost \$169 per 100 using Prime Vendor, compared to \$205 from other commercial sources. The turnaround time is one to two days from Prime Vendor, compared to two to three weeks using other sources. The question is whether this program can work effectively for overseas operations and provide similar savings.

To assess that question, MED and the Office of the Procurement Executive (OPE) are conducting a pilot study on the use of Prime Vendor. The study is one of OPE's strategic source review initiatives, required by the Office of Management and Budget in FY 2005 and will assess the impact of cost and transportation savings. The Department uses commercial carriers, not military air carriers, and Prime Vendor's ability to transport to posts supplies that have a limited usable shelf life is a concern. All the effects of the program need to be analyzed for posts to know what to expect and how to use Prime Vendor. The medical supply pilot is being tested at embassies in La Paz, Mexico City, and Jakarta. The pharmaceutical pilot is being tested at Consulate General Hong Kong and embassies in Doha, Almaty, Port of Spain, Conakry, and Prague. An assessment will be made at the end of FY 2006 to determine how the Department can maximize Prime Vendor's benefits.

## Using Commercial Sources for Services

Another area where MED could achieve savings is in outsourcing clinical and administrative services. For example, MED is closing its radiology services after an in-house study showed savings of about \$346,000 per year could be gained by using local health care companies. Other services provided by MED in-house may be good candidates for outsourcing. MED is reviewing laboratory services for outsourcing, as indicated in the Fair Act Inventory completed by the office in FY 2005, but has not yet begun a review of its Occupational Health Unit. The examination clinic, which has 16 employees and an average examination workload of four patients per day per provider, is another area that should be reviewed by MED. Although the clinic's workload varies, it is a discrete unit with functions that have the potential to be successfully outsourced. Lastly, the Medical Informatics Branch, with a staff of 12 full-time employees and 40 contractors, performs functions that are readily available through commercial sources.

Other potential savings could be derived from imposition of a fee-for-service program, where insurance companies would be charged each time an employee uses a health unit. A contractor could be used to evaluate the cost benefit of outsourcing and to implement a fee-for-service program. At present, the Department absorbs all costs of health unit visits, some of which may be payable by insurance companies. Presently, the U.S. government is paying for health insurance coverage for employees, but not charging these insurance plans for covered medical care. There are a number of legal and insurance issues that the Department would have to resolve to make its health units eligible for insurance claims, but the long-term savings could be very significant as health care costs continue to increase.

**Recommendation 13:** The Office of Medical Services should review its laboratory services, and, if it is determined that outsourcing would be a cost-effective alternative, take action to implement a fee-for-service program. (Action: MED)

**Recommendation 14:** The Office of Medical Services should review its occupational health services, and, if it is determined that outsourcing would be a cost-effective alternative, take action to implement a fee-for-service program. (Action: MED)

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**Recommendation 16:** The Office of Medical Services should review its medical informatics services, and, if it is determined that outsourcing would be a cost-effective alternative, take action to implement a fee-for-service program. (Action: MED)

**Recommendation 17:** The Bureau of Resource Management, in coordination with the Bureau of Administration and the Office of the Legal Adviser, should review the impact of a fee-for-service program on the use of medical services, seeking to learn whether implementation would be feasible and cost effective under the law. (Action: RM, in coordination with A and L)

## Reimbursements for Overseas Hospitalizations

The Department guarantees full payment for the overseas hospitalizations of Department employees and eligible dependents. The embassy's full-payment guarantee expedites hospitalization, eases the immediate burden on the employee, and is accepted by local care providers worldwide. Upon completion of care, employees receive the bill for services and file a claim with their insurance company. The employee deposits the insurance reimbursement check with the post cashier.

In 2004, overseas hospitalization costs totaled \$4.8 million and in 2005 rose to over \$8 million. As of March 2006, MED has collected for FY 2004 over \$3 million from insurance companies for employee overseas hospitalizations and, \$1.8 million remains uncollected. At present, only one MED employee is assigned to ensuring cost recovery for overseas hospitalizations. The workload prevents that employee from reviewing insurers' explanations of benefits documentation to ensure accuracy of employee billing and insurers' reimbursements. MED could thus be missing opportunities to identify and enhance its health care cost-recovery effort.

**Recommendation 18:** The Office of Medical Services should assess overseas hospital reimbursements and take steps to increase reimbursements from insurance companies. (Action: MED)

## HUMAN RESOURCES

MED's Human Resources Branch is customer-service oriented, and MED employees rate its staff as user friendly. The branch has two full-time human resources specialists, one part-time specialist, and one human resources assistant. It provides general human resources management services for 122 domestic employees and works closely with DGHR during the selection and assignment of overseas medical personnel. The human resources staff provides good oversight for work requirements and employee evaluations. However, weaknesses exist in the time and attendance approval process. This issue is further discussed in the Management Controls section of this report.

### Recruitment and Retention

MED has been seriously challenged in recruiting and retaining well-qualified employees. Position grades have not always been competitive with similar positions in other government agencies nor have salaries been competitive with the private sector. MED has been working to address this problem, and some positions have already been upgraded, while others are pending a decision by DGHR. The executive office has instituted weekly briefings to keep senior-level management informed of recruitment and retention issues so that problems can be addressed quickly. MED has made excellent use of the Department's upward mobility program in filling positions, as well as in hiring worker trainees under Washington, DC, training programs.

### Overseas Assignments

MED is responsible for assigning approximately 150 Foreign Service medical specialists in 192 health units or regional offices overseas. Medical specialists bid on positions through the open assignments process. Once the bids are received, MED's senior management makes the selection and submits the information to DGHR to finalize the assignment.

Although MED makes the assignment decisions, it does not “own” the positions. Medical positions overseas, except for the three regional medical manager positions, are owned and funded by the regional bureaus. For the most part, MED, the regional bureaus, and DGHR work collegially to ensure that medical positions are assigned effectively and efficiently. However, this arrangement limits MED’s ability to reassign medical positions within and between geographic regions to meet the changing needs of the service.

At present, 80 percent of MED’s overseas positions are assigned to hardship posts. With the Secretary’s new Transformational Diplomacy Initiative, the number of hardship assignments will most likely increase, making recruitment and retention of medical professionals more difficult. The need to move medical positions between regions will also pose a challenge.

## Time-In-Class Limits for Foreign Service Health Practitioners

The Foreign Service time-in-class requirements are threatening to further deplete an already sparse group of FSHPs. The average age of incoming FSHPs is 47.5 years. FSHPs normally join the service as second careers and take a pay cut, opting instead for the travel and the challenge of serving abroad. In 10 or 15 years, these employees will be forced out of the service because of time-in-class restrictions. Currently, three of MED’s most experienced senior FSHPs will soon be forced to retire due to the time-in-class rules. In 1999, when MED was having problems recruiting qualified physicians and psychiatrists to meet the needs of the service, DGHR granted all senior Foreign Service physicians and psychiatrists an exemption to the time-in-class rule and granted a 30-year time-in-service career potential for medical specialists who are reaching the senior ranks. At that time, there were no FSHPs at the senior level, and therefore FSHPs were not included in this exemption.

In a memo to DGHR in November 2005, MED requested that FSHPs receive the same exemption from the time-in-class requirement as physicians and psychiatrists. At the time of the inspection, DGHR had not made a decision. Despite its aggressive recruitment efforts, MED continues to struggle to attract well-qualified FSHP candidates for jobs that are often in remote and medically austere environments.

There will be increasing demands for medical providers at hardship posts because the Secretary's Transformational Diplomacy Initiative will increase the customer base at several such posts. Extending the time-in-class exemption to include FSHPs would support MED's ability to meet the Secretary's initiative and provide for critical Foreign Service needs.

**Recommendation 19:** The Bureau of Human Resources should grant Foreign Service health practitioners an exemption to the time-in-class and time-in-service rules. (Action: DGHR)

## Orientation Program

MED provides a comprehensive six-week orientation program for its Foreign Service medical officers. This session includes three weeks of FSI training that encompasses general Foreign Service courses and three weeks of training in MED on how to manage the medical program overseas, all in addition to medical-related courses at the Bethesda Naval Hospital. Participants found the orientation very useful. MED's standard orientation program for domestic employees consists of a mandatory two-week course at FSI and a welcome kit with pertinent information. A checklist directs the employee to meet for a briefing with the medical director and key officials in the executive office. Participants in these activities offered OIG mixed assessments of them, which may indicate a need for some improvements. OIG informally recommended that MED review the domestic orientation program.

## Training

MED's training program has been designed to address the needs of medical and nonmedical staff. Training for medical professionals focuses on medical conferences and specialized courses to fulfill the employees' continuing medical education requirements. In addition, MED has a formal mentoring program in which every new medical professional is assigned a mentor to provide advice and guidance during the new employee's first year overseas. MED allocated \$129,000 for training in FY 2006, representing \$1,000 for each full-time equivalent position in Washington, DC.

In 2005, MED attempted to implement a program to obtain certification for the occupational health nurses. The program was extensive and involved enormous costs and was stopped. Smaller steps are being taken this year towards the certifi-

cation goal, with MED allocating \$20,631 for occupational health nurses to attend continuing medical education courses. To better manage its training program, MED has drafted its training processes in preparation for implementation of the ISO 9001 standard.

## Equal Employment Opportunity

Most employees expressed confidence in MED's attention to Equal Employment Opportunity (EEO) matters and rated EEO second highest on OIG's management questionnaire. However, MED has not had an EEO counselor for the past two years. On the questionnaires and in interviews, employees in two MED offices alleged instances of a hostile working environment. To prevent and address any potential EEO issues, MED should develop a more pronounced and proactive program that enforces zero tolerance for discrimination and harassment. During the inspection, MED initiated actions to select an EEO counselor and to issue guidance on maintaining a professional and collegial work environment. OIG informally recommended that MED require all managers to attend appropriate EEO training.

## FINANCIAL MANAGEMENT

During the tenure of the current supervisory budget analyst, MED's annual budget has grown from around \$15 million to \$60 million. The mix of medical funds with those of the Department, bureaus, and ICASS presents MED with a complex challenge. The Financial Management Branch's supervisor has a staff of 12 in two sections, Reimbursements and Claims. During his eight years in the office, the supervisor has designed systems to maintain internal controls for an operation that both spends and collects funds. The office collects between \$4 million and \$6 million annually in reimbursements for hospitalizations from private insurance companies. The section also prepares all billings for overseas hospitalizations for other agencies. The reimbursement issue requires detailed work from employees with experience in hospital billings and is discussed in the Management Controls section of this report. The Reimbursement Section received high marks on OIG's management questionnaire for processing travel vouchers.

The hiring of qualified financial staff has been an issue for MED. The supervisory analyst is at a pay grade that may not reflect the new requirements and responsibilities in the finance area, and the supervisor's lower grade means that the budget analyst cannot be upgraded. Furthermore, qualified candidates cannot be recruited

at the current pay grades. As a result, MED has not filled vacancies and instead has trained employees in-house. Several qualified individuals have been promoted within this system, but they have no incentive to stay when they can take higher pay grades in other bureaus. OIG informally recommended that MED request a classification review of the positions in the Financial Management Branch to ensure they reflect the current levels of responsibility.

## Logistics

The logistics management officer has been in MED for 18 months, following a long career as a logistics officer in the U.S. Navy. The staff of six in the Logistics Branch provides all the logistical support, mail, supplies, and contracts to MED/Washington. On OIG's management operations questionnaire, MED employees gave high marks to the office for maintenance and mail service, but improvements are needed in expendable supplies.

MED's Logistics Branch is a leader and pioneer in the use of the Prime Vendor contract. The logistics officer's interaction with posts on how to save money when ordering pharmaceuticals and medical supplies is important. For example, while attending a conference for general services officers, the logistics officer interacted with others who saw how the Department could use Prime Vendor. He has also initiated contracts in Washington, DC, to streamline procurements for laboratory services. Logistics is an area where improvements always can be made, and the officer's leadership is a valued asset.

## Medical Informatics

Information management and information systems security are handled by the Medical Informatics Branch, which has 12 full-time employees and 40 contract employees. The branch has three sections: Medical Records, Clinical Services, and Systems. Medical Records handles the registering, scanning, indexing, and quality assurance of medical documents received externally in support of an employee's medical records. Clinical Services provides educational and training modules on MED applications. The Systems Section manages the operations, network, data, and web responsibilities of domestic and overseas MED employees, including the development and implementation of MED's electronic medical records system.

On OIG's management operations questionnaire, the Medical Informatics Branch received high scores in its use of the Internet. The section chief's position is currently vacant, and its responsibilities have been temporarily assumed by the

deputy executive director. MED had the position reclassified from Foreign Service to Civil Service at the GS-15 level and included requirements in it for expertise in information technology and medicine. The Office of Personnel Management has just advertised the position, which will provide MED with the expertise and continuity essential to the management of information technology for the office.

## INFORMATION MANAGEMENT AND INFORMATION SYSTEMS SECURITY

OIG identified several key areas where information management and information systems security could be improved to ensure effective and efficient management of MED operations. Specifically, the information systems security officer (ISSO) responsibilities are not being performed in compliance with Department regulations, and all of the requirements for the claims database have not been completed. MED is establishing, but has not completed, a local change control board (CCB) to ensure that unapproved hardware and software are not installed on its networks and that sensitive information is not inappropriately shared with the public. Also, the development and implementation of the electronic medical records system must be reviewed to determine its functions within MED. At present, there are two separate systems, one for domestic medical records and one for overseas medical records.

### Information Systems Security Responsibilities

ISSO responsibilities are not being performed adequately. Neither the primary nor the alternate ISSO in the Medical Informatics Branch have performed information systems security duties consistently, as required by 12 FAM 622.1. Currently, the two individuals perform ISSO duties along with other job functions, and only minimum ISSO requirements are being performed. For example, there are no random checks to ensure that users are appropriately processing Privacy Act information, and systems maintenance and audit logs are not reviewed consistently.

MED recognizes that its performance of minimum ISSO requirements is insufficient and has set a goal of increasing information systems security efforts. However, a MED representative said the amount of time that will be dedicated to performing ISSO duties depends on other job responsibilities. MED has not designated and trained additional individuals to serve as alternate ISSOs, who

would provide additional resources for performing these duties. By training additional staff, MED could divide the duties among several individuals to ensure that more than minimal ISSO requirements are being performed. Without adequate performance of ISSO duties, MED cannot ensure that its applications and networks are protected from physical and technical threats. OIG made an informal recommendation on this issue.

## Claims Database

MED has not completed all of the refinements necessary to improve its claims database, which its claims staff uses to process payments for authorized medical services provided in the United States. The staff processes itemized bills for authorized physical examinations, specialist evaluations, and approved inpatient/outpatient treatments.

The medical informatics staff identified requirements to develop the claims database. However, only half of those requirements were included in the database, and this has caused several items to need action by the Medical Informatics Branch. For example, the printing function is slow and cumbersome. It is also difficult for staff to search for approved claims since claims numbers are not printed on the vouchers. When such problems are experienced simultaneously, they can create delays in claims processing. The claims staff was told by Medical Informatics and the executive office that the issues would be resolved after the staff deployed its upgraded version of the domestic electronic medical records system. OIG made an informal recommendation to resolve these issues.

## Local Change Control Board Process

MED's CCB will ensure that unapproved hardware and software are not installed on its networks and that sensitive information is not inappropriately shared with the public. During interviews, OIG learned of instances where staff members and management were contacting vendors for product purchases or were considering products that had not been approved. Under 5 FAM 860 and 12 FAM 622, MED is responsible for establishing a local CCB to ensure that any hardware, software, or component installed on the network does not adversely affect the existing information technology infrastructure. Further, the local CCB must approve all information systems that process or store medically privileged information that is protected under the Privacy Act of 1974. Without an adequately managed local CCB process, MED is vulnerable to unprotected sharing of the sensitive information on its networks.

**Recommendation 20:** The Office of Medical Services should develop local change control board procedures that include steps to be followed for approval of hardware and software on its networks and the process for sharing and storing medically privileged information. (Action: MED)

**Recommendation 21:** The Office of Medical Services should implement and inform staff of actions to be taken in response to staff members' failure to comply with local change control board procedures. (Action: MED)

## EMed and OMed

The development of an electronic medical record system for MED has been time consuming and difficult. The move to electronic medical records is a trend extending throughout the health care industry, but all health care providers have struggled to develop a system for their unique needs. MED needs a system that works domestically and overseas, including in remote geographical areas. MED implemented one domestic system, EMed, and a separate overseas system, OMed, in 2002 and 2004, respectively. With EMed and OMed, MED hoped to achieve a more efficient medical process and better patient care by making electronic medical records available regardless of location. However, the two systems, which cost MED approximately \$27.5 million, cannot interact, which limits their current and potential usefulness.

After the deployment of EMed and OMed, MED experienced numerous difficulties. For example, MED's help desk received a significant number of calls from EMed users. Examination of a list of MED help desk calls from November 2005 to February 2006 shows that, of the more than 900 calls, more than 500 dealt with EMed. Users reported problems with documents appearing blank, duplication of records, and patient information and images that were not viewable. MED also received negative feedback regarding OMed from overseas users. The problems included absences of medication and allergies lists, inability to view old notes, and the absence of immunization and vaccination charts.

In addition to users' complaints, the Department identified (b) (2)(b) (2) (b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2) (b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2) (b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)

The upgrade included in-house reprogramming of EMed's application code and increasing its text field size and providing it with enhanced search capabilities. The upgrade project does not include modifications to OMed, however. EMed Version 2.0 was scheduled for deployment at the end of April 2006.

## Lack of Effective Project Planning and Information Technology Management

MED has not successfully managed the development and implementation of EMed and OMed, under the guidance set forth in 5 FAM 620, Managing State Projects. Managing State Projects provides a logical approach to developing and implementing high-visibility information technology projects that cost more than \$500,000 and have a life cycle exceeding one year. A key to successful information technology projects, Managing State Projects' methodology, identifies steps on defining requirements, identifying risks and technical feasibility, performing cost-benefit analysis, preparing a project plan, and setting clear performance measures.

According to MED management, the development of the electronic medical records system did involve requirements analyses, risk assessments, and cost-benefit analyses. However, MED was unable to provide OIG with project documentation or with requirements analyses that defined the user, system, technical, and security requirements for the project. Similarly, risk and technical feasibility assessments, cost-benefit analyses, and performance measures could not be found. MED's staff spent weeks locating required project documentation and eventually located several versions of it. A MED representative said planning occurred during regular meetings with the medical director and Medical Informatics staff. However, during development, MED had four chiefs of the Medical Informatics Branch, which was then a Foreign Service position, and one company working on the development went bankrupt. These disruptions contributed to delays, as did piecemeal funding for the overall project. Furthermore, the changing needs of the clinical staff led to revisions. Nevertheless, having a comprehensive project plan that could be updated and revised in response to changes would have assisted the development.

The absence of a long-term information technology project manager within the Medical Informatics Branch has also contributed to delays in development of the electronic medical records project. MED experienced significant ongoing changes in its information technology leadership during the initial discussions on developing

an electronic medical records system. Currently, the position of chief of the Medical Informatics Branch is vacant, and the staff has assumed those responsibilities to continue information technology operations. MED recognizes the importance of having an information technology project manager and has given the deputy executive director temporary management responsibilities. The position of chief of Medical Informatics has been converted to a Civil Service position to provide consistent leadership and is presently being advertised.

Adequate project planning that involves defined objectives and performance measures will allow MED to review and consider other available electronic medical record systems. For example, the Department of Veterans Affairs has an electronic medical record system that can be used in its entirety in other countries. The Veterans Affairs system, as well as other available electronic medical record systems, may be more complex than required, but these systems could be customized to meet the Department's needs. Available systems should be reviewed and considered since they represent potential cost savings for the Department.

**Recommendation 22:** The Office of Medical Services, in coordination with the Bureau of Information Resource Management, should use the Managing State Projects methodology to develop a comprehensive project plan for its electronic medical records systems project, a plan that includes roles and responsibilities, requirements analyses, cost-benefit analyses, and performance measures. (Action: MED, in coordination with IRM)

**Recommendation 23:** The Office of Medical Services, in coordination with the Bureau of Information Resource Management, should review and consider other system alternatives for its electronic medical records systems project. (Action: MED, in coordination with IRM)

## MANAGEMENT CONTROLS

### ISO 9001: A SYSTEM OF QUALITY CARE

MED has made a quality management system a priority. The implementation of the ISO 9001 standard will improve patient care and customer service by using standard procedures and setting goals for every section in MED. ISO 9001 is used by other services within the Department, but the system used by MED has been specifically developed for health care organizations.

ISO 9001 focuses on management responsibility, resource management, product realization, measurement, analysis, and improvement. Steps include identifying the critical processes, determining the proper sequences, and developing a self-assessment program that monitors, measures, and analyzes the processes. A MED official said that even the employees who initially resisted the idea are finding ISO 9001 preparation to be helpful and useful.

MED's Quality Improvement Office, which reports to the deputy medical director, leads the ISO 9001 project and is to be commended for extensively implementing a system to improve and maintain quality health care services.

### RISK ASSESSMENTS

MED received good scores on its December 2005 risk assessment; however, deficiencies were identified in the areas of mental health services, clinical services, foreign programs, emergency medical responses, and the budget process. OIG found other weaknesses during the inspection, but also found that management is working to correct all reportable conditions and strengthen controls through the implementation of ISO 9001.

## Finance

The 2005 risk assessment identified an inherent risk in MED's budget process arising from the complexity of the budget process with other bureaus, as discussed elsewhere in this report. The scope and interaction of the budget process indicates that management needs to be diligent in monitoring funds. No internal control weakness was noted; however, the Claims Section needs formal training in internal control standards because it has not had the training. OIG informally recommended that MED provide formal training for Claims and Reimbursement Section employees.

## Expediting Reimbursement Payments

MED has established a revised method of reimbursement with two major health care insurers that expedites the initial recovery of medical costs by requiring that reimbursement checks be sent directly to an embassy's finance section. The reimbursement begins when a letter is sent from the health unit at post to the insurance company, providing the details on the hospitalization. With direct payments, MED can more rapidly review the collection and determine if it is sufficient. MED plans to implement this direct reimbursement process with all major insurers.

## Premium Class Travel

MED follows the Department guidelines on premium class travel. The current guidance in Announcement Number 2006-03-008, published March 1, 2006, lists important internal control procedures. MED strictly adheres to the policy, with both the Financial Management Branch and the deputy executive director reviewing all requests for premium class travel.

## Time and Attendance

Internal controls need to be strengthened in the time and attendance process since OIG found that proper procedures are not being followed. In some instances, responsible officers are not signing the final time and attendance report, DS-1734M. In one case, a supervisor had self-certified a time and attendance report. In addition, records are not retained, as required by 4 FAH-3 H-524.1. OIG informally recommended that MED follow proper procedures for time and attendance processing.

## FORMAL RECOMMENDATIONS

**Recommendation 1:** The Office of Medical Services should conduct a utilization review to determine whether all four health units in the Washington, DC, area are needed and if they are appropriately located. (Action: MED)

**Recommendation 2:** The Office of Medical Services, in coordination with the Bureau of Human Resources, should evaluate the timeliness of the clearance process, specifically the time required to create electronic personnel and medical records and the additional staff hours required as a result of the geographic separation of the clearance staff and the consultative physicians, and develop and implement a plan to improve timeliness. (Action: MED, in coordination with DGHR)

**Recommendation 3:** The Office of Medical Services should inform Department employees of the disciplinary actions that can be taken when there is an intentional omission or falsification of critical medical clearance data. (Action: MED)

**Recommendation 4:** The Bureau of Human Resources should establish procedures to ensure that employees who intentionally omit crucial medical information on form DS-1843 are subject to the appropriate referrals and disciplinary action, including reimbursement for medical costs. (Action: DGHR)

**Recommendation 5:** The Office of Medical Services, in coordination with the Bureau of Human Resources, should revise the clinician employee evaluation reports to include a critical element on the employee's clinical skills to be rated by the appropriate regional medical officer or regional medical manager. (Action: MED, in coordination with DGHR)

**Recommendation 6:** The Office of Medical Services should establish guidelines for the site visits of the regional medical manager, regional medical officer, and regional psychiatrist to ensure consistent evaluation of health unit functions and should include in the guidelines specific indicators regarding the quality and environment of care being provided. (Action: MED)

**Recommendation 7:** The Office of Medical Services should institute a formal peer review process for all health care providers engaged in direct patient care. (Action: MED)

**Recommendation 8:** The Office of Medical Services should implement formal practice guidelines to ensure consistency in the quality of health care delivery system-wide. (Action: MED)

**Recommendation 9:** The Office of Medical Services should establish mandatory Health Insurance Portability and Accountability Act training sessions for new and existing employees. (Action: MED)

**Recommendation 10:** The Office of Medical Services should develop written policies and procedures for the use and disclosure of protected health information. (Action: MED)

**Recommendation 11:** The Office of Medical Services should require that all records containing patients' personal information are properly maintained in the State-24 records system. (Action: MED)

**Recommendation 12:** The Office of Medical Services should implement the memorandum of understanding between the Department and the Peace Corps at all posts where reciprocal medical coverage is appropriate. (Action: MED)

**Recommendation 13:** The Office of Medical Services should review its laboratory services, and, if it is determined that outsourcing would be a cost-effective alternative, take action to implement a fee-for-service program. (Action: MED)

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**Recommendation 17:** The Bureau of Resource Management, in coordination with the Bureau of Administration and the Office of the Legal Adviser, should review the impact of a fee-for-service program on the use of medical services, seeking to learn whether implementation would be feasible and cost effective under the law. (Action: RM, in coordination with A and L)

**Recommendation 18:** The Office of Medical Services should assess overseas hospital reimbursements and take steps to increase reimbursements from insurance companies. (Action: MED)

**Recommendation 19:** The Bureau of Human Resources should grant Foreign Service health practitioners an exemption to the time-in-class and time-in-service rules. (Action: DGHR)

**Recommendation 20:** The Office of Medical Services should develop local change control board procedures that include steps to be followed for approval of hardware and software on its networks and the process for sharing and storing medically privileged information. (Action: MED)

**Recommendation 21:** The Office of Medical Services should implement and inform staff of actions to be taken in response to staff members' failure to comply with local change control board procedures. (Action: MED)

**Recommendation 22:** The Office of Medical Services, in coordination with the Bureau of Information Resource Management, should use the Managing State Projects methodology to develop a comprehensive project plan for its electronic medical records systems project, a plan that includes roles and responsibilities, requirements analyses, cost-benefit analyses, and performance measures. (Action: MED, in coordination with IRM)

**Recommendation 23:** The Office of Medical Services, in coordination with the Bureau of Information Resource Management, should review and consider other system alternatives for its electronic medical records systems project. (Action: MED, in coordination with IRM)



## INFORMAL RECOMMENDATIONS

Informal recommendations cover matters not requiring action by organizations outside of the inspected unit and/or the parent regional bureau and are not be subject to the OIG compliance process. However, any subsequent OIG inspection or on-site compliance review will assess the unit's progress in implementing the informal recommendations.

To facilitate familiarity with the needs of each location and their duties at each, nurses staffing the health units rotate between the units. At present, rotation may occur daily. The frequency of rotation between units could compromise the continuity of care and has affected staff morale.

**Informal Recommendation 1:** The Office of Medical Services should identify adjustments in the rotation schedule of nurses that will improve continuity of care and staff morale.

Some Department employees expressed confusion over the process of obtaining from MED the personal medical and administrative information they may receive under the Privacy Act and/or the Freedom of Information Act.

**Informal Recommendation 2:** The Office of Medical Services should clearly define the processes for obtaining personal medical and administrative information and make that information easily accessible to all employees.

Some MED employees expressed dissatisfaction with MED's domestic orientation program.

**Informal Recommendation 3:** The Office of Medical Services should revise its domestic orientation program to encompass all aspects of its medical services.

Qualified applicants have not applied for positions in MED's budget section.

**Informal Recommendation 4:** The Office of Medical Services should request a classification review of all positions in its Budget Office to determine whether the positions reflect current responsibilities.

MED's information systems security responsibilities are being performed by assigned individuals on a collateral basis. Having additional alternate ISSOs would provide the office with added resources to perform more than minimal duties.

**Informal Recommendation 5:** The Office of Medical Services should designate and train additional individuals as alternate information systems security officers to perform the required information management and systems security duties outlined by Department regulations.

MED has not completed all of the refinements necessary to improve its claims database, and this has led to staff problems with claims processing.

**Informal Recommendation 6:** The Office of Medical Services should address and resolve identified outstanding issues concerning its claims database.

Staff members in MED's budget section, including those processing reimbursements and claims, have no formal training in internal controls.

**Informal Recommendation 7:** The Office of Medical Services should require employees in the Reimbursements and Claims sections to take formal training in the internal controls process.

OIG received complaints from employees in two MED offices who alleged hostile work environments.

**Informal Recommendation 8:** The Office of Medical Services should require managers to take appropriate Equal Employment Opportunity training.

Some MED timekeepers do not follow the proper procedures for time and attendance processing.

**Informal Recommendation 9:** The Office of Medical Services should issue current time and attendance procedures to all of its timekeepers.

PRINCIPAL OFFICIALS

	<b>Name</b>	<b>Arrival Date</b>
Medical Director	Laurence G. Brown	04/03
Deputy Medical Director	Nicholas J. Riesland	07/04
<b>Office Directors:</b>		
Designated Agency Safety and Health Official Operations	Peter S. Wood	06/04
Mental Health Services	Samuel B. Thielman	08/04
Foreign Service Health Practitioners Clinical Services	Carol L. Dorsey	10/01
Executive Director	James W. Bayuk	07/04
	Mary F. Martinez	08/04



## ABBREVIATIONS

CCB	Change control board
Department	Department of State
DGHR	Bureau of Human Resources
DS	Bureau of Diplomatic Security
EEO	Equal Employment Opportunity
FSHP	Foreign Service health practitioner
FSI	Foreign Service Institute
HIPAA	Health Insurance Portability and Accountability Act of 1996
HST	Harry S Truman building
ICASS	International Cooperative Administrative Support Services
IRM	Bureau of Information Resource Management
ISSO	Information systems security officer
M	Under Secretary for Management
MED	Office of Medical Services
OIG	Office of Inspector General
OPE	Office of the Procurement Executive
RM	Bureau of Resource Management
RMO	Regional medical officer
RMO/P	Regional medical officer, psychiatry

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