1978

Ambulatory care improvement demo project evaluation study.

J Lee

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K. Yazzie

Cook Inlet Native Association

AMBULATORY CARE IMPROVEMENT DEMONSTRATION PROJECT

EVALUATION STUDY

Funded by

U.S. Department of Health, Education & Welfare

Indian Health Service

Tribal Evaluation & Organizations Office

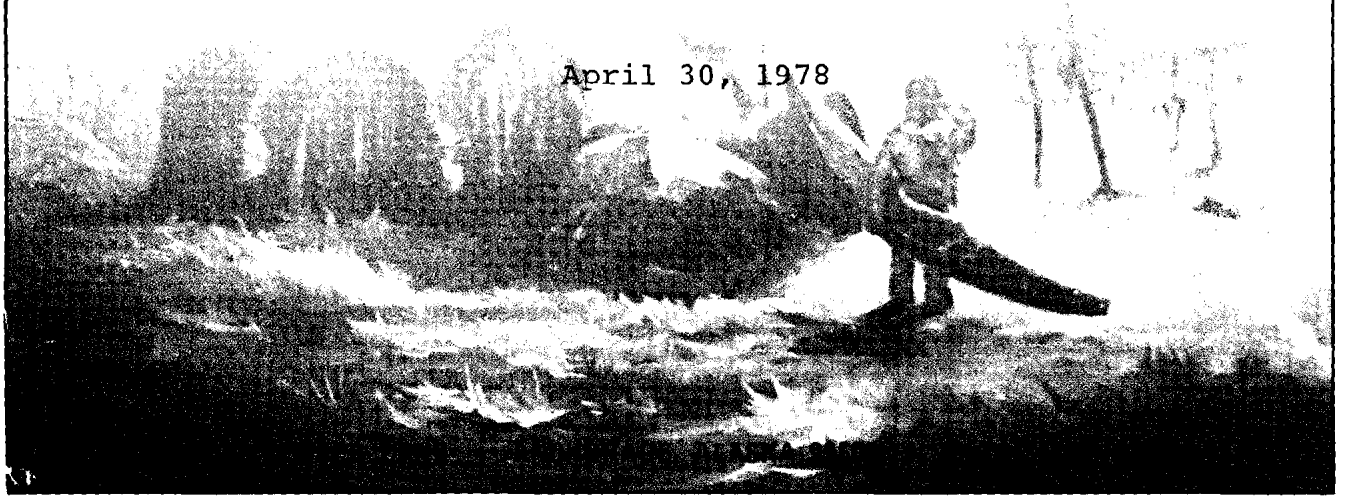
Report submitted by

Cook Inlet Native Association

1057 West Fireweed Lane

Anchorage, Alaska 99503

April 30, 1978



MEMORAI DUM

DEPART JT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION
INDIAN HEALTH SERVICE

TO : Gerald H. Ivey
Director
Alaska Area Native Health Service

DATE: February 15, 1978

FROM : Acting Evaluation Officer

SUBJECT: Additional Funding for Cook Inlet Native Association TEO Project

Additional funding in the amount of $5,500 for the Cook Inlet Native Association Ambulatory Care Project has been approved. Your FMO should have received the attached wire committing the money for the February workmonth.

Sherry A. Salway

Sherry A. Salway

Attachment

cc: Dan Slaby, Cook Inlet Native Association
George Mumm, Project Officer

DHEW/PHS/HSA/IHS

PRIORITY

7580390

FEB 16

MR. S. J. CERRA

443,1118

DIRECTOR
ALASKA AREA NATIVE HEALTH SERVICE

DIRECT PATIENT CARE (HOSP SVCS) 2ND QTR AND ANNUAL ALLOWANCES INCREASED $5,500 (NON-RECURRING) TO COMPLETE THE COOK INLET TRIBAL EVALUATION ORGANIZATION PROJECT FOR FY 1977. THE TEO PROJECT FOR FY 1978 HAVE RECEIVED APPROVAL FROM "H" AND "P"

DOCUMENTS WILL BE PROCESSED DURING FEBRUARY WORKMONTH.

JOSEPH N. EXENDINE, DR. P.H.
DEPUTY DIRECTOR
INDIAN HEALTH SERVICE

cc:
Dr. Exendine
Mr. Danielson
Ms. Salway
Mr. Casebolt
Dr. Todd
Mr. Orden
Mr. Strachan
Mr. Cerra
IH-FM File
b11/SC 2/14/78

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION
INDIAN HEALTH SERVICE

TO : Chief, Financial Management Branch

DATE: February 10, 1978

FROM : Acting Director
Division of Resource Coordination

SUBJECT: Additional Funding for the Cook Inlet Native Association Ambulatory Care Project

Mr. Gerald Ivey, Director, Alaska Native Health Service, has requested additional funds to complete the Cook Inlet Tribal Evaluation Organization project for FY 1977. The TEO projects for FY 1978 have received approval from "H" and "P". Although formal confirmation has not been received to date, this is expected shortly.

In an effort to prevent a delay in the completion of this project, please forward $5500 to the Alaska Area Native Health Service for the continuation of the FY 1977 Cook Inlet Native Association TEO project.

Jack V. Casebolt

DHEW/PHS/HSA/IHS PRIORITY

7570390

x

MR. J. CS. CERRA 443-1118

DIRECTOR
ALASKA AREA NATIVE HEALTH SERVICE

DIRECT PATIENT CARE (HOSP SVCS) 4TH QTR AND ANNUAL ALLOWANCES INCREASED $76,500 (NON-RECURRING) FOR FY 1977. TRIBAL EVALUATION AND ORGANIZATIONAL PROPOSAL. "EVALUATION OF SELECTED MANAGEMENT AND ORGANIZATIONAL ISSUES OF THE ALASKA NATIVE MEDICAL CENTER AMBULATORY CARE PROGRAM." IT HAS BEEN APPROVED BY THE HEALTH SERVICE ADMINISTRATION AS OF 9/27/77.

DOCUMENTS WILL BEEPROCESSED DURING SEPTEMBER WORKMONTH.

JOSEPH H. EXENDINE, DR. P.H.
DEPUTY DIRECTOR
INDIAN HEALTH SERVICE

cc:
Dr. Exendine
Mr. Canebolt
Dr. Todd
Mr. Orden
Mr. Strachan
Mr. Cerra
IH-Fm file
bll/SC 9/28/77

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION
INDIAN HEALTH SERVICE

TO : Evaluation Project Officer
Alaska Area Native Health Service

DATE: September 28, 1977

FROM : Acting Evaluation Officer

SUBJECT: "Evaluation of Selected Management and Organizational Issues of the Alaska Native Medical Center Ambulatory Care Program"

The Cook Inlet Native Association proposal has been approved by the Health Services Administration, September 27, 1977. Your FMO should receive the attached wire committing the $78,500 for the September workmonth to the Alaska Area to carry out this project.

In order to maintain up-to-date complete files on all evaluation studies the Health Services Planning Branch is requesting the following information as soon as it becomes available:

1. Revisions as suggested by HSA (comments attached).
2. A copy of the contract.
3. Copy of reports - monthly or quarterly depending on the contract.
4. Five copies of the final report.

If there are any questions, please contact me at 443-4724.

Sherry A. Salway

Attachments

MEMORANDU I

DEPARTMENT OF ALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION
INDIAN HEALTH SERVICE

TO : Chief, Financial Management Branch
THROUGH: Acting Director, Office of
Program Planning, DRC

DATE: September 27, 1977

FROM : Acting Director
Division of Resource Coordination

SUBJECT: FY 1977 Alaska Area Tribal Evaluation Proposal

Please forward $78,426 to the Alaska Area Native Health Service for the FY 1977 Tribal Evaluation and Organization proposal, "Evaluation of Selected Management and Organizational Issues of the Alaska Native Medical Center Ambulatory Care Program. It has been approved by the Health Services Administration as of September 27, 1977.

Donald A. Swetter MD

Donald A. Swetter, M.D.

MEMORANDUI

DEPARTMENT OF HF TH, EDUCATION, AND WELFARE
PUb. HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION
OFFICE OF THE ADMINISTRATOR

TO : Acting Director
Division of Resource Coordination
Indian Health Service

DATE: SEP 2 7 1977

Director
FROM : Office of Evaluation, OPEL

SUBJECT: Alaska Area Native Health Service Evaluation Organization Proposal for FY 1977

Subject proposal has been reviewed and approved with the understanding that it be revised as follows:

(1) To reflect as an objective, the training of CINA staff in evaluation process and methodology, to meet mandates of P.L. 93-638.

(2) Task #1 more probably is establishment of an administrative process, since a working relationship is already underway between CINA and the outpatient department.

(3) Under methodology, include the requirement for OMB clearance, or eliminate "consumer interviews" as a source of data and information.

Daniel E. Nickelson/pq

Daniel E. Nickelson

cc: Doc Center

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

January 19, 1978

Alaska Area Native Health Service
P.O. Box 7-741
Anchorage, Alaska 99510

Refer to: A-DIR

W. Timothy Shea
Chief of Health Planning
Indian Health Service - Headquarters
Parklawn Building, 5600 Fishers Lane
Rockville, Maryland 20852

Dear Mr. Shea:

Cook Inlet Native Association, a Native non-profit organization, presented Indian Health Service with a proposal to evaluate selected Management and Organizational issues of the Alaska Native Medical Center's Ambulatory Health Care Program in Fiscal Year 1977. The evaluation project commenced November 1977 and is scheduled for completion in September 1978. The activities surrounding the project are related directly with the operation of the Alaska Native Medical Center Out-Patient Department, and supported by a staff of seven qualified people who are funded by Cook Inlet Native Association. The anticipated approach to accomplish this study was to be divided into two (2) phases.

> Phase I - to consist of an operational analysis of a number of selected components of the ANMC Out-patient department.
>
> Phase II - to be developed as the final task of Phase I.

The above paragraph summarizes the proposal funded through Tribal Evaluation Operation project funds. The amount allocated to CINA to carry out the Ambulatory Care Evaluation Project has exhausted. CINA's original proposal mentioned the funding to support the project as an anticipated budget requirement, which also anticipates encountering many barriers during the evaluation study.

CINA's effort in reaching their goal to add new and/or improved management practices and to improve the ambulatory health care at the ANMC, can only be obtained by additional funding.

I find the Ambulatory Care Project as a pedestal for future involvement of the Alaska Native in the management and improvement in the health care field. In support of this challenging and worthwhile effort, I request that an additional funding in the amount of $5,424.00 be allocated to CINA to continue their program. CINA faces the following tasks yet to be accomplished;

1. Data collection is requiring more time than anticipated.

2. Reasonable sample size (data collection) for consumer satisfaction.

3. Chart audits for the patient problem profile.

4. Time frame for completion is pressured.

The amount of budget requested is an extension of salaries to accomodate the data collection staff and consultants for meeting the above barriers. The amount appropriated to CINA will not effect their course of action, only increase the quanity and quality of statistical data needed for provider and consumers satisfaction. Time is of utmost importance to CINA to implement this project study, so in order for them to keep in course with future programs, your full consideration given to this request will be appreciated. The Ambulatory Care project has been receiving excellent cooperative by both providers and consumers of health care.

Sincerely,

G. H. Ivey
Director
Alaska Area Native Health Service

Project Director

John Lee, M.D., M.P.H.

Report prepared by

Richard Wells & Associates

Redmond, Washington

Research Assistants

Mary Hoepner

Marge Shoogukwruk

Kathleen Yazzie, P.A.

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I. INTRODUCTION

Cook Inlet Native Association, a nonprofit organization serving all Alaskan Natives within the Cook Inlet Region, received funding during FY 1977 from the U.S. Indian Health Service to conduct an evaluation of the Outpatient Department (OPD) of the Alaska Native Medical Center (ANMC). The need for this evaluation was identified through the activities of the CINA Health Board and health planning staff. The study tasks were developed cooperatively between CINA and the Alaska Native Medical Center.

Work began on the project in October of 1977 and continued until March of 1978. The purpose of conducting the evaluation process was threefold. First, many Native people had expressed concern over a lack of knowledge about the Ambulatory Health Care delivery process at the Alaska Native Medical Center. Many individuals expressed strong opinions about the issues of quality of care, accessibility of care and overall operational efficiency of the department. However, these opinions were generally not based on documented information. There existed a need to review many of these issues from a Native perspective and in the process to as closely as possible assess the level of consumer satisfaction with Outpatient Department services. A second purpose of the study was to identify areas where one or more Native regional corporations could appropriately provide assistance or support for reducing barriers to existing services or developing new programs. While the study was in the pre-proposal stage, it became obvious that Indian Health Service personnel and CINA shared many of the same concerns. Each placed a primary emphasis on expending future resources which may become available in such a way that those resources would have the maximum possible positive impact on the health status of the Native people. The third purpose of the study was to develop a model whereby the Indian Health Service and the Alaska Native Medical Center could work cooperatively with CINA over the next five years. Each step along the path to implementation of PL 93-638 and PL 94-437 could be carefully considered in the light of these mutual goals. The goal of developing a cooperative working relationship with Indian Health Service staff at all levels, but most importantly at the level of the provider, has not only been met, but exceeded our highest expectations. The study was structured in six independent tasks selected with the assistance of ANMC administrators. Those tasks are as follows:

Project Initiation

- Develop a structured working relationship with the Outpatient Department staff and Cook Inlet Native Association.

Task 1 - Assess Consumer Satisfaction with Outpatient Services at Alaska Native Medical Center

- Determine the general level of consumer satisfaction with present ambulatory care services.
- Identify specific consumer problems in obtaining services from the Outpatient Department.
- Determine need for new or improved ambulatory care services from consumer viewpoint.
- Assess the perceived accessibility of care in the greater Anchorage area and in the Cook Inlet Region.
- Determine the availability of third party payment sources and factors affecting consumer involvement in obtaining third party payments.

Task 2 - Develop Consumer Problem Profile

- Assess the quality of present patient population data as it relates to optimum use of clinic resources.
- Survey a minimum of 1000 individual patient records and categorize medical problems and frequency and nature of visitations.
- Analyze patient utilization patterns and determine degree of under-utilization/over-utilization; and appropriateness of utilization.
- Develop strategies for alternative service configuration to better fit patient problem and utilization patterns.

Task 3 - Review Selected Day to Day Operational Issues

- Assess the efficiency of the front desk/reception functions of the Outpatient Department.
- Evaluate the procedures for patient scheduling.
- Identify barriers to patient flow within the Outpatient Department.
- Identify barriers to patient flow when utilizing other Alaska Native Medical Center departments, i.e., lab, pharmacy, x-ray and specialty clinics.
- Review and identify problems in administrative relationships with other hospital services or departments.

Task 4 - Review Selected Issues of Concern to Provider Staff

- Evaluate provider staffing pattern.
- Analyze nursing staff time utilization.
- Assess the level of provider satisfaction.
- Design a format for the evaluation of the field medical program.

Task 5 - Budget Review

- Omitted

Task 6 - Develop Final Report

- Identify issues for further study and design an evaluation format which will result in long range solutions to identified operational problems.

As will be discussed later, the budget review task (#5) was dropped from the study design after it proved unfeasible. The completion of the other tasks required considerably more time and energy than our original estimate; however, once the study was under way, the OPD staff became increasingly involved in the evaluation process and provided much of the momentum for the completion of several of the tasks. The OPD staff formed study groups around selected issues of concern and participated in a one day workshop to discuss results of OPD staff efforts. The extent to which individual staff were willing to participate was a key factor in the thoroughness of the evaluation process and the confidence CINA has felt regarding the appropriateness of the study recommendations.

This report of study findings is structured in several major sections. The first section addresses each individual task included in the study proposal. It includes a discussion of the objectives of that task, the methodology used to meet those objectives and an overview of the findings for each task. This section also includes a review of the results of each Outpatient Department staff study group which participated in the evaluation effort.

Many functional areas or issues of major concern surfaced again and again throughout all of the study tasks. CINA has elected to present the major portion of the study findings by presenting conclusions and recommendations by functional areas or issues of concern. This detailed set of conclusions and corresponding recommendations for the improvement of ambulatory care services included in this report CINA believes are well supported with data, reasonable and such that they can be implemented by Indian Health Service (IHS) over the next several

years within expected resources. CINA has limited its final recommendations from Phase I of the study to those areas where CINA has enough data to feel confident that the recommendations are sound. In addition, the study addresses areas where further evaluation is necessary and if undertaken in a timely manner could result in changes in the service delivery program which could be of considerable benefit in the future.

II. METHODOLOGY

Our approach to this evaluation project was based on the desire of CINA to work cooperatively with the OPD staff in identifying issues or areas of concern where barriers to improved ambulatory care services exist. Because of the need to develop a cooperative relationship and the desire by CINA to address as many functional areas or issues as possible, the methodology for the study was quite subjective. Throughout the study, findings, conclusions and recommendations are primarily based on the professional judgement of the study participants. Each task was conducted somewhat differently. More objective data was used to develop conclusions and recommendations of some tasks than others. In general, the methodology of the study followed these steps.

Step 1: Develop a cooperative working relationship with the individual or group of individuals responsible for the area covered by each task.

Step 2: Collect and review data from existing sources.

Step 3: Conduct observations where appropriate.

Step 4: Conduct interviews when appropriate. Review and analyze findings in a series of meeting with study participants and OPD staff.

Step 5: Seek participation of OPD staff with the development of study groups focusing on areas or issues of concern.

Step 6: Conduct a one day study workshop which includes OPD staff, CINA staff and consultant to review results of study.

The study was conducted by the CINA Health Department under the direction of John Lee, M.D., M.P.H., Medical Director. A further description of the study methodology is included in the discussion of individual tasks where appropriate.

III. REVIEW OF FINDINGS BY STUDY TASKS

Task 1 - Consumer Satisfaction Opinion Poll

The results of the Consumer Satisfaction Opinion Poll are discussed in detail in this section. This task was designed to simply assess as well as possible the satisfaction level of the users of the OPD. In addition, an effort was made to solicit suggestions for strengthening program planning, direct service and program administration. The results of this task made a major contribution to both the report of findings by function and the report of conclusions and recommendations. An open-ended "opinion poll" format was used. This format, while presenting problems in data analysis and leaving many questions about the reliability of the findings unanswered, was useful in providing the CINA with an excellent perspective of the OPD as viewed by people depending on ANMC for their primary health care. In addition, this approach resulted in many unique suggestions for improved service.

The Consumer Satisfaction Opinion Poll attracted considerable interest among Native people in Anchorage. For people coming from the villages the entire idea of consumer satisfaction related to IHS services was sometimes difficult to understand, but the chance to voice an opinion was appreciated.

The objectives of this task were as follows:

- Determine the general level of consumer satisfaction with present ambulatory care services.
- Identify specific consumer problems in obtaining services from the OPD.
- Determine need for new or improved ambulatory care services from consumer viewpoint.
- Assess the perceived accessibility of care in the greater Anchorage area and in the Cook Inlet Region.
- Determine the availability of third party payment sources and factors affecting consumer involvement in third party payments.

The achievement of these objectives was the primary purpose of this component of the study.

The opinion poll was developed in a cooperative effort by CINA Health Department staff and the Director of Ambulatory Care and the Chief of the OPD at the Alaska Native Medical Center. Technical assistance was provided by several consultants including Richard Wells, Joanne Hagen and Dr. Frank Becker. Several

individuals from the Native community including CINA Health Board members also provided assistance in setting a direction for the poll. In addition, they provided sensitive input into possible methods for conducting the actual poll. The process began slowly with the selection of research assistants and the pre-testing of several approaches to gathering data. As a result of these preliminary activities and the subsequent feedback from consumers, a basic approach or philosophy emerged. This philosophy, which was developed in the early stages of the study, reflected the desire of the CINA to respect the dignity and privacy of the individual consumer. While the study participants endeavored to adhere to guidelines which would result in objective findings, a number of factors interfered significantly. Some examples are:

- Limitations on the setting which resulted in the polling being conducted in an oftentimes crowded waiting room.

- The polling was conducted in English, making it difficult for some consumers to truly comprehend the questions.

- A reluctance of Native consumers to discuss some specific questions or issues.

- The lack of familiarity with the polling process and the uncomfortable feeling with having one's communication structured in this manner.

- The necessity to poll consumers at a time when they were ill or uncomfortable.

- Uncertainty about how the results of the poll might be used.

As a result of these factors and other concerns expressed by the Native research assistants, an effort was made to structure the polling process in a way which would be consistent with Native cultural attitudes. Many questions were left open-ended and consumers were encouraged to express personal concerns about health care and to relate personal or family experiences with the OPD. Hopefully the consumer would feel that the polling process was worthwhile and that a genuine opportunity to express their opinions had been offered.

The primary problem with this subjective polling process was that the analysis of the results also had to be subjective. While the results of the survey are rich with Native cultural values, interesting anecdotal information and helpful suggestions for improving service, CINA can never be sure that the results could be replicated if the study was to be conducted at a different time by a different researcher using a more structured format.

While being fully aware of these limitations, the study participants agreed that the consumer polling process was highly successful. While each consumer's views and opinions were carefully considered on an individual basis, significant trends appeared. In fact, considering the variety of age, sex and cultural background, the major positive and negative aspects of OPD services were consistently pointed out by large numbers of consumers. The emergence of these major trends along with a general similarity in findings with other often more structured consumer satisfaction surveys in the health care field, led the researchers to feel some confidence that an accurate assessment of consumer satisfaction had been obtained. The consistency of the survey results was especially important considering the total lack of previous consumer satisfaction information related to ambulatory care services. At present, the Alaska Native Medical Center has a patient advocacy committee which provides an avenue for expressing specific complaints or resolving specific misunderstandings; however, no method existed for expressing a level of satisfaction or for making constructive recommendations for improving services from the consumer viewpoint.

A final introductory point which the study participants would like to express is their feeling that this survey effort should put to rest the general negative methodology about ambulatory care services which has been widely held by many Native people living in the region. Often this negative attitude has been based on rumors or frustrating experiences on the part of individuals but has never really reflected the total picture. When CINA study participants began the polling effort, they, like many individual Native people, had no idea what the real level of consumer satisfaction with ambulatory care services was nor did they know what suggestions for improved services might be offered.

CINA, as a tribal organization representing the residents of the Cook Inlet Region, has the responsibility for planning with the Indian Health Service for providing continued medical care to the residents of the region. Without an assessment of the level of consumer satisfaction with present services, it would have been difficult to conduct a good planning effort.

Methodology

The Consumer Satisfaction Opinion Poll was conducted at the Alaska Native Medical Center's Outpatient Department. As can be seen from Table III-1, six hundred and forty-eight (648) individual consumers were contacted. The researchers were responsible to the Director of the OPD while on the premises. The poll was conducted during regular clinic hours and evenings over a ten (10) week period from November 14, 1977 to February 10, 1978.

TABLE III-1

CONSUMERS POLLED

Polls Completed	648
Refused to Participate	151

. The Setting

The OPD is located on the first floor, south wing of ANMC. The OPD provides family practice and primary ambulatory care to the Native residents of Anchorage as well as to Native people traveling in from the villages for various health reasons. The OPD also provides 24-hour emergency room services. Approximately 35 percent of the patients requesting service in the Outpatient Department come with an appointment. The remainder come on a walk-in basis. The interviews were conducted in a waiting room of approximately 1000 square feet. The waiting room is used by all OPD consumers including appointment, walk-in and emergencies. There are 38 chairs, a small children's table, a men and women's lavatory and a reception counter. During the pre-testing stage, an attempt was made to poll consumers in private. However, most consumers were reluctant to leave the waiting room area and go to an adjoining room or trainer for fear that their name would be called and they would miss their appointment. Because of the problems and confusion which resulted, no effort was made to remove consumers to a private area for polling during the remainder of the study. The chairs in the waiting room are lined up in rows facing one direction. This sometimes presented difficulties for the interviewers in finding places to sit. On occasion, the waiting room was completely full and no chairs were available. This overcrowded condition undoubtedly contributed to some individuals' refusal or reluctance to participate in the survey.

. The Sample

The patient load at the OPD varies from 130 to 160 patients per day depending on the day of the week and certain holidays or celebrations. The goal of the researchers was to obtain a 15 percent sample of consumers above the age of sixteen. The researchers were instructed to randomly approach consumers after they had checked in at the front desk. Since the consumers were not asked for their names or identified in any way, it was impossible to control the sample. Only the total number of interviews per day compared with the total number of patients per day provided us with an indication of sample size. The most significant problem in estimating the sample size was the inability of the OPD record-keeping system to provide an unduplicated count of users for a specific period of time. As the study progressed, the researchers noted that many of the patients in the waiting room had already been interviewed during previous weeks.

In spite of these problems, an attempt was made to estimate the total unduplicated number of users during the survey period. This estimate was based on a periodic spot check of chart

numbers, an analysis of the appointment schedule and preliminary information from the consumer problem profile portion of the study. The unduplicated user estimate for the study period was 5,200 patients. This figure appears low and is reported as an estimate only.

With the nature of the setting and the peculiarities of patient flow, the randomness of the sample could not be assured. The primary problem in the randomness of the sample was the high number of males who declined to be interviewed. This can be attributed to several factors including cultural values, a less utilization by males, and the fact that both the research assistants were women. In spite of the problem of obtaining interviews from male consumers, a general age and sex breakdown of the sample was not totally inconsistent with the utilization data gathered in the consumer problem profile task of the evaluation study. Another factor affecting the sample was the patient's discomfort from illness or injury. In some cases the patient was either injured, obviously feeling too uncomfortable to communicate or intoxicated and was not approached at all. A number of these factors influencing the make-up of the sample could have been controlled with a stricter study design using a standard format. However, the study participants felt that a first priority was to respect the consumers' privacy and to avoid any possible disruption or unpleasant situation in the waiting room setting. Table III-2 shows the number of responses.

- Research Assistants

Two research assistants conducted most of the polling. They were selected after open advertisement for the positions. The interviewers were selected for their sensitivity and ability to communicate with Native people. Both were young adult women in their early 30's. One researcher had extensive counseling experience. Another had no related experience. Both participated in the development of the polling format and were provided with specific training and instructions. The researchers generally worked together during regular clinic hours. After-hours polling was generally limited to one researcher. In a sensitive polling situation such as the one in this study, problems can be expected. It is to the credit of the interviewers that no complaints were received either from patients or the OPD about any aspect of the consumer interview process.

- The Polling Format

The format was developed by the study participants with input from several individuals from the Native community including CINA Health Board members. A draft list of topics and questions was pre-tested with approximately 70 consumers.

TABLE III-2

REASONS FOR REFUSAL TO PARTICIPATE

1st or 2nd time at OPD	78
"Too sick"	21
"No opinions" about OPD	25
Other	27

Extensive revisions were made after pre-testing. The list of topics consisted of a series of questions or general issues to guide the researchers. The format consisted of 15 open-ended questions. The researcher wrote down all responses. The consumer was encouraged to ask questions or to discuss any issues or experiences of personal concern. The researchers were instructed to follow the polling format as closely as possible. At a minimum, the interviewers were required to cover all of the major topics on the polling format.

The methodology was not designed to provide unchallengeable data. The study participants recognized that the limitations which were necessarily part of the effort precluded usual methodical restrictions. For example, no effort was made to contact Native people in the community who have elected for various reasons to not make use of the ANMC but use private resources. Subsequent CINA PL 94-437 planning efforts will certainly address this question.

Procedure

A summary of the data collection procedures are as follows: A consumer enters the Outpatient Department and proceeds to the front desk. Once the front desk activities are completed, the consumer takes a seat in the waiting room. The consumer was then approached by a CINA researcher wearing a name tag identifying them as CINA staff assigned to the ANMC. The nature of the study was explained to the consumer and their participation requested. If participation was refused, a reason for refusal was asked and recorded on a separate sheet. If participation was agreed to, the CINA researcher attempted to take a seat with the consumer or request that the consumer move to another part of the waiting room where several seats were open together. The researcher explained that they would not be asked for names or identified in any way. The polling format was then followed. The researchers recorded verbatim the answers to all questions and relevant comments. The data was tabulated in sets of 50 and reviewed periodically by the study director. In addition, the researchers met with the study directors on a weekly basis to discuss the progress of polling. The raw data was tabulated by issues. No cross tabulations were performed due to the subjective nature of many of the responses. In addition to the tabulation of data and the review of subjective answers, each researcher provided a written statement of their experiences and impressions while conducting the study.

Results of the Poll

- Age

The researchers attempted to estimate the approximate age of each consumer. Table III-3 shows the age categories and the number of consumers in each category. As can be seen from the table, the majority (308) of the participants were in the young adult category. The young adult category was generally considered to be anyone between the age of 16 and 30. The adult category estimate of 30-40 or 45. Middle age was 45-55 or 60. Elderly was over 60. This age breakdown was somewhat consistent with information derived from the consumer problem profile and other tasks of the evaluation. Again, it should be noted that middle aged individuals were most likely to refuse participation. No attempt was made to correlate age estimates with concerns about specific issues.

- Sex

As can be seen from Table III-4, the majority of respondents were female. This proportion of female consumers polled exceeded the proportion of female patients using the OPD. Throughout the study, this problem was recognized and attempts were made to solicit the maximum number of males for participation.

- Region Enrolled

Each consumer was asked in which of the thirteen regions set up under the Land Claims Settlement Act were they enrolled. Table III-5 shows the results. As can be seen from this table, 24 percent of the sample (152) of the consumers polled were registered in the Cook Inlet Region. As can also be seen from the table, a substantial number of consumers were enrolled in the regions within the Anchorage Service Unit. Regional enrollment is traditionally associated with place of residence. However, the Alaskan Native is becoming more mobile and this relationship does not necessarily hold true. Twelve percent of the sample was made up of Non-Native PHS users or Indians from outside Alaska. CINA planning efforts being conducted under PL 94-437 planning guidelines will attempt to further refine demographic statistics related to Anchorage Native residency and utilization of IHS facilities.

- Years Living in Anchorage

Each consumer was asked how long they have lived in Anchorage. Table III-6 shows the results. As can be seen from this table, 27 percent of the sample had lived in Anchorage for one to five years. Twenty-three percent of this sample lived in

TABLE III-3

AGE ESTIMATES

Young Adult	308
Adult	118
Middle Age	134
Elderly	47
Not Recorded	41

TABLE III-4

RESPONDENTS BY SEX

Male	168
Female	479

TABLE III-5

RESPONDENTS BY REGION

Sealaska	49
Chugiak	29
Bristol Bay	68
Aleut	20
Cook Inlet Region	152
Athna	20
Doyon	39
Bering Straits	67
NANA	16
Arctic Slope	15
Koniag	24
Calista	60
Outside Indians or PHS Utilizers	73
Na	16

TABLE III-6

ANCHORAGE RESIDENCY

0-3 Months	30
3 Mos. - 1 Year	39
1-5 Years	177
5-9 Years	155
10-15 Years	95
15-20 Years	61
20-Over	74
Visiting, Passing Through	44
No Answer	--

Anchorage from five to nine years. This total of approximately 50 percent of the sample with a residence of one to ten years shows the population group to be considerably more stable than popular belief. As can be seen, long term residents also made up a substantial percentage of the sample with seventy-four (74) people reporting they had lived in Anchorage for over twenty (20) years. Only eleven (11) percent of the sample reported living in Anchorage for less than one year.

Many consumers related that over a period of years their principal residency had been Anchorage but they had made numerous trips back and forth to various villages or spent substantial time involved in fishing or employment in other areas. Forty-four (44) people were not residents of Anchorage but were visiting or passing through to other places. The researchers reported that this particular question was sometimes confusing to the consumer. Several times they were asked, "Do you mean official residency - such as drivers' license, etc., or does this mean that I just live here in Anchorage?" Researchers did not pursue this issue in the polling. A further study of Native migration to and from Anchorage will be included in the CINA PL 94-437 plan.

. Perceived Utilization

Each consumer was asked, "How often do you come to the Outpatient Department Clinic?" The results of this inquiry are shown in Table III-7. As can be seen from this table, perceived utilization of clinic services was quite high, eleven (11) people reported more than once a week, eighty-three (83) people reported every two weeks, and one-hundred and thirty-nine people reported using the clinic monthly. Thirty-six (36) percent of the sample therefore reported using the clinic at least once a month. While it is extremely difficult and inappropriate to compare this utilization rate with a typical Health Maintenance Organization or Community Health Center, it should be noted that this perceived utilization rate is quite high, but also quite consistent with estimates from the consumer problem profile. This question of utilization will be addressed at another point in the findings. What should be noted from the consumer satisfaction survey is that patients generally are aware of how often they utilize services. Consumers did not feel that this utilization was particularly inappropriate. In related discussions, a number of consumers pointed out that they "had" to come to the OPD "all the time".

. Transportation

Each consumer was asked, "How do you get to the Medical Center and is transportation a problem?" The results are shown in

TABLE III-7

PERCEIVED UTILIZATION OF OUTPATIENT DEPARTMENT

More than once a week.	11
Once a week.	21
Every 2 weeks.	83
Every 3 weeks.	5
Monthly	139
Every 2 months.	74
Every 3 months.	85
Every 4 months.	30
Every 6 months.	72
Once a year.	29

Table III-8. As can be seen from this table, the majority of individuals, 304, get to the OPD by car. In addition, a substantial number of individuals, 102, get to the OPD by city bus. A high number of individuals, 146, reported that transportation was a problem. Researchers reported that it was their impression that elderly people more often reported transportation problems. The issue of problems with transportation will be addressed during the PL 94 437 planning process. Lack of quarters was mentioned as a problem related to transportation; however, most consumers polled did not have personal experience with quarters as a problem. They reported this to be a problem told to them by friends and family. This issue will be discussed later in the study.

- Appointment Problems

As can be seen from Table III-9, three hundred and fifty (350) consumers reported that they had no problem getting appointments at the OPD, one hundred and seventeen (117) reported that they had had problems, and ninety-seven (97) reported that they sometimes had problems. Thirteen (13) reported that when requesting an appointment they were told to walk in. In addition, consumers were questioned about the length of time it took to get an appointment. The majority of respondents to this question, fifty-six (56) reported one week and thirty-seven (37) reported within three days. Only seven (7) people reported that a month or more was necessary. Table III-10 shows the number of people interviewed who had appointments vs. the number of people interviewed who were walk-ins. As can be seen from Table III-10, three hundred and ninety-two (392) of the patients asked this question reported that they were walk-in patients, one hundred and sixty-two (162) reported that they had appointments. This indicates that 29% of the people asked this question were appointment patients. Appointment patients were sometimes seen faster and thus did not provide adequate time to discuss consumer satisfaction issues. However, when compared to the approximately 35% of the OPD users that come with an appointment, the number of walk-ins in the opinion survey, it was not unusual.

- Things Liked About the Outpatient Department

During the course of the poll, many people were asked what specific things they liked best about the OPD. Because this question was totally open-ended and because the researchers did not wish to present any "options" the answers were recorded verbatim and later categorized. Table III-11 shows the results of this inquiry. As can be seen from this table, eighty-eight (88) individuals reported that they were generally satisfied with the service or the care they received. Fifty-nine (59) people specifically mentioned they liked the

TABLE III-8

TRANSPORTATION TO THE OPD

Personal Auto	304
Taxi Cab	32
Public Transportation	102
Family & Friends Provide Transportation	81
Depends on Situation	158
No Answer	---

TABLE III-9

APPOINTMENTS

"Any problems encountered when requesting an appointment?"

No problem	350
Had problems	117
Sometimes had problems	97
Told to walk in.	13

"How long did you have to wait for an appointment?"

Two weeks	64
One week	56
Three days	37
Month or more	7

TABLE III-10

APPOINTMENT VS. WALK IN

By Appointment	162
Walk In	392

29% of the patients were seen by appointment.

TABLE III-11

"WHAT DO YOU LIKE ABOUT THE OPD?"

Generally satisfied	88
Liked the doctors	59
Friendly people	39
Services available for free.	44
Staff tries hard and are helpful.	29
Appreciate no smoking rule in OPD.	11
24-hour emergency services	16
Nothing specific.	64
No comment.	69

"ARE THERE THINGS YOU DON'T LIKE ABOUT THE OPD?"

Waiting time	317
Front desk staff not organized.	35
General attitude	53
Not thorough	48
Never see same physician.	16
Inexperienced physicians	17
Waiting in exam rooms.	16
Lack of privacy.	18
Drunks in waiting area.	14
Crowding and lack of children's waiting area.	10

doctors. Thirty-nine (39) people mentioned the friendly people in general. Forty-four (44) consumers mentioned the fact that the service is available and available for free was what they liked best. Another twenty-nine (29) people mentioned that the staff try very hard and that the staff are helpful. Eleven (11) respondents mentioned that they appreciated the new rule regarding no smoking in the waiting rooms. Sixteen (16) respondents mentioned the 24-hour emergency room service. Sixty-nine (69) people declined to mention anything while sixty-four (64) mentioned that there was nothing very specific that they liked about the program. In general, consumers appreciated the staff, the free care and the fact that good service was available.

Table III-11 also shows response to the question, "Are there things you don't like about the OPD?" These answers were generally more varied with over 40 different items being mentioned. The most frequently mentioned problem was waiting time. A total of three-hundred and seventeen (317) individuals responded to the question by mentioning the long waiting time. In related complaints, thirty-five (35) people reported concern that the front desk staff did not appear organized or did not seem competent for the job they were handling. A number of people reported individual complaints such as being put on hold on the telephone (3), getting the "run around" (1), and being offended by the general attitude of the staff (53).

Some individuals reported complaints about the medical service and the facility. The most frequent complaint was that the physicians were not thorough. Forty-eight (48) individuals responded specifically that they felt rushed or did not receive "complete" care. Fourteen (14) people reported the medical staff were somewhat indifferent to their problems. Twelve (12) mentioned that the physicians were not experienced. Sixteen (16) mentioned that they were never allowed to see the same physician. Thirteen (13) mentioned that the OPD was understaffed. Three (3) mentioned that the physicians don't explain their instructions carefully. Sixteen (16) complained about being left waiting in the examining rooms by the physicians. Complaints related directly to the facility numbered approximately forty-five (45). Eighteen (18) people reported that there was a lack of privacy. Fourteen (14) people reported that drunks harrassing them was a problem. Five (5) people reported crowded waiting room conditions. Five (5) responded to the lack of a childrens' waiting area. Three (3) people complained about being exposed to disease.

The analysis of the responses on open-ended questions is by nature subjective. However, we feel the primary complaints

can be easily categorized. First and foremost problem from a consumer viewpoint is waiting time. The second major concern appears to be front desk related services, lost charts, organization, etc. The third most reported group of complaints can be categorized as "not having a family physician" or a perceived lack of continuity of care. This was expressed in responses such as "physicians are not being thorough enough", "we should not have to go through screening", "we never see the same physician." In addition, a problem with the facility in general was a constant undercurrent. The question of waiting time was discussed further with the patients, several mentioned the lack of exam rooms. Often they were asked what they considered to be a reasonable waiting time. Two-hundred and eighty-five (285) consumers responded "on time" when you have an appointment. Sixty-two (62) responded "depending on the illness". One-hundred and eight (108) patients felt that with an appointment, 15 to 20 minutes was the maximum amount of time one should be kept waiting and without an appointment, the majority of people felt that between 30 minutes and one hour was the maximum amount of time one should be kept waiting. One-hundred and eighty-eight (188) felt that even without an appointment, that 45 minutes to one hour waiting was appropriate.

Table III-12 shows the results of further questioning about the courtesy of staff. In this particular case, a more structured question was used. As can be seen from this table, the majority of respondents felt that front desk staff, doctors, nurses, pharmacy, x-ray and lab were courteous all or most of the time.

- Communication

Many consumers, four-hundred and seventy-five (475), were asked, "Do the doctors and nurses understand your problems?" Table III-13 shows the number of people responding that they felt doctors and nurses understood their problems.

As can be seen, three-hundred and eighty-four (384) respondents felt that doctors and nurses understood their problems, thirty-nine (39) did not and one hundred (100) responded vaguely or not at all. Of those responding vaguely or negatively, forty-two (42) mentioned physicians were not thorough enough and twenty-six (26) mentioned that they had no one to compare them with.

- Choice of Clinic

When discussing issues related to choice of clinic for services, Table III-14 summarizes the responses. Three-hundred and eighteen (318) people responded that the ANMC

Table III-12

Courtesy

	All	Most	Sometimes	Never	No Contact
Front Desk Staff	172	239	118	13	1
Doctors	208	236	79	6	9
Nurses	215	249	68	5	4
Pharmacy	206	217	42	2	80
X-Ray	183	202	32	3	109
Lab	182	214	35	3	107

Table III-13

"Do doctors and nurses understand your problem?"

Yes	384
No	39
Other	120

Other includes

"Sometimes" (28)

"Do not take enough time." (42)

"Nothing to compare it with." (26)

Table III-14

Choice of Clinic

ANMC	318
Other clinic	188

was their choice of place to obtain health care. Twenty-two (22) people mentioned specifically that the ANMC had their records and another twenty-nine (29) mentioned specifically that they felt comfortable there. In general, people were asked, "If you had a choice to go elsewhere to receive service, where would you go and why?" One-hundred eighty-eight (188) people responded that they would rather go elsewhere. Eighty-five (85) said that they would receive better service, seven (7) said that they would receive faster service. This was generally in response to a specific question and was not an open-ended response.

Health Insurance

Table III-15 shows that a significant number of the people responding had some type of health insurance. This is an extremely difficult area to analyze. Many people were not aware what type of health insurance they had, if any, and one-hundred and forty-eight (148) vague or incomplete answers were received. Of those people having insurance, eighty-three (83) specifically mentioned that they do use it elsewhere on occasion. Fifty-six (56) mentioned that they do not use it at all.

Table III-16 represents responses to the question, "How would you rate the overall services in the Outpatient Department?" As can be seen from Table III-16, the majority of consumers rated the services "good" or "fair". When asked the question, "What kinds of programs do you think would improve the OPD services?" the answers fell into three broad categories. Details of response to this question can be seen in Table III-17. As can be seen from this table, a large number of people, twenty-five (25) reported that service could be improved by improving general clinic organization. The training of the front desk staff and a better chart system was mentioned numerous times. The second major section that can be seen from the table was the desire for a better facility. Approximately ninety (90) people expressed concern about the condition of the facility. The third major group of suggestions for the improvement of services was to organize the physicians better, to hire more physicians or to better train physicians. In addition, three (3) people expressed concern that oftentimes the most ill patients were not seen first or that the screening process should be eliminated. Several people suggested that services could be improved by having family physicians (6), an area for intoxicated people (2) and just better communication between the medical staff (2). Another area covered in the opinion poll: Whenever possible individuals were polled as to their knowledge about organizations or boards which could express their opinions for them about their health care concerns. Two-hundred and

Table III-15

Have health insurance	138
Do not have health insurance	364

37% of people responding have health insurance.

TABLE III-16

"HOW WOULD YOU RATE THE OVERALL SERVICES IN OPD?"

-Excellent	33
Good	229
Fair	236
Poor	39

TABLE III-17

"WHAT KINDS OF PROGRAMS DO YOU THINK WOULD IMPROVE THE OPD SERVICES?"

Better organization.	25
Train front desk staff.	36
Cut waiting time.	4
Have a family doctor.	7
Have better trained doctors.	17
Move emergency room.	6
Separate area for intoxicated patients.	4
Separate clinic for walk-in patients.	11
Better communication.	9
Have more staff in general.	45
Patients need more privacy.	5
OPD should have better chart system.	13
Provide comfortable area for very ill.	4
Have a children's waiting area.	39
Provide a better facility.	39
Have more doctors	24
Children should be seen first.	1
Most ill should be seen first.	19
There should be more rooms.	6
There should be more magazines.	7
There should be more nurses.	3
Should provide experienced doctors.	1

fifty-nine (259) people responded that they knew of no place where they were represented in matters of health care. When asked if they would be willing to participate in planning meetings to try and improve ambulatory health care, two-hundred and ninety (290) responded that they would not be willing to attend meetings, most saying that they were fairly satisfied with the present system.

As a conclusion to the opinion poll, consumers were often asked if they noted any changes in the service or the facility in recent months. Two-hundred thirty-six (236) people responded that no changes had occurred. One-hundred and forty-four (144) responded that some positive changes had occurred - some things were better.

- Summary - Consumer Satisfaction Survey

The findings of our opinion poll can best be summarized by addressing each of our original objectives and discussing the conclusions jointly reached by the study participants.

- Objective 1: Determine the general level of consumer satisfaction with present ambulatory care services.

  In the opinion of the study participants, consumers were generally satisfied with the ANMC system and OPD services in particular. The important factors which contributed to this satisfaction were as follows:

  - That services were available;
  - That services are provided without charge;
  - That 24-hour service is available;
  - That the staff tried to provide good service.

  Consumers also recognize that specific problems existed in the OPD which were beyond the control of the staff working there. They generally expressed satisfaction with the effort of the staff to try hard, to be courteous and to provide good service. The vast majority of consumers rated the service either good or fair. Where dissatisfaction was noted, it was primarily with internal operating procedures or the results of space and resource limitations. The fact that almost 31% of the individuals questioned about their personal health insurance responded that they definitely had insurance but they still elected to use the Medical Center is another good indication that even when alternative choices are available, many people elect to continue to use the IHS system.

It should also be noted that the research assistants conducting the opinion poll often noted that consumers were somewhat defensive about the system when asked to rate it. Many consumers who reported they had been using the system for many years asked such questions as, "Does this mean they are going to close the hospital?" or made such statements as, "Well, we've had some problems over the years but overall the people here have been just wonderful." The study participants concluded that the level of consumer satisfaction for overall OPD service was consistent with the general level of consumer satisfaction in the private sector. More significantly, there was no indication that any smoldering dissatisfaction existed or that significant numbers of consumers felt that they were trapped by lack of resources into using what they considered inferior medical services.

Objective 2: Identify specific consumer problems in obtaining services from the Outpatient Department.

A large number of specific consumer problems were reported in the opinion poll. The study participants have elected to limit our discussion to those consumer problems which were mentioned by more than a dozen consumers. The major consumer problem to arise throughout the opinion poll was long waiting times. Many individuals reported waiting time from two to five hours for services sometimes with an appointment. Three-hundred and seventeen (317) individuals related waiting time as a primary problem in response to open-ended discussions. In addition, sixteen (16) people related waiting in the exam rooms as a significant problem with another twelve (12) people related generally waiting time when one has an appointment. In the opinion of the research consultants, the issue of waiting time could often be pivotal when discussing other preceived service delivery problems. Consumers who had waited two or three hours for care were oftentimes more agitated and willing to complain about the general level of organization. There is no question that consistently long waiting times contributes greatly to general attitudes about the OPD.

The second most mentioned problem was a perceived lack of organization in the OPD. Consumers specifically mentioned lack of training and courtesy at the front desk (28), no privacy at the front desk (18), lost charts (29), attitude of front desk staff (53), general indifference of front desk staff (14), problems with screening nurses (10), general disorganization (38). While consumers were sympathetic to the problems of running a large 24-hour OPD and emergency room, they often mentioned that organization could and should be better. Many people did not have

private sector experiences to compare them with but still felt that general phone conduct, courtesy and efficiency could be higher.

A third major problem area noted by consumers was the poor quality of the facility. Lack of space, lack of examining room space, lack of childrens' waiting area, a necessity to have drunks and emergency room patients using the same waiting area as appointment patients, the necessity to sometimes be treated in the hallway in front of the exam rooms, lack of privacy in the exam rooms, and generally poor facilities were consistently mentioned. While a variety of other problems were noted on the Consumer Satisfaction Survey, these three major areas were considered by the study participants to be of general concern to a significant number of consumers.

. Objective 3: Determine need for improved ambulatory care services from consumer viewpoint.

Consumers had a number of suggestions for improvement of services. The most often mentioned improvements were to upgrade general organization, improve waiting times and upgrade the facility. In addition to these problems which have already been noted, consumers mentioned a number of specific services which they felt were lacking. Most often mentioned was program or special services for alcoholics using the OPD. These services were most often mentioned in the context of not subjecting other nonalcoholic patients to the behavior of alcoholics either in the clinic or the waiting room. Consumers often felt that a family physician or the opportunity to see the same physician from visit to visit was extremely important. In addition, eleven (11) individuals mentioned that a separate walk-in clinic would allow more attention for appointment patients. Forty-five (45) individuals mentioned that more staff in general would improve services in the OPD. Patients did not mention issues such as mental health, alcoholism, or social services as services they expected the OPD to provide. In general, the perception of consumers was to provide better organized services similar to the services now being provided. Twenty-nine (29) reported that nothing needs to be done to improve the OPD's services. The study participants concluded that consumers do not perceive the OPD as being significantly improved by the addition of new services, but are primarily interested in a more thorough delivery of present services.

Task 2 - Consumer Problem Profile

Overview

A second task in the original evaluation proposal was the development of a Consumer Problem Profile. The lack of a computerized patient information system common to most ambulatory care programs had left the OPD with only the most rudimentary tabulations of patient utilization. At the time CINA conducted the study, there were no measures of unduplicated use over a period of time. Without basic encounter data, sophisticated utilization research was impossible. In spite of this problem, it was felt that it was necessary to review utilization patterns through review of individual charts even though the effort could not be exhaustive and would have to be limited to the collection of data relative to several already identified issues. During the first steps of the task, it became clear that little or no similar work has been done or published and that efforts to categorize patients by type of utilization would prove a difficult task. A great deal of discussion about what data to take off of the charts and how to subsequently use that data occurred. The chart review process was begun on an experimental basis and after several pre-test trials much of the information originally recorded seemed to be inappropriate. As a result, the study participants decided to collect as much data as possible while reviewing the charts, but to limit reporting of data to findings which could be well supported. A set of chart review criteria was cooperatively developed by the study participants. Criteria for chart review were as follows:

- Age of patient;
- Sex of patient;
- Inpatient history last six visits;
- Outpatient history;
- Current visit data and diagnosis;
- Last three previous visits, date and problem, including diagnosis;
- Estimate of the number of visits in the last six months;
- Assessment of whether or not those visits were alcohol or mental health related;
- Presence of alcohol mental health related problem recorded as a significant problem in the chart;

- Assessment on the part of the reviewer whether or not the patient's complaint and diagnosis fell into a loosely defined category of "worried well".

During November and December of 1977, the chart review was conducted by a physician's assistant familiar with the OPD services and on CINA staff. A total of five-hundred and sixty-five (565) records were reviewed. The raw data from the record review was reviewed by the study participants on a monthly basis. Day-to-day supervision of the chart reviewer and questions about individual diagnoses or problems in charting were directed to the Chief of the Outpatient Department. The data is being analyzed in two stages. The first stage is now complete. This includes an analysis of age, sex, alcohol and mental health related visits, worried well visits and other factors where general agreement as to the validity of the data could be revised. A more sophisticated analysis of diagnostic information and other more subjective data will be conducted during Phase II evaluation effort.

- Results

  - Utilization by Age Group

    The results of data analysis to date can be seen in Tables III-18 through III-21. Table III-19 shows the number of outpatient visits by each age group during the study period. As can be seen from the table, children under the age of ten and young adults between 20 and 30 years of age comprise approximately 52 percent of the patient visits to the OPD. As can be seen, the pediatric load, ages one to five, is especially high.

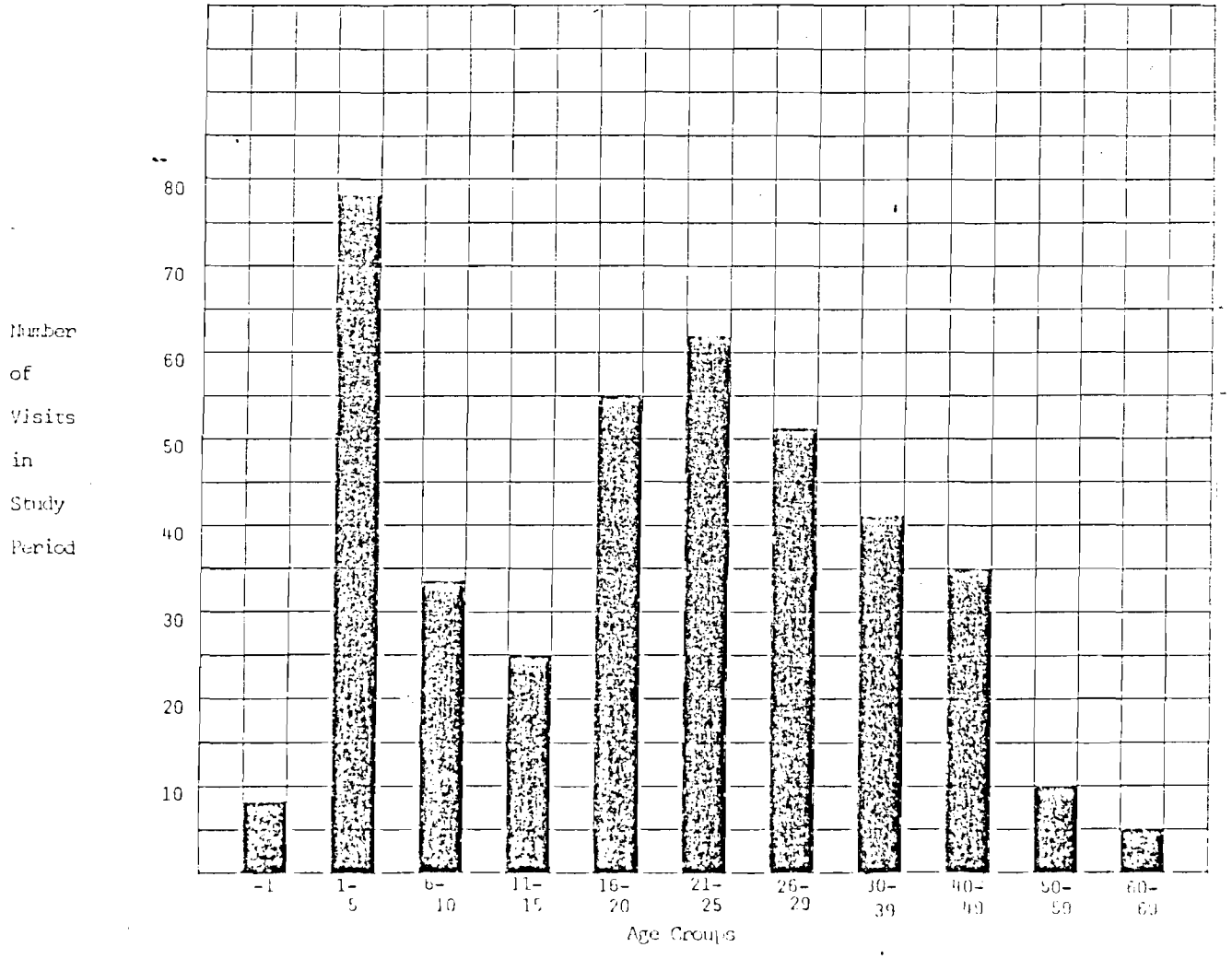
    Table III-19 shows the number of visits per person in the last six months. As can be seen from this table, all age groups have a high utilization level when all departments at the Medical Center are included. All age groups averaged more than one visit to the ANMC per month except children between the ages of six and 15, adults 60 years of age and older. These visits included pharmacy, dental and specialty clinics. The chart reviewers noted that even with this high volume of chart entries, the problem lists were often blank or incomplete.

  - Use of Other Departments

    The one to ten age group also accounted for high utilization in other areas of the hospital. Of the last three visits to the Medical Center recorded from each of the records, an average of 25% of the visits were to other departments in the hospital. Of this 25%, it was noted

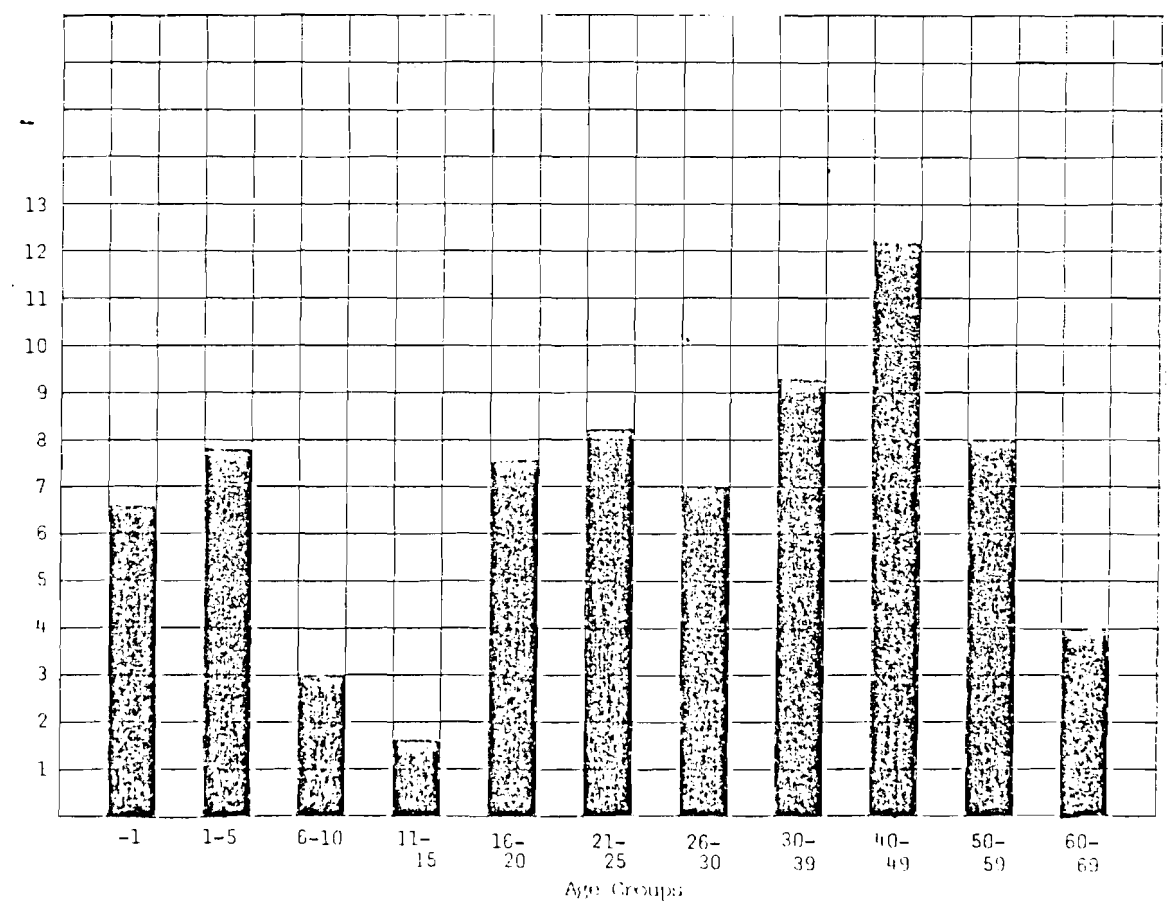
III-18

NUMBER OF OUTPATIENT VISITS GENERATED BY EACH AGE GROUP DURING STUDY PERIOD
(FOR AGE 30+ GREATER AGE GROUPS ADJUSTED TO THAT OF BELOW 30 I.E., ADJ. TO 5 YEAR INTERVAL)



III-19

ANMC VISITS PER PERSON LAST 6 MONTHS



that 35% children, ages one to five, were seen in Well Baby Clinic within the last three visits to the OPD. The most frequently used other departments were dental, pharmacy, eye, orthopedics and ENT.

. Appointments and Walk In

Table III-20 shows a breakdown by age distribution of patients having an appointment and those being seen on a walk in basis. As can be seen from this table, the majority of patients in the higher utilization age categories, one to ten and between 20 and 30, have the poorest appointment rates. 38% of the children between the ages of one and ten are seen by appointment. 36% of the age group 21 to 30 are seen by appointments. This can be contrasted to the age group of 11 to 20 where 51% are seen by appointments. The rate of utilization of appointments for all age groups is extremely low.

. Alcohol Related Visits

Table III-21 shows the findings from our analysis of alcohol related visits. Each chart was reviewed and an assessment was made of the number of visits which were alcohol related and whether or not a significant alcohol or mental health related problem was noted in the chart. As can be seen from Table III-21, by age 40-49, 35% of adults have an alcoholism or alcohol related disease listed as a significant problem in their medical record. 28% of adults have a problem noted by age 30-39; when age group of 50-59 is isolated the percentage of alcohol related problems decreases. This may be due to morbidity or some unknown factor affecting OPD utilization such as higher utilization of specialty clinics for patients with alcohol related problems.

Age group of 16-20 shows 7% of the patients with an alcohol problem noted as significant in the chart. The study participants noted that this issue needs further investigation but point to a growing problem in teenage alcohol abuse.

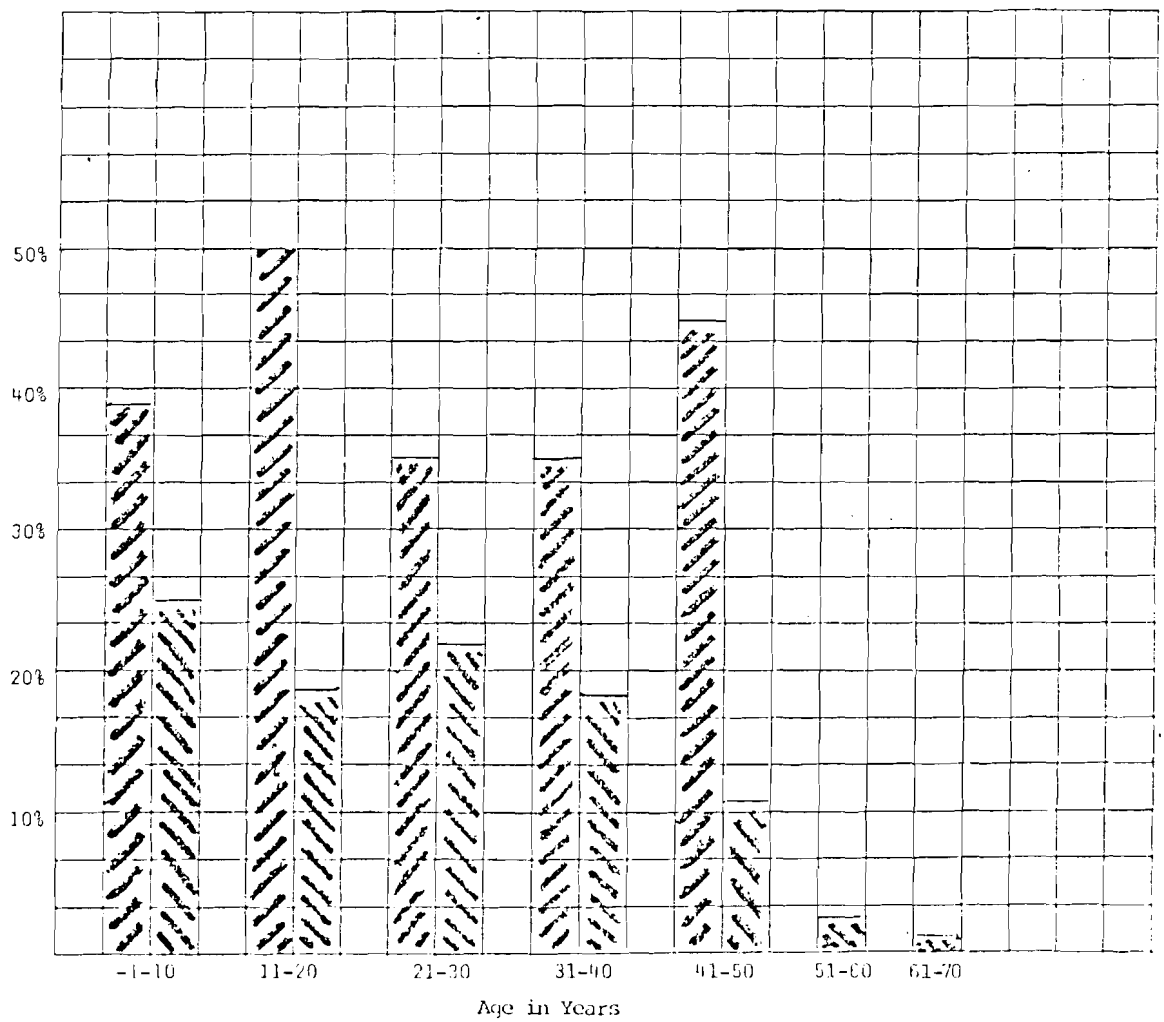
. Mental Health Related Visits

Table III-21 also shows the percentage of patients where mental health problems were noted as a significant problem in the chart. By age 26-30, 30% of the patients using the OPD during the study period had mental health problems noted in the chart. 19% had mental health problems noted between ages 21-25.

III-20

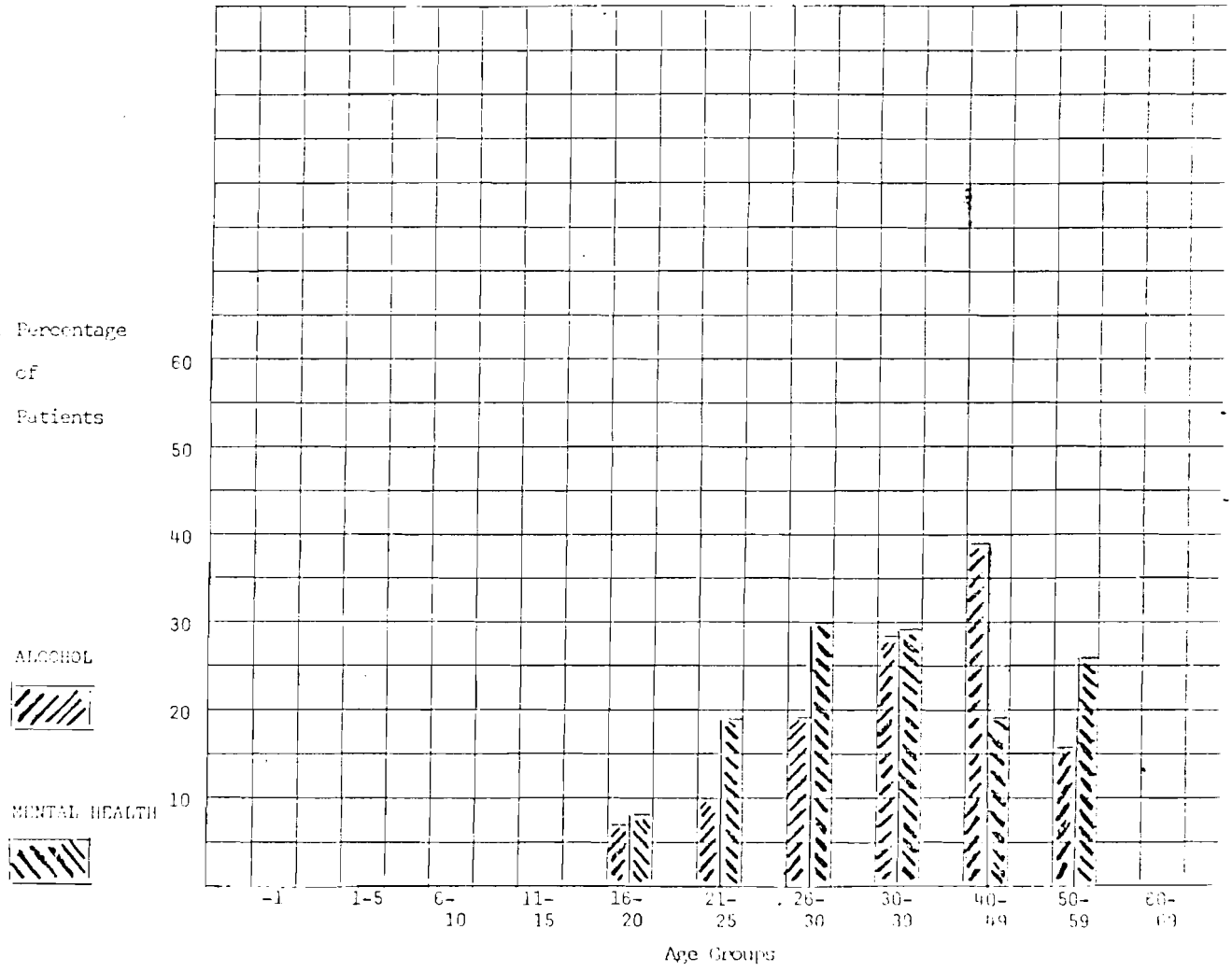
AGE DISTRIBUTION BY PERCENTAGE OF POPULATION SEEN IN OUTPATIENT DEPARTMENT

PERCENTAGE IN EACH AGE GROUP THAT ARE SEEN BY APPOINTMENT



III-21

PERCENTAGE OF PATIENTS SEEN DURING STUDY PERIOD WITH MENTAL HEALTH OR ALCOHOL NOTED AS A SIGNIFICANT PROBLEM IN THEIR CHART BY AGE



- Discussion

  The most interesting finding from the Consumer Problem Profile task was the identification of a large group, average of 22% of adults, with mental health and alcohol related problems. This high number of alcohol and mental health related problems noted in the charts of OPD patients points out the need for special programming or intervention policies and procedures to better provide appropriate service to these patients. In addition, the cost of provider time in dealing with problems for which they were not trained should be considered.

  Another significant finding was the high utilization rate of the patients between 21-39. This is generally a healthy age group yet they account for a high percentage of clinic utilization. In the judgement of the chart reviewer, 35% of visits in this age group were classified as worried well and better health information or education may have prevented the visit. Also noted was a high level of mental health and alcohol related visits for this age group, as classified by our chart reviewers. This data is not presented in table form due to need for further refinement.

- Objectives - Consumer Problem Profile

  - Objective 1: Assess the quality of present patient population data as it relates to optimum use of clinic resources.

    Patient demographic and utilization data was available from the IHS information system. However, this data was not considered accurate by providers and did not provide useful workload information for the management of clinic operations.

    The patient information system being proposed for ambulatory care at the ANMC would correct the present deficiencies in management information. Because this system is scheduled for implementation in the near future and because the information from present system using APC forms for input was not available for the study period at the time this report was prepared, no effort was made to compare consumer problem profile data with that from the present system.

    The study participants reviewed the proposal for the proposed patient information system and found the proposal to be excellent and concluded that implementation could potentially provide a significant contribution to future efforts to improve ambulatory care.

- Objective 2: Survey a minimum of 3000 individual patient records and categorize medical problems.

  The goal of reviewing 3000 charts was revised as the amount of data to be collected from each chart increased. The study participants elected to survey a sample of no less than 10% of all charts but to collect sufficient data so as to accurately reflect the patients' problems. A total of five-hundred and forty-one (541) charts were reviewed out of an estimated 4,200 individual users over the study period. Since no unduplicated count of users is available, this figure was estimated using results of a sample of chart requests for matching chart numbers, analysis of the appointment schedule and results of consumer satisfaction survey questions about utilization.

  Patient problems were categorized and results were reported in the previous section. The effort to classify problems by diagnosis is not complete and will be reported in part of Phase II.

- Objective 3: Analyze patient utilization patterns to determine the degree of over/under utilization and appropriateness of utilization and develop strategies for alternative service configurations to better fit patient problem and utilization patterns.

  The question of over and under-utilization was discussed at some length as the study progressed. Definitions for these terms were not well thought out prior to the beginning of the study. As the perspective of the patient about utilization became more clear during the Consumer Satisfaction Survey, the problems of setting a standard for over-utilization was left to subjective judgement. As a result, findings which were not conclusive were not reported. However, several patterns of agreed upon over-utilization were identified. They were:

  - The 21-39 age group;
  - Mental health patients seeking non-medical advice;
  - Alcoholics seeking non-medical assistance;
  - A high percentage (over 30%) of visits which were judged as "worried well".

  Suspected patterns of under-utilization were as follows:

  - Adolescents seeking health information and family planning.

. Patients needing follow up services for chronic illness.

The question of utilization patterns will be addressed in the second phase of the evaluation where data from the chart review process can be further analyzed. Areas where the study participants felt that the data was helpful in developing recommendations, but not valid enough to be published in the present form were as follows:

. Diagnostic categories;

. The category of "worried well";

. Analysis of hospital inpatient visits and history.

Task 3: Review of Selected Day-to-Day Operational Issues.

The purpose of this task was to review a selected series of day-to-day operational issues which the study participants felt impacted the accessibility or quality of patient care.

. Front Desk Operation

The first step in this task was to review OPD front desk and reception practices. This review was accomplished by several consultants working with and observing front desk activities for a period of seven days. During this time, basic workload data was collected and a review of medical records flow and control procedures was conducted. While a number of areas for improvement were found, the front desk operation in and of itself did not prove to be inefficient to the point where responsibility for long waiting times or clinic disorganization could be placed on this area alone. The findings of the analysis of front desk operations are described below:

. Working Space

Work space for the front desk was inadequate. There are approximately 90 square feet total work space in the front desk area. This also accommodates an electronic tramway for delivering charts which requires 25 square feet. There is less than 24 square feet of working surface which must accommodate a telewriter terminal and a telephone system. The front desk area is open to the patient waiting room across a 3 foot counter on two sides. Patients come to the front desk and wait for someone to come to their assistance. The counter space was often crowded during peak hours. This arrangement offered no privacy for telephone contacts or for staff to conduct small administrative chores. This space was compared with three non-IHS ambulatory care facilities with approximately same

patient load. Space for similar functions ranged from 290 square feet to 430 square feet.

- Positions

The front desk was staffed by five clerks. They were classified as GS 3's. These are entry level positions. They were often filled by inexperienced individuals hired under Native preference. This GS level is extremely low, making it difficult for a front desk/reception staff to maintain a home or family in Anchorage. This low pay scale has resulted in considerable staff turnover. Numerous efforts have been made to upgrade these positions through the Personnel Department. All efforts to upgrade these positions through the Civil Service system resulted in failure.

- Work Flow

The basic duties of the front desk staff are to greet patients entering the Outpatient Department, request patient's name, birthdate and chart number, order chart, determine if patient is a walk in or appointment patient. If walk in, determine presenting problem, obtain chart from rack for appointment patients and transfer to physicians' rack in clinical area. In the case of walk ins, the desk staff must order charts from chart room, wait for chart to arrive and leave the chart for the screening nurse who will then determine disposition. In addition, the front desk staff must order charts for the next day's appointments, stamp charts and log slips with day of encounter, handle the disposition of all telephone calls coming into the OPD. The general steps and work flow are well organized and understood by all of the staff. The primary problem of completing this work is general volume with high peaks early mornings, early afternoons and Mondays and Fridays.

- Staff Training

There are no formal staff training procedures for front desk and reception staff. The staff are generally trained on the job by the department supervisor or other reception personnel. This can be an extremely hectic and unpleasant experience for all concerned. Training often must take place during a high volume time period or when absenteeism reduces the number of staff available.

- Procedures

The front desk operating procedures contained in the OPD Clinic Procedures Manual are extremely outdated. The two page procedures no longer reflect current operations. The last addition to the written clinic procedures for front desk operations was in 1975. Lack of written procedures hinders day-to-day performance and requires staff to base decisions on the experience alone. This lack of written procedures requires that training of new staff be done verbally.

- Medical Records

Medical records are ordered from the chart room via a telewriter and delivered to the OPD by tramway. This procedure for ordering charts works extremely well if the following conditions are met:

- The records room is fully staffed during peak hours of OPD:
- The front desk staff accurately record the name, birthdate and, if possible, patient number;
- The front desk staff order the charts in a timely manner;
- If a chart cannot be found, the chart room calls the OPD within 20 minutes;
- OPD staff monitor chart requests to determine those which are overdue from chart room.

Obviously these conditions are not always met and breakdowns in the process result in long waits for charts. When charts are located in other departments and no staff from OPD or the patient is available to pick the chart up, long delays can occur. When charts cannot be located in the chart room, patients can be seen on continuation sheets. Table III-22 shows a sample of charts monitored by the research consultant during the observation of front desk activities. As can be seen, out of 100 charts monitored, the majority of charts (52) came between 20 and 30 minutes from time ordered. 32 came between 10 and 20 minutes. A total of 86 charts were received within 30 minutes. A brief review of the Medical Records Department and discussions with the Director of Medical Records revealed that the chart room was understaffed. A large number of chart requests are filled per day without the use of a computerized chart tracking system. At present no improvements in the difference between the time which OPD

charts are requested and the time which charts are received could reasonably be expected.

- Telephone System

The telephone system for the OPD was found to be inadequate. Primary problems were as follows:

- Equipment - The telephone equipment was outdated and inadequate for a clinical setting. Present system consisted of a total of 7 pushbutton business office lines which were often either ringing simultaneously or in use simultaneously.

- A small sample of calls were monitored by the consultant. Calls for physicians and other medical staff made up approximately 14% of the telephone load. An attempt is made by the front desk staff to take messages for physicians whenever possible unless the caller is another physician.

- Calls for general health information or what are referred to in the OPD as "nurse calls" make up approximately 18% of the telephone call load. During peak hours there may be as many as 10 nurse calls per hour. The remainder of calls are patients seeking appointments or other general business calls from other hospital departments, outside agencies or the chart room.

- One problem area was the time required to page a physician or nurse in the clinical area. Failure to respond promptly to a page will require that the calling individual be placed on hold and will tie up one phone line. The consultants observed a number of occasions where callers waited up to 10 minutes before some kind of action was taken. This problem was especially critical for nurse calls during peak hours. Pages for a nurse call oftentimes had to be repeated two or three times before a nurse was available to answer the call.

- Patients requiring appointments were oftentimes put on hold until clerks had finished a present task and were able to get to the appointment book. Because of the open desk and patients constantly attempting to catch the attention of the front desk staff, on numerous occasions people waiting for an opportunity to make appointments were kept on hold an inordinate length of time.

- At present any individual with knowledge of the front desk in the immediate vicinity is likely to answer a telephone. During one four hour observation period,

TABLE III-22

CHARTS MONITORED AT FRONT DESK

TIME FROM CHART ORDERED TO TIME CHART RECEIVED

32	10-20 minutes
52	20-30 minutes
13	30-40 minutes
3	Over 40 minutes

consultants observed nine (9) individuals left on hold who finally hung up.

- At present, all telephone calls coming into the OPD are routed through the front desk. No telephone log or other record of telephone contacts is made.

- Courteousness

Lack of courtesy on the part of the front desk staff was mentioned as a problem by consumers in the Consumer Satisfaction Opinion Poll. Observation of the front desk activities did not wholly confirm this complaint. On occasion, front desk staff appeared harried, disorganized and indifferent. Never were front desk staff observed treating patients in a discourteous manner unless patients were making loud and unreasonable demands or were generally acting discourteous themselves. On numerous occasions during the observation period it was necessary to call security officers to remove or deal with discourteous patients. One primary factor in the issue of courteousness was the fact that front desk staff have no privacy for the performance of clerical chores that are necessary to keep the patients moving through the system. On a number of occasions, patients waiting at the front desk would stand over the shoulders of front desk staff typing or working on charts or appointment books, and become upset that the front desk staff were "ignoring them". This type of pressure can contribute to inaccuracy on the part of the front desk staff in completing these clerical tasks and can contribute to agitation on the part of the patients. In other business office settings, these tasks are either conducted by one person who is obviously not available for reception work or these tasks are conducted out of sight of the reception window.

- Coverage

Maintaining adequate coverage at the front desk has been a chronic problem for a number of years. Historically, absenteeism has been the number one contributor to lack of coverage. Depending on the skill, motivation and maturity of the front desk staff working at the time, absenteeism can run as high as two days of inadequate coverage per week and even higher evenings and nights. During the course of the evaluation study, a new technique was tried by the supervisor of the front desk operation. Rotating shifts was employed which spread responsibility for evening and weekend coverage across all receptionists and provided opportunity for individual receptionists to work at both peak times and quiet times. The implementation of a