

**Frontier Extended Stay Clinic Project:
Qualitative Data**

Alicia Roberts Medical Center, Klawock

Submitted to:

**Alicia Roberts Medical Center
Klawock, Alaska**

Submitted by:



**Alaska Center for Rural Health –
Alaska's AHEC**

School of Nursing
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3211 Providence Drive
Anchorage, Alaska 99508

November 2006

Introduction

The Alaska Frontier Extended Stay Clinic (FESC) Consortium contracted with the Alaska Center for Rural Health - Alaska's AHEC, UAA (ACRH) for the evaluation of the Alaska Frontier Extended Stay Clinic Demonstration Project. ACRH, with technical assistance from the Cecil Sheps Center for Health Research, agreed to assess the impact of the FESC Project at the four participating clinics, from four perspectives: i) impact on staffing; ii) impact on clinical services; iii) impact on quality/disposition; and iv) impact on finance. The first area, staffing, was assessed via in-person qualitative interviews at each clinic near the commencement of data collection and again approximately one year later. The last three areas were (and continue to be) assessed using quantitative data for each FESC encounter collected by the clinics and transmitted to ACRH via an on-line data tracking system, the Clinical Outcome Log. Reports documenting the impact on clinical services and finance are provided separately.

This report presents an analysis and discussion of the qualitative data specific to Alicia Roberts Medical Center (ARMC), focusing on impact on staffing, representing the time period between March 2005 and June 2006.

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I. Methodology

To assess the impact of extended care services on staffing, ACRH conducted in-person confidential interviews with eight staff in each participating clinic, specifically staff involved in the provision of FESC services. An ACRH interview team of one or two persons conducted the interviews, with one staff taking notes in MSWord files that constituted the interview transcripts. The interviews were not tape recorded.

Clinic site staff interviewed included clinic administrators, physicians, physician assistants, nurses, lab and x-ray staff and EMTs. Questions related to clinic roles, work stress, and the impact on the clinic of providing FESC services and participating in the FESC project. Interviews lasted 30-45 minutes. At the close of each interview, ACRH interviewer(s) implemented a brief one-page survey to assess stress levels and the sense of control over the work environment.

These interviews were done at the beginning of the data collection period, and again approximately a year later. The analyses presented in this report incorporate both sets of interviews. Intentionally, about half of the interviewees were redundant between Year 1 and Year 2, to accommodate for staff turnover, and because the unit of analysis was the clinic rather than the interviewee. A copy of the interview instrument is found in the Appendix.

II. Findings

BACKGROUND:

Eight staff members were interviewed in both Year 1 and Year 2. Respondents performed a wide range of professional job duties, including physicians, mid-level practitioners, nursing staff, administrative and supervisory staff, and support staff such as LPN's and EMT-II's.

In Year 1, the range of longevity at the clinic varied from under 6 months to 15 years. In Year 2, all of the respondents had been at the clinic for less than 2 years except for one respondent who had been with the clinic for more than a decade. In general, Year 2 respondents were comparatively new to the clinic.

WORKLOAD:

Respondents, with the exception of after-hours clinicians, reported working Monday-Friday from 8am-5pm. Nurses take call one night a week, and every 7th weekend. Call can vary if staff members are sick or positions are unfilled. Others reported working extra hours in other capacities outside their primary work role, specifically on grants.

The addition of after-hours clinicians was new in Year 2. Respondents noted a decrease in the amount of call required for day staff clinicians since the hiring of two dedicated after-hours providers. The inclusion of an after-hours physician and physician's assistant has made clinician after-hours call rare.

CALL SCHEDULE:

Physicians and mid-levels described call in Year 1 as stressful, especially providers who had been at the clinic for less than 4 years. A typical comment shared was, *"It is stressful to be on call and to not be able to go home the next day. It takes away from our personal and family life. It would be nice to take the afternoon off and it doesn't always happen."* (Year 1 Respondent)

The need for provider call was generally eliminated by Year 2 with the addition of after-hours providers. The providers were generally gratified with the change and how it had impacted their need to take call. *"I no longer have after hours duties. It has been that way since this team started. We can continue this arrangement until FESC funding ceases. Everybody on the 'regular staff' has no expectation of weekend or evening work at all."* (Year 2 Respondent)

Nursing staff continue to take call, and it continues to be burdensome.

TURNOVER AND CAUSES:

In both years of interviews, ARMC reported a fair degree of turnover. In Year 1, turnover was described as impacting provider categories, as well as nurses. In Year 2, turnover was mentioned as impacting provider staff, a pharmacist, and support staff. Nursing was seen as somewhat stable, although one vacancy from the previous year continued to be unfilled.

Although turnover itself was not terribly variable between years, the perceived causes of the turnover were quite different. In Year 1, turnover was perceived to be related to three main

causes: communication issues, call schedule, and problems with the diversity of training and job expectations for support staff.

In Year 2, the perceived causes for turnover were more varied, and quite different than the reasons cited in Year 1. The reason cited most frequently in Year 2 was personality conflicts among staff. A common sentiment was, *“Since I have been here, personality issues have been the primary reason [why people have left].”* (Year 2 Respondent) Other issues such as work stress, job opportunities elsewhere, the remote location of the clinic, and the desires of spouse and family to leave were also cited.

STRESS:

Causes of clinic stress between the two years varied significantly. In Year 1, respondents had a much higher volume of comments than the second year. In both years, FESC patients were a relevant consideration throughout the interview. In Year 1, the other major factors included: working the day after a night of call, personality issues amongst staff (especially support staff) and supervision confusion. Lesser issues were: insufficient staffing, scheduling and communication. In Year 2, respondents only mentioned six issues, including FESC. They included: personality conflicts amongst staff and with difficult patients, administration disconnect, turnover (dealing with temporary clinicians and training new people), and trying to help patients with insufficient resources.

IMPACT OF FESC CASES ON STAFF:

In Year 1, staff had some concerns that FESC would initially make the job more stressful, but that the stress level would invariably decrease after working through the processes. A typical Year 1 respondent stated, *“I think FESC will initially overwhelm us and there will be a lot of crud going on. . . . Once it gets going, it will be a good thing.”* (Year 1 Respondent)

By Year 2, staff generally felt that FESC had not created a tremendous new source of stress, especially on the provider staff. Year 2 respondents generally agreed that the brunt of stress from FESC falls on the support staff. The perception is linked to two separate issues in the clinic – an existing nursing shortage that is exacerbated by FESC patients, and the fact that there are no dedicated night nurses like there are providers. *“The feeling among nursing staff is that we have put in the full day and we are ready to go home. The providers do [get to go home], because they have dedicated after-hours clinicians. But nursing staff doesn’t have that luxury. It affects me personally when I am up all night with a FESC patient and then have to come in the next day.”* (Year 2 Respondent)

III. Discussion

The quantitative data [see separate report] revealed that 40% of ARMC FESC patients were seen outside of normal clinic hours. That this percentage is so high should be no surprise: the urgent conditions requiring extended stays and/or medevacs occur 24/7. This high percentage also indicates the considerable FESC workload falling to the on-call staff of the clinic.

The addition of dedicated after-hours clinicians utilizing FESC funds has relieved regular ARMC clinical staff of the stress of being on-call. However, this after-hours FESC burden continues to fall on the nursing/support staff, as there are no corresponding dedicated after-hours nursing/support staff, in part due to difficulty recruiting for a still-vacant nursing position. Nursing/support staff must still put in on-call hours, much of this time spent treating after hours FESC patients. To this stress is added stress reported from various other non-FESC-related causes, such as administrative, personality, and turnover issues, issues that would need to be addressed outside the scope of this project.

Year 2 Key Informant Interviews: FESC

Everything you say will be confidential. We will not identify you or your clinic. However, people will be able to determine that the information came from a clinic participating in the Alaska FESC demonstration project.

1. [New Respondent] Can you tell me a little bit about your job: your role in the clinic, what your duties are, how long you've worked here.
2. [New Respondent] How would you describe your workload? What is your schedule like? How about your on-call schedule? Who do you share call with?
[Previous respondent] How has your schedule changed in the past year?
3. What is turnover like at your clinic? (How many new people do you have this year?)
4. What are the major reasons people leave, why do they come and stay? What about medical staff turnover?
5. What is the main source of work-related stress for medical staff in your clinic?
6. [Clinic Administrator] Does your facility have comp time or overtime benefits for staff when they work through the night to take care of patients?
7. How does it affect the clinic, the staff, etc. when you have FESC patients?
PROBE: does it affect staff workload and stress levels? Do you ever send patients home to self-observe? How does it affect the flow of patient care?
8. This clinic has participated in the FESC project for the past year. From your perspective, to what extent does being a FESC affect your work environment? Has it increased or decreased staff stress to provide these services?
9. Do you have any advice for other clinics who are considering becoming a FESC?

Please complete this short employee satisfaction survey.

<Scheduling>

1. I have little influence over the things that happen to me in the clinic.

a. Strongly agree b. agree c. not sure d. disagree e. strongly disagree

2. I cannot plan my day because we never know what will happen.

a. Strongly agree b. agree c. not sure d. disagree e. strongly disagree

<Modified work requirements>

3. I am often asked to do things that I am not trained to do.

a. Strongly agree b. agree c. not sure d. disagree e. strongly disagree

4. There are not enough trained people at the clinic to take care of all patients.

a. Strongly agree b. agree c. not sure d. disagree e. strongly disagree

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5. The clinical management needs to plan better for patient care.

a. Strongly agree b. agree c. not sure d. disagree e. strongly disagree

<Other>

6. Overall I am satisfied with my work.

a. Strongly agree b. agree c. not sure d. disagree e. strongly disagree

7. The amount of time I am “on call” is excessive.

a. Strongly agree b. agree c. not sure d. disagree e. strongly disagree

Frontier Extended Stay Clinic Project: Qualitative Data

Cross Road Medical center, Glennallen

Submitted to:

**Cross Road Medical Center
Glennallen, Alaska**

Submitted by:



**Alaska Center for Rural Health –
Alaska's AHEC**

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This report presents an analysis and discussion of the qualitative data specific to Cross Roads Medical Center (CRMC), focusing on impact on staffing, representing the time period between March 2005 and May 2006.

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I. Methodology

To assess the impact of extended care services on staffing, ACRH conducted in-person confidential interviews with eight staff in each participating clinic, specifically staff involved in the provision of FESC services. An ACRH interview team of one or two persons conducted the interviews, with one staff taking notes in MSWord files that constituted the interview transcripts. The interviews were not tape recorded.

Clinic site staff interviewed included clinic administrators, physicians, physician assistants, nurses, lab and x-ray staff and EMTs. Questions related to clinic roles, work stress, and the impact on the clinic of providing FESC services and participating in the FESC project. Interviews lasted 30-45 minutes. At the close of each interview, ACRH interviewer(s) implemented a brief one-page survey to assess stress levels and the sense of control over the work environment.

These interviews were done at the beginning of the data collection period, and again approximately a year later. The analyses presented in this report incorporate both sets of interviews. Intentionally, about half of the interviewees were redundant between Year 1 and Year 2, to accommodate for staff turnover, and because the unit of analysis was the clinic rather than the interviewee. A copy of the interview instrument is found in the Appendix.

II. Findings

BACKGROUND:

Eight CRMC employees were interviewed in both Year 1 and Year 2. The professional make-up of those interviewed differed slightly between years. Year 1 included two physician respondents, while Year 2 included no physicians but one midlevel provider. At the time of Year 2 interviews, CRMC had no physicians on staff, and the 2nd midlevel provider was scheduled to leave shortly. Both years included a large number of nurses and one member of the lab staff.

Respondents tended to be either very new to CRMC (employed within the past several years) or long-term employees who had been with the clinic for well over 10 years. In Year 2, the new employees interviewed tended to be “newer” than those interviewed in Year 1 with the majority of respondents having tenure of less than one year with the clinic.

WORKLOAD and CALL:

At the time of the Year 2 interviews, the single midlevel provider was not aware of any provider back-up support in the near future. Due to anticipated nurse resignations, the remaining nurses had just transitioned to 12 hour shifts. They all would oscillate between day and night shifts each week, which was a concern for sleep regularity.

TURNOVER AND CAUSES:

Staff turnover is high at the clinic. In Year 1, turnover was particularly high for nursing staff, who tend to have short-term missionary assignments. Year 2 experienced a high rate of turnover for all types of workers, including administrative personnel, nurses, midlevels, pharmacists and lab workers.

For both years, the most prevalently cited cause of turnover is the reliance on missionary staff that only plan on short-term employment. However, other causes were also discussed. Cited causes of turnover include the following:

- **Missionary nurses** -- *“there have been 30 nurses in the past 2.5 years. . . We come as short-term missionaries.”* (Year 1 Respondent) *“Our turnover rate is 25% over the past two years. I think one of the reasons it is so high is that our nursing staff are temporary. They come with the idea that they will be here 1-2 years. One thing we are trying to change is the recruitment of permanent staff. We still want short-term missionaries, but we are making a commitment to hiring permanent staff.”* (Year 2 Respondent)
- **Nurses starting families** – *“Turnover depends on the number of eligible men around here. There are times when we have married off three women in six months.”* (Year 1 Respondent)
- **Distance from family** – *“Distance from home is a big deal. Many of the nurses don’t have family here.”* (Year 2 Respondent)
- **Wages** – *“I don’t think the nurse wages are sufficient to support a family.”* (Year 2 Respondent)
- **Nature of work** – *“[There is a] lack of work challenges – we are over-scheduled and under-challenged professionally – not a good place for adrenaline junkies.”* (Year 2 Respondent)

Respondent) *“One reason [for turnover] is job experience. You get a bit of everything here, but not a lot of anything...”* (Year 2 Respondent)

SOURCES OF STRESS:

Sources of stress varied considerably both within and between years. Sources of stress were somewhat dependent on the type of job of the respondent. Administrative personnel discussed budget and recruitment stresses while clinical staff talked about call, workload, and professional isolation. Sources of stress cited by respondents in each year include:

- **Workload** -- *“The major source of stress is feeling like you live here when it is very busy. Also, we must have a broad base of knowledge to work here. We have to do everything and that is a huge stress.”* (Year 1 Respondent)
- **Call** -- *“It is the on-call. Some find the schedule change/shift rotation (nights to days and back) difficult. Some say it is the demands on knowledge; you must have a huge breadth of skills, which creates stress.”* (Year 2 Respondent)
- **Professional isolation** – *“I can’t call a specialist upstairs and ask him/her to take a look at this case.”* (Year 2 Respondent)
- **Staff turnover** – *“Over the years, the stress varies by the turnover of leadership.”* (Year 1 Respondent) *“Another big stressor is trusting your colleagues. Since there is a big scope of practice, it is hard to trust new people because you don’t know what their background is.”* (Year 1 Respondent)
- **Inappropriate use of call** – *“For me, the patients’ abuse of the system is stressful. We are open all hours; there is abuse of the system. People call at 2am to say they are coming in for something very minor.”* (Year 2 Respondent)

COMPENSATION AND BENEFITS:

Changes in compensation for overtime and call were instituted between the Year 1 and Year 2 interviews. Previously, providers were either salaried or unpaid missionary workers. They were ineligible for overtime for working on-call. With recent changes, workers are provided with 1 day of comp time for every 7-8 days of call. Many respondents stated that compensation is not an issue since they are missionary nurses and not paid by the clinic.

FESC IMPACT ON CLINIC FLOW AND STRESS:

Serving FESC patients creates more stress according to many respondents. The stress is greater when the patient requires night observation.

Year 2 respondents were more likely to discuss FESC patients as stressful – which seems to be related to the lower number of nurses available at the time of Year 2 interviews. Year 2 respondents were also more likely to state that FESC interrupts patient flow at the clinic. Some of the specific sources of FESC related stress that were mentioned are described below:

- **Clinic flow** -- *“Regarding daytime FESC patients affecting clinic flow -- it affects nursing more than others. If we have to admit someone to observation, we call in the extra nurse.”* (Year 1 Respondent) *“If we have a FESC patient in the clinic during the day, it does interrupt patient flow. And the staff on-call has to come in after hours to care for FESC patients. It definitely increases the workload and stress levels.”* (Year 2 Respondent)

- **Anticipatory stress of FESC** – *“There is also the anticipatory stress. It affects your quality of life because if you are on-call, you can’t be out of town. I can be at church in Copper Center (20 minutes), but the cell phone doesn’t work out there.”* (Year 2 Respondent)
- **Affect of night FESC patients** --*“During the day, it is not so hard. That is not the same level of stress. There are enough people around to help....The difficulty comes when it is overnight, through the night. Because both providers and some nurses work during the day too, it is draining to serve someone through the night.”* (Year 2 Respondent)
- **Variability of FESC demands** -- *“We are geared to care for FESC patients; it is part of who we are. When you are rural like this, it is part of the job. What is hard is the feast and famine. Some nights are so boring; another night you have a medevac, ambulance run, stroke, and more.”*

CHANGES TO STAFFING AND STRESS FROM BECOMING A FESC:

In Year 1, respondents were asked to describe the changes to staffing and stress that they anticipated from becoming a FESC. Most felt that there would be few changes to the workload or staffing. Some Year 1 respondents expressed concerns about adequate nursing staff while others felt that staff was adequate. Year 1 comments included:

Year 1 Comments:

- *“Any facility providing round the clock care needs to have a minimum of 15 nurses. So you have one nurse here and two on call.”*
- *“As a FESC, we will have more call support (Melodie is coming in May).”*
- *“We have plenty of nurses and other staff to handle FESC level services.”*
- *“Regarding anticipated impact of being a FESC, I don’t see any. Other than the additional PA, we won’t change our staffing. I hope we see a standard to follow, a standard of practice, for consistency across facilities.”*

In Year 2 after FESC funding was in place, all respondents felt that FESC had either decreased stress or at worst, had not increased stress. All respondents felt that being part of the FESC project had proven beneficial in some way.

Year 2 Comments:

- *“The staff and equipment have decreased staff stress. Whenever you have more resources to provide care, it helps.”*
- *“It has not increased stress, because we have been doing it. I suppose it is lower as the equipment has eased the burden. Some new monitoring equipment has made the nurses’ job better – they can care for patients better. And being recognized as doing something different, a FESC, is a good thing. It is also good to be involved with the other clinics. “*
- *“We have been providing FESC services for a long time. Being involved with the FESC project has helped us know we are not by ourselves...The FESC resources have affected us in a wonderful, positive way. I think at every level staff would say they appreciate the equipment.”*

ADVICE TO OTHER CLINICS:

Respondent advice focused on staffing, appropriate equipment, and staff support services. Year 2 respondents, in particular, would encourage other clinics to become a FESC.

- **Staffing** -- *“Final advice: We are a RN heavy site. Other sites have different staffing structures. It is important to be clear about roles and responsibilities and keeping people in*

line with their scope of practice. The experience base is also crucial, given the breadth of patients we see.” (Year 1 Respondent). “If a clinic is going to expand services, the sporadic ebb/flow of patient flow makes it difficult to recruit and retain the needed personnel. You want quality nurses that can handle emergencies, and yet they aren’t going to see those emergencies every hour.” (Year 2 Respondent). “I wish the CMS demo would start sooner rather than later. We should be able to bill ER codes. We need operational money, not toys.” (Year 2 Respondent)

- **Equipment** – *“The right equipment has been key. We have run for years on archaic equipment. We got a new defibrillator that is functional and up-to-date. Every FESC will look different and provide a different array of services, but they need to look at the worst elective FESC and how to best care for them.” (Year 1 Respondent)*
- **Site support** – *“I also like working with the other FESC clinics; they are a great resource to us in finding specific things, learning about staff compensation, etc.” (Year 2 Respondent)*
- **Staff support services** – *“Regarding advice for other clinics, one of the things we don’t do well is provide for staff sharing and getting rid of our stress. Parties, self-care for providers, stress seminars – we need something like that.” (Year 1 Respondent)*

III. Discussion

Of the participating FESC clinics, CRMC had the highest percentage of its FESC encounters (55%) beginning outside of normal clinic hours (“after hours”). With CRMC’s RN-rich staff working rotating 12-hour shifts, this represents a significant workload for the after hours/”night shift” staff, who reported affected sleep quality, anticipatory stress, heavy demands on their skills and knowledge, and the stress of long after hours Mon Ob encounters: “... *it is draining to serve someone through the night.*”

Staff turnover continues to be an issue, though largely for reasons external to the FESC project: missionary staff who serve for limited time periods; marriages and children; and distance from family in the lower 48. The stressors inherent in rural clinic work, such as professional isolation, and “feast or famine” workloads, also contribute to turnover. However, most staff reported a reduction in FESC-related stress in the past year, in part due to the addition of staff and new equipment. Staff are generally supportive of the project, citing recognition of their FESC work and the opportunity to work with other FESC clinics.

Appendix: Interview Instrument

Year 2 Key Informant Interviews: FESC

Everything you say will be confidential . We will not identify you or your clinic. However, people will be able to determine that the information came from a clinic participating in the Alaska FESC demonstration project.

1. [New Respondent] Can you tell me a little bit about your job: your role in the clinic, what your duties are, how long you've worked here.
2. [New Respondent] How would you describe your workload? What is your schedule like? How about your on-call schedule? Who do you share call with?
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4. What are the major reasons people leave, why do they come and stay? What about medical staff turnover?
5. What is the main source of work-related stress for medical staff in your clinic?
6. [Clinic Administrator] Does your facility have comp time or overtime benefits for staff when they work through the night to take care of patients?
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8. This clinic has participated in the FESC project for the past year. From your perspective, to what extent does being a FESC affect your work environment? Has it increased or decreased staff stress to provide these services?
9. Do you have any advice for other clinics who are considering becoming a FESC?

Please complete this short employee satisfaction survey.

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Iliuliuk Family Health services, Unalaska

Submitted to:

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Unalaska, Alaska**

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II. Findings

BACKGROUND:

Eight Iliuliuk employees were interviewed in both Year 1 and Year 2. Both years included personnel from a variety of health professions, including physicians, midlevels, nurses, LPNs, medical assistants, administrators, and lab staff. Tenure of Year 1 respondents varied from six months to 18 years, with the majority of respondents being employed at IHFS less than four years. In Year 2, respondent tenure varied from nine months to 18 years, with three respondents employed at IHFS under a year.

CALL SCHEDULE:

Providers (physicians and midlevels) take call for a week at a time. On-call starts at 9:00 am Saturday morning. They are off M-F during regular business hours, but come into the clinic from 4:30-6:00 pm to pick-up patients, and are on call till the next day at 8am. Their call cycle ends at 9am the next Saturday morning. Nurses get called only when the provider needs them. However, during the busy seasons, there is a dedicated night nurse to handle off-hours patients.

Providers get paid “time and a half” if they get called in, plus \$20 per day for being on-call, regardless of whether they actually get called in. Call did not seem to be a major issue for respondents in either Year 1 or Year 2.

SCHEDULE CHANGES:

The major change in the schedule between Year 1 and Year 2 was the addition of a dedicated night shift nurse during the busy season. Respondents were overwhelmingly pleased with this change and felt that it decreased staff burnout and stress. Day shift workers noted that having a night shift decreased their workload during the day while minimizing schedule changes to existing providers due to call. Patient care improved. Overtime costs were decreased substantially with the addition of the dedicated shift.

- *“It helped a lot to have night shift. Normally, I don’t call a nurse unless there’s something I absolutely can’t do. But having a nurse here that can do the x-ray, flow sheet, etc. reduced our workload.”* (Year 2 Respondent)

TURNOVER AND CAUSES:

There were changes in the rate of turnover occurring at the clinic between Year 1 and Year 2.

In Year 1, respondents described low turnover and stable staffing. *“Turnover among providers is low. . . Even my itinerants are very stable- the team has been coming here since 2002 and another used to be employed out here and has been itinerating for 4 years. People like working here. Students want to come back and work here.”* (Year 1 Respondent) Respondents felt that the biggest reason for turnover, when it occurred, was personal reasons, including spousal employment opportunities off the island.

Turnover was perceived to be a bigger issue among Year 2 respondents. Physicians, midlevels, dental assistants, nurses, and administrative personnel were all cited as having a fairly high

turnover rate. By far, the most commonly cited cause of turnover was personal issues. *“Some of the people left due to relocation pressure/opportunities (husband transferred, etc.)...I don’t think people left because of their schedule.”* (Year 2 Respondent) Most respondents felt that turnover was not related to the call schedule or FESC.

CAUSES OF STRESS:

In Year 1, causes of stress fell into three general categories: perception of inadequate compensation, weather as a patient transport barrier, and the busy season.

In Year 2, the primary source of stress continued to be the role of weather as a patient transport barrier. Subsequent causes of stress were varied. They included: training new staff, medical isolation, transitioning to a primary clinic (as opposed to walk-in patients only), and patient personalities.

IMPACT of FESC:

In Year 1, respondents did not anticipate that FESC would change or negatively impact the clinic work environment, primarily because they are already providing FESC services. If anything, the additional compensation to support additional staff was predicted to make for a less stressful environment.

This expectation was supported in the Year 2 interviews. Respondents either said that the FESC project had no impact on clinic stress or that the night nurse decreased clinic stress.

III. Discussion

Forty-two percent of IFHS's FESC encounters occur after normal clinic hours, representing a significant workload for the after hours/on-call staff [see separate report]. The addition of a dedicated night shift nurse during the busy season to help deal with the after hours workload (both FESC and non-FESC) has not only relieved considerable staff stress, but decreased staff burnout, improved patient care, and decreased overtime costs. This is borne out by the fact that call schedules were no longer cited by staff as contributing to staff turnover. These results were anticipated at the beginning of the FESC project and staff report that their expectations have been fulfilled.

Staff stress and turnover, however, continue to be challenges due to inclement weather that impedes timely patient transfer, personal issues (e.g., relocation of spouses), training new staff, professional isolation, and patient personality issues. However, these issues either fall outside of the scope of the FESC project or are beyond the control of clinic staff.

Year 2 Key Informant Interviews: FESC

Everything you say will be confidential . We will not identify you or your clinic. However, people will be able to determine that the information came from a clinic participating in the Alaska FESC demonstration project.

1. [New Respondent] Can you tell me a little bit about your job: your role in the clinic, what your duties are, how long you've worked here.
2. [New Respondent] How would you describe your workload? What is your schedule like? How about your on-call schedule? Who do you share call with?
[Previous respondent] How has your schedule changed in the past year?
3. What is turnover like at your clinic? (How many new people do you have this year?)
4. What are the major reasons people leave, why do they come and stay? What about medical staff turnover?
5. What is the main source of work-related stress for medical staff in your clinic?
6. [Clinic Administrator] Does your facility have comp time or overtime benefits for staff when they work through the night to take care of patients?
7. How does it affect the clinic, the staff, etc. when you have FESC patients?
PROBE: does it affect staff workload and stress levels? Do you ever send patients home to self-observe? How does it affect the flow of patient care?
8. This clinic has participated in the FESC project for the past year. From your perspective, to what extent does being a FESC affect your work environment? Has it increased or decreased staff stress to provide these services?
9. Do you have any advice for other clinics who are considering becoming a FESC?

Please complete this short employee satisfaction survey.

<Scheduling>

1. I have little influence over the things that happen to me in the clinic.

a. Strongly agree b. agree c. not sure d. disagree e. strongly disagree

2. I cannot plan my day because we never know what will happen.

a. Strongly agree b. agree c. not sure d. disagree e. strongly disagree

<Modified work requirements>

3. I am often asked to do things that I am not trained to do.

a. Strongly agree b. agree c. not sure d. disagree e. strongly disagree

4. There are not enough trained people at the clinic to take care of all patients.

a. Strongly agree b. agree c. not sure d. disagree e. strongly disagree

<Supervisory attitudes>

5. The clinical management needs to plan better for patient care.

a. Strongly agree b. agree c. not sure d. disagree e. strongly disagree

<Other>

6. Overall I am satisfied with my work.

a. Strongly agree b. agree c. not sure d. disagree e. strongly disagree

7. The amount of time I am “on call” is excessive.

a. Strongly agree b. agree c. not sure d. disagree e. strongly disagree

**Frontier Extended Stay Clinic Project:
Qualitative Data**

**Inter-Island Medical Center
Friday Harbor, Washington**

Submitted to:

**Inter-Island Medical Center
Friday Harbor, Washington**

Submitted by:



**Alaska Center for Rural Health –
Alaska's AHEC**

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November 2006

Introduction

The Alaska Frontier Extended Stay Clinic (FESC) Consortium contracted with the Alaska Center for Rural Health - Alaska's AHEC, UAA (ACRH) for the evaluation of the Alaska Frontier Extended Stay Clinic Demonstration Project. ACRH, with technical assistance from the Cecil Sheps Center for Health Research, agreed to assess the impact of the FESC Project at the four participating clinics, from four perspectives: i) impact on staffing; ii) impact on clinical services; iii) impact on quality/disposition; and iv) impact on finance. The first area, staffing, was assessed via in-person qualitative interviews at each clinic near the commencement of data collection and again approximately one year later. The last three areas were (and continue to be) assessed using quantitative data for each FESC encounter collected by the clinics and transmitted to ACRH via an on-line data tracking system, the Clinical Outcome Log. Reports documenting the impact on clinical services and finance are provided separately.

This report presents an analysis and discussion of the qualitative data specific to Inter-Island Medical Center, focusing on impact on staffing, representing the time period between September 2005 and October 2006.

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I. Methodology

To assess the impact of extended care services on staffing, ACRH conducted in-person confidential interviews with eight staff in each participating clinic, specifically staff involved in the provision of FESC services. An ACRH interview team of two persons conducted the interviews, with one staff taking notes in MSWord files that constituted the interview transcripts. The interviews were not tape recorded.

Clinic site staff interviewed included clinic administrators, physicians, physician assistants, nurses, lab and x-ray staff and EMTs. Questions related to clinic roles, work stress, and the impact on the clinic of providing FESC services and participating in the FESC project. Interviews lasted 30-45 minutes. At the close of each interview, the ACRH interviewer(s) implemented a brief one-page survey to assess stress levels and the sense of control over the work environment.

These interviews were done at the beginning of the data collection period, and again approximately a year later. The analysis presented in this report incorporates both sets of interviews. Intentionally, about half of the interviewees were redundant between Year 1 and Year 2, to accommodate for staff turnover, and because the unit of analysis was the clinic rather than the interviewee. A copy of the interview instrument is found in the Appendix.

II. Findings

BACKGROUND:

Eight staff members of the Inter-Island Medical Center in Friday Harbor, WA were interviewed in both Year 1 and Year 2. Respondents performed a wide range of professional job duties, including physicians, nurses, and the clinic administrator.

In Year 1, the range of longevity at the clinic varied from under 6 months to 21 years. In Year 2, longevity ranged from under 6 months to 15 years.

WORKLOAD:

Workload changed very little between Year 1 and Year 2 of the clinic. FESC participation did not appear to impact employee work schedules. In fact, several interviewees clearly stated in their Year 2 interviews that there had been absolutely no change in their workload over the course of the year of the demonstration project.

Full-time physicians work 17-19 days per month with 24 hour shifts. During normal clinic hours, the physicians see scheduled patients in 15 minute intervals. They often see up to 35 patients per day. Each physician has a nurse assigned to them in a "pod" model.

Most nurses work four days per week and take call. Some nurses are assigned to a specific physician to work on that team, while others work as triage/float nurses.

The summer months constitute a peak season for the clinic due to the influx of tourists and visitors. The holiday season can also bring an increased workload, due to both increases in people to care for, as well as reduced staffing from vacations.

CALL SCHEDULE AND COMPENSATION:

Call schedules also did not vary substantially between Year 1 and Year 2. Physicians take call every 2-3 days while nurses take call about once a week. The presence of a vacancy for the position of back-up nurse, which was present during both Year 1 and Year 2, caused some nurses take call more often. Each call shift last 24 hours, beginning at 8am and ending at 8am the following morning.

Physicians are on-call 6 days per month as part of their regular salary. They receive extra pay for accepting call for additional days. Nurses get a call rate of \$30 per night, and then get paid a minimum of \$80 for each time they are called in. The rate goes up after 10pm.

SATISFACTION WITH CALL COMPENSATION:

Clinical staff members are paid differently for their on-call services depending on their professional role. Nurses get paid a flat rate for being on-call, and paid additionally if

they have to come in. Doctors are compensated separately for call and receive payment whether they come in or not.

Year 1 Respondents provided input as to satisfaction with the call compensation structure. Year 2 respondents did not. Reactions from respondents in Year 1 were mixed regarding the adequacy of compensation for call. One physician respondent stated, *"I can't speak for how the nurses feel about their compensation. The docs are fairly comfortable with the compensation, as long as it [the number of calls] isn't too much"* (Year 1 Respondent). Others affirmed, *"It is better than it used to be. I am not unhappy with it"* (Year 1 Respondent).

Several Year 1 respondents, though, were decidedly unhappy about the state of the on-call system and the accompanying compensation. *"Everyone will agree that we need more money for call compensation. People are not thrilled about being on call"* (Year 1 Respondent). Another elaborated on the cause of the dissatisfaction. *"No, I don't think we are adequately compensated. We are fairly compensated for a call-in, to come in. I don't think we are adequately compensated for carrying the pager"* (Year 1 Respondent).

TURNOVER AND STRESS:

In general, participants in both Year 1 and Year 2 felt that turnover was not a major issue at the clinic. *"This is one of the best employers in town with full benefits and a good salary. We are part of the County, which is a great employer"* (Year 2 Respondent). Another commented, *"Turnover is remarkably small relative to other companies on island"* (Year 2 Respondent).

The one exception to this rule, in both Year 1 and Year 2, was turnover for front desk staff. *"Our primary source of stress has been staffing the front desk...."* (Year 1 Respondent). A Year 2 respondent concurred, stating, *"Turnover rate, as far as nurses and physicians, is very stable and low. The most turnover is at the reception desk. It is difficult to find someone who will work for a relatively low salary and manage an electronic records system. Uninsured patients and tourists can be confusing and challenging to command."*

One difference between Year 1 and Year 2 was in respondents' reported sources of stress. In Year 1, respondents focused their comments towards two sources of stress – front desk office staff and appropriate staffing for seasonal peaks in demand for services. In regards to peak season staffing, one respondent noted, *"Our nursing staff work extremely hard and in the summer are overworked. Because of the call responsibility, we have the nurses in here and a couple of them, in particular, take an unusual amount of call. I am concerned at times about overworking our best nurses. Part of the nursing issue is the seasonal nature of our workload. In the summer, we feel understaffed. In the winter, we feel almost overstaffed. On the other hand, it is very difficult to attract a nurse to work 6 months/year on the island"* (Year 1 Respondent.).

Front desk staffing was also discussed heavily in both years. Stress came from both the problem of recruiting front office staff, as well as stress caused by the front office staff that is employed. *"Our employee pool on the island is limited. .. By island standards, front desk salaries are lower than cleaning houses. It is hard to attract high quality employees"* (Year 1 Respondent). A Year 2 Respondent noted that the front office staff often adds to the stress levels of other employees at the clinic. *"The main source of stress is the front office staff. It is stressful when you are busy in the back with patients and you are called to the Front Desk and it is not an urgent need. It wears on you day in and day out"* (Year 2 Respondent).

While in Year 1, front office staff and seasonal peaks were the focus of discussion, in Year 2 respondents noted sources of stress that were more varied. Although dealing with front office staff and meeting the demands of seasonal highs both continued to be sources of stress, other stressors were also cited, including:

- **15 minute Patient Visits** – *"I personally think a 15 minute doctor's visit is a joke. Not one doc can do a decent job in that timeframe. Patients invariably stay over, and it upsets the next patient, who is seen late"* (Year 2 Respondent). Another added, *"The elderly patients need more than 15 minute office visits, taking more time from the urgent care demands"* (Year 2 Respondent).
- **Call** – *"The docs interact with EMS at all hours; the call issue"* (Year 2 Respondent). Another added, *"There are a lot of surprises with call; you never know what is going to come in. It is the 'not knowing'"* (Year 2 Respondent).
- **Primary Care Needs vs. Urgent Care Needs** – *"The biggest source of stress is the balancing act between primary care and urgent care...Residents see us as an ER. I think the docs find it tough to wear the two hats of primary care and urgent care."* (Year 2 Respondent).
- **Unrealistic Patient Demands** – *"I think the uninsured and under-insured who are not taking responsibility for their health are a concern. They may have a gallbladder attack for example, they have no way to get to the mainland, so they want us to resolve the problem, which is beyond our scope, rather than go somewhere else."* (Year 2 Respondent). Another added, *"The stress now is unrealistic expectation of patients. They ask for ridiculous things, making big deals out of stupid stuff"* (Year 2 Respondent).
- **Paperwork** – *"For the physicians, the paperwork is the main source of stress. We see a lot of acuity and complexity than in a regular practice setting (elderly population). These generate a lot more paperwork in terms of progress notes I have to prepare. For me, that is fairly stressful"* (Year 2 Respondent).
- **Multitasking** – *"For nursing staff, I would say sometimes there are just a lot of irons in the fire at once and not enough hands for what they have to deal with"* (Year 2 Respondent). Another added, *"Multi-tasking is stressful. The phones are ringing, there is someone waiting in a room, and emergency – stuff like that. This happens to everyone"* (Year 2 Respondent).

CHANGES IN STRESS WITH FESC PARTICIPATION:

Respondents overwhelmingly agreed that participation in the FESC project provided no changes to the stress level or work level of the clinic. *"We have always been a level-5 trauma center; we work in concert with EMS (under one hospital district governing board) – thus we are already set-up to operate this way."*

Some noted that there has been a slight increase in the level of paperwork, but nothing that has been overly stressful or difficult. *"There is no change at a clinical level. The patients are no different. There is more paperwork, but not for me. There is no impact on stress levels."*

REASONS WHY PEOPLE STAY AND LEAVE:

Year 2 Respondents discussed their perceived reasons why people stay and leave clinic employ. There was little consensus on perceptions for why employees either leave the clinic or choose to stay. Rather, a wide variety of causes were cited, showing the complexity of factors that impact an individual's employment decision.

Cited reasons for why people leave the clinic included:

- **Lack of skills required for the job** – *"Some people have left who should not have been hired in the first place. They may have needed the job and perhaps were not sufficiently forthright about their skills" (Year 2 Respondent).*
- **On-Call Schedule** – *"The major reason people leave is the call factor. People say that if they didn't have to take call, it would be an ideal job" (Year 2 Respondent).*
- **Educational Opportunities** – *"People tend to leave for educational opportunities. For example, they might be 22 years old and decide to go off-island for a broader educational setting" (Year 2 Respondent).*
- **Lifestyle Issues** – *"Usually it's a lifestyle issue. One gal who left was in her 20's. When you are in your 20's, you don't need to be stuck on an island" (Year 2 Respondent).*
- **Family Issues** – *"The other person [who left] ... her husband was transferred" (Year 2 Respondent).*

Similarly, the reasons why people choose to stay were many and varied, and included the following:

- **Work Environment** – *"In terms of why people come and stay, there is a feeling of camaraderie, almost family. People pitch in and help each other. It is a very open effort to help each other. People dig in and go the extra mile" (Year 2 Respondent). Another agreed, "I think the fact that people are good friends, get along well, enjoy cohesive teams – is why people stay" (Year 2 Respondent).*
- **Work Variety** – *"The one main reason cited in performance evaluations for people to stay is the work variety. Everyone is up on their skills. They get diversity" (Year 2 Respondent).*

- **Patients** – *“For the most part, we have a great patient base. They so appreciate us being here, and for me, that is the coolest thing – the positive reinforcement” (Year 2 Respondent).*
- **Quality of Life** – *“Docs come here for quality of life. There are two female doctors that have kids, one has a sailboat. It’s a great position for them” (Year 2 Respondent).* Another added, *“They come for the lifestyle – beautiful scenery, quality of life” (Year 2 Respondent).*
- **Good Job on Island** – *“A fulltime job with benefits is rare here on-island” (Year 2 Respondent).*

IMPACT OF EXTENDED STAY PATIENTS ON CLINIC FLOW:

The impact on the clinic from extended stay patients did not change substantially between Year 1 and Year 2. The same areas of impact were described in both Year 1 and Year 2. Respondents in both years felt that if staffing were appropriate, and the facility had an appropriate number of beds to handle the demand for services then the stress would be manageable. The stress from these patients is most acute when staffing or appropriate bed space is unavailable.

- **Staffing:** *“If there are two people in the observation beds, the nurses don’t figure out how to work the patient in. The nurses and docs get antsy about it” (Year 1 Respondent.)* Another emphasized, *“A FESC patient takes the float nurse off of supporting scheduled patients. At times it can be hairy” (Year 2 Respondent).*
- **Facility Configuration/Bed Space:** One respondent noted how the current facility configuration adds to the problems of staffing described above. *“We have a 2 bed ER with a nurse’s station nearby. If someone needs to stay longer, they must be moved to a room in the back that is isolated from the rest of the clinic and thus administratively difficult. It requires a nurse to monitor that patient, and thus not be available to the rest of the clinic” (Year 2 Respondent).*
- **Stress/Fatigue:** *“The fatigue factor -- during the day, it can make a huge difference. If a patient takes an extra hour, and you are supposed to see four patients per hour, it totally mucks up the day. It feels like a MASH unit sometimes, total chaos and you are doing the best you can” (Year 1 Respondent).* Another respondent felt stress from the struggle to simultaneously care for the needs of both primary care and urgent care patients. *“You feel bad for the residents of the island who come in for a dedicated appointment and then have to wait an hour to be seen [due to an urgent patient]. That is stressful; the patients are in the waiting room glaring at Reception. If it happens to a scheduled patient repeatedly, that creates discomfort” (Year 2 Respondent).*

PERCEIVED FREQUENCY AND TYPES OF FESC SERVICES:

Year 1 respondents discussed the frequency and types of FESC-type services typical for the clinic. They reported an average of 6-8 medevacs each week, mostly for patients with Myocardial Infarctions or other trauma. They reported holding only six to seven people overnight each year, but also hold approximately 1-2 patients during clinic hours each week.

Clinicians take a very conservative approach to patient care, citing less concern about transport costs than in the past, and a greater concern for lawsuits. *"We aren't afraid to ship people to be safe. It is not uncommon to ship someone, and for them to be discharged and sent back the next day"* (Year 1 Respondent).

Patients are rarely held overnight because the medevac provider is responsive and there are several possible receiving hospitals. Further, fog can be a problem and the ferry does not run at night, which can cause transport problems if air travel is required.

Year 1 respondents observed that most of their FESC encounters happen during daytime clinic hours. *"The extended stay patients happen during the day. Most of the time, our observation room is full all day long"* (Year 1 Respondent). Generally, these longer daytime encounters include ancillary testing to provide data to the mainland hospital that will be accepting them.

Weather-related FESC patients are generally due to heavy fog that stops helicopters or fixed-wing planes from flying during hours when the ferry is not available. *"Fog is our problem...The choppers weren't flying, nor were the fixed wing planes. The last ferry had left. We had to load both patients onto the sheriff's boat and transport them to Anacortes. There are times when the patient is critical and you can't stop caring for them during the transport process. In those cases, the sheriff's boat is not an option. The same occurs for someone in active labor. We have to hold people in those cases"* (Year 1 Respondent).

UNAVOIDABLE TRANSFERS

Unavoidable transfers do occur, often due to accidents and trauma. However, at least one respondent felt that the need for unavoidable transfers were decreasing as the testing capacity and clinical capacity of the clinic improved. *"This group of physicians is very skilled at assessing, getting tests done and making a decision for what to do now/next. That hasn't always been the case. Right now we have lab capability that we didn't have 5-6 years ago. A lot of the assessing and diagnosing then was done with hands and observation"* (Year 1 Respondent).

HELD PATIENTS:

Respondents are familiar with cases where patients were held, but most stated that they were rare cases. Two main causes were cited for patients being held – the cost of transport for patients without means, or patients with ambiguous symptoms that could benefit from observation.

Several Year 1 interviewees mentioned reasons for the lower number of held patients. One respondent noted potential changes in weather that could make future transfers unavailable as a reason to ship out patients more quickly. *"We ask if they are well enough to be on-island or not. Once that is determined, we try to facilitate the*

transport immediately. We have to make the decisions quickly, due to potential weather issues" (Year 1 Respondent). Another mentioned fear of lawsuits as another reason for quicker transport rather than holding patients at the clinic. "The flavor of lawsuits has changed too; they must consider the situation within their scope of practice" (Year 1 Respondent).

SELF-OBSERVATION PATIENTS:

In Year 1, respondents stated that during peak summer months, at least one patient per week is released from the clinic for self-observation, but they are generally released to the Convalescent Center. A drawback to releasing the patient to the Convalescent Center is the cost. *"It requires the patient to pay out of pocket about \$250 per day. They may need hydration, PT, or something else straightforward" (Year 1 Respondent).*

Otherwise, patients are generally not released home for self-observation unless they are considered stable and have a guardian who can watch over them.

ADVICE TO OTHER CLINICS:

In Year 1, respondents were generally concerned about having an appropriate amount of staffing, and considered the potential need for identified FESC staff. *"You almost have to have dedicated part-time people to take those longer hours. The nurses we have today would not be happy taking extended stay hours and be expected to be on the schedule the following morning. It is tough."*

Staffing concerns were not brought up in Year 2, however. Instead, advice centered on encouraging other clinics to participate in the RFP process. *My advice is for sites to get organized, participate in the RFPs, and to get ready."* Others agreed that participating in FESC was positive for both the clinic as well as patients. *"I think this is a really great thing. Patients don't want to leave the island or go to a hospital. It is great that they can receive care here."*

III. Discussion

Staff reported little or no change in either staff stress or turnover in the past year as a result of participating in the FESC project. Stress and turnover remain challenges for reasons both within and outside of the purview of the FESC project.

Staff report several sources of stress and turnover related to serving FESC patients:

- 1) The demands of the call schedule, which responds in part to the demands of after-hours FESC encounters, which comprise 54% of all IIMC FESC encounters, one of the highest rates of after-hours encounters reported by the participating clinics [see separate report]. This was an issue primarily for the nursing staff, rather than the physicians, for reasons of work stress, inconvenience, demands on their skills, and compensation.
- 2) The stress of medevacs, regardless of time of day. IIMC medevacs 74% of its FESC patients, the highest percentage [and number] of any participating clinic ("6-8 each week").
- 3) The disruption caused by FESC encounters during normal clinic hours and the demands on limited clinic space.
- 4) Patient/community expectations that the clinic provide both primary and urgent care, the latter including FESC services.
- 5) The demands on staff skills to be able to provide both routine primary and sporadic urgent care.

Other sources of stress and staff turnover unrelated to providing FESC services were cited, including:

- 1) Turnover and inappropriate personnel at the front desk position.
- 2) The marked seasonality of the workload, peaking during summer tourist season.
- 3) The multitasking inherent in rural clinic work.
- 4) Paperwork (cited by physicians).
- 5) Lack of educational opportunities on the island.
- 6) Personal and family issues.

On a positive note, staff cited the camaraderie and supportive working environment of the clinic, good job security and benefits, the high quality of life on San Juan Island, appreciative patients/community, and the skills of clinical staff, particularly in treating FESC patients. Though little had changed in the past year, staff were generally quite positive about the FESC project.

Appendix: Interview Instrument

Year 2 Key Informant Interviews: FESC

Everything you say will be confidential . We will not identify you or your clinic. However, people will be able to determine that the information came from a clinic participating in the Alaska FESC demonstration project.

1. [New Respondent] Can you tell me a little bit about your job: your role in the clinic, what your duties are, how long you've worked here.
2. [New Respondent] How would you describe your workload? What is your schedule like? How about your on-call schedule? Who do you share call with?
[Previous respondent] How has your schedule changed in the past year?
3. What is turnover like at your clinic? (How many new people do you have this year?)
4. What are the major reasons people leave, why do they come and stay? What about medical staff turnover?
5. What is the main source of work-related stress for medical staff in your clinic?
6. [Clinic Administrator] Does your facility have comp time or overtime benefits for staff when they work through the night to take care of patients?
7. How does it affect the clinic, the staff, etc. when you have FESC patients?
PROBE: does it affect staff workload and stress levels? Do you ever send patients home to self-observe? How does it affect the flow of patient care?
8. This clinic has participated in the FESC project for the past year. From your perspective, to what extent does being a FESC affect your work environment? Has it increased or decreased staff stress to provide these services?
9. Do you have any advice for other clinics who are considering becoming a FESC?

Please complete this short employee satisfaction survey.

<Scheduling>

1. I have little influence over the things that happen to me in the clinic.

a. Strongly agree b. agree c. not sure d. disagree e. strongly disagree

2. I cannot plan my day because we never know what will happen.

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<Modified work requirements>

3. I am often asked to do things that I am not trained to do.

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4. There are not enough trained people at the clinic to take care of all patients.

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5. The clinical management needs to plan better for patient care.

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<Other>

6. Overall I am satisfied with my work.

a. Strongly agree b. agree c. not sure d. disagree e. strongly disagree

7. The amount of time I am “on call” is excessive.

a. Strongly agree b. agree c. not sure d. disagree e. strongly disagree