Program Review:
Assessment of a Medical Program

Report of a Practicum Presented to
The Faculty of Graduate Studies

in partial fulfullment of the requirements
for the degree of

MASTER OF SOCIAL WORK

by

Linda L. Campbell

September, 1986

Winnipeg, Manitoba

PROGRAM REVIEW:

ASSESSMENT OF A MEDICAL PROGRAM

BY

LINDA L. CAMPBELL

A practicum submitted to the Faculty of Graduate Studies
of the University of Manitoba in partial fulfillment of the
requirements of the degree of

MASTER OF SOCIAL WORK

Ө 1987

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

I would like to express my appreciation to the Staff of
the Medical Program at Klinic Inc. who actively supported
the examination of their program. Without their openness to
discovery and change this practicum would not have been
possible. I would especially like to thank Ellen Kruger,
Co-ordinator of Health Services and Mark Etkin, Physician/
Medical Co-ordinator for the time and energy they devoted to
the study. I would also like to express my gratitude to the
Support Staff at Klinic who provided me with assistance
during the consumer survey and to Klinic Management who
provided me with access to the Medical Program.

Several people assisted in the planning, implementation
and analysis of the Program Review. Shirley Grosser, my
principle faculty advisor, provided inspiration and
invaluable advice during and after the Review. Dr. Don
Fuchs provided technical assistance during the design phase
and insight into the evaluation process. Lynn McLure, my
on-site faculty advisor, provided helpful suggestions during
the practicum, adding to my understanding of the Medical
Program. My appreciation goes out also to Barry Trute and
Gerry Dandeneau for their contribution towards the
completion of this report.

A very special thank you goes to my parents, Bev and
Bert Butcher, my husband Larry, and my children Christopher
and Jenny for their constant assistance and understanding.

PREFACE

The practicum reported herein consisted of a program review of the Medical Program at Klinic Inc., completed in the summer of 1984.

In conducting this review as a neophyte evaluator, enamoured with methodology, I readily accepted the emphasis on technique and the apparent absence of a theoretical basis for the assessment of health and social services. The bulk of the literature in the fields examined prior to, during and following the practicum exercise supported and still supports this omission. The approaches to assessment and evaluation are framed according to the method of analysis, the data source, or the stage of program development. Underlying assumptions are generally ignored or given cursory attention in favor of developing approximations of the dominant research paradigm: the controlled experiment.

The "product" of the practicum, the final report to the agency, was produced out of this narrow framework. My thinking however, has evolved since 1984. My interpretation of the literature reviewed during the practicum experience and the literature examined since that time reflect what I believe to be a more thorough understanding of what Chen and Rossi (1983) refer to as the importance of a theory-driven approach to evaluation. The discrepancy between my past and present perspective is addressed in the final section of the report, reflecting a commitment to the need for a theoretical approach which can be pragmatically applied in evaluation settings.

INTRODUCTION TO THE REPORT

Program review is conceptualized in this report as a method of social work practice which combines an understanding of the scientific method and the social work process. This unusual marriage was complicated by the selection of a medical setting as the target for the study, a site which usually falls outside of the purview of evaluative social science research. Approaching the design thus entailed a literature review which extended beyond the Program Evaluation field, in addition to including an examination of that area. The Quality Assurance approach to health care assessment was explored and found to add a unique perspective to the enterprise.

The report itself is divided into two parts. The first part addresses the history of Quality Assurance and Program Evaluation and provides a tour through some of the vast amounts of literature in each field. The objective of Part I is to present quality assurance and program evaluation as discrete but compatible approaches to the evaluation of health care services. To illustrate this philosophy, the final section in Part I outlines a comprehensive model of assessment employing both approaches.

Part II of this report is composed of a description of the practicum experience which consisted of a Program Review of the Medical Program at Klinic, Inc. The evaluability assessment process is described as is the review itself, blending the two approaches described in Part I.

A self-evaluation is presented in Part III and ends with a response to the comments made in the Preface.

The final report to the Medical Program is appended.

3

PART I

A REVIEW OF THE LITERATURE

QUALITY ASSURANCE AND PROGRAM EVALUATION: BRIEF HISTORICAL
REVIEW

Quality assurance and program evaluation are two
central methods for the systematic evaluation of health care
services, providing varied, though at times fragmented
perspectives on health care assessment. Nutter and Weiden
(1985) note that quality assurance and program evaluation
operate out of two distinct traditions which rarely overlap
in the literature. Quality assurance measures have been
traced to the licensing and examining boards of Baghdad,
established in 931 A.D. (McGaghie, 1980) and initially
focussed on competence in the medical profession. "More
recent" quality assurance efforts include the review of
hospital care conducted by Florence Nightengale in the
mid-nineteenth century, the 1914 development of the medical
audit by E.A. Codman, and the 1919 review of quality of care
in 700 American hospitals described by Baker (1983). The
outcome of the 1919 study was the establishment of minimum
standards for hospitals. These standards were later adopted
and expanded by the United States Joint Commission for the
Accreditation of Hospitals (JCAH) which now assumes
considerable responsibility for hospital-based quality
assurance programs in that country.

These reviews were prompted by concerns about the
quality of medical care expressed by an increasingly vocal

consumer group and economic constraints which marked the beginning of a cost-efficiency approach to service provision.

In the mid-1960's, utilization reviews were required of health care providers receiving medicare and medicaid benefits. The establishment of the Professional Standards Review Organization (PSRO) in 1972 formalized the quality assurance review process and addressed some of the requirements for fiscal and program accountability.

In conjunction with these more recent political processes, discussions of quality assurance techniques proliferated in the literature. These techniques have been refined in medical settings in the U.S., framed at a fundamental level in terms of the conceptual and operational definition of quality and at a methodological level in terms of the aspect of health care being assessed.

The Canadian quality assurance scene has been considerably less organized. Until 1983, quality assurance in Canada was primarily a responsibility of individual professional organizations. Although subject to different pressures than their U.S. counterpart, the Canadian Council on Hospital Accreditation changed the context for evaluating health institutions in 1983 by mandating quality assurance programs (McLean and Winchell, 1984; Turner and Mapa, 1984). As McLean and Winchell (1984) note, quality assurance "has officially 'arrived' in Canadian health care" (p. 20). The important aspect of its arrival is the requirement that the

results of quality assurance studies be communicated within
the system rather than remain the property of any one
discipline.

The history of program evaluation is shorter than that
of quality assurance and was recently described as "a new
and exciting applied social science" (Posovac and Carey,
1980, p. 3). While program evaluation has reached its peak
in this century, it is not as new as these authors suggest.
Suchman (1967) notes that rudimentary evaluations were
carried out in conjunction with the development of public
services. With the advent of social and behavioral science
technology, and the increasing confidence in the scientific
method, evaluative research gained momentum. By the late
1800's, pioneers in the field of public health were
conducting health surveys to evaluate the impact of
community health programs. In 1874 the newly formed
American Public Health Association formally committed their
organization to the routine collection of information for
evaluative purposes, firmly establishing the survey as an
evaluation tool.

Rossi and Freeman (1982), commenting on the
developments in the field of program evaluation since the
turn of the century, note that program evaluation is linked
"to efforts...to provide literacy and occupational training
by the most effective and efficient means" (p. 21). In
addition to education-based research, health surveys

continued as the predominant form of pre-World War II
evaluation (Freeman, 1977).

At the end of World War II, large scale social programs
were developed in the United States. With the increase in
spending, the importance of the assessment of the
effectiveness and efficiency of these programs was apparent.
The American government's policy of retrenchment firmly
established the need for ongoing evaluation. Program
evaluation has been an important part of U.S. federal
employment and training since the Manpower Development and
Training Act of 1962 (Wholey, 1986). In 1964, routine
assessments were also instituted as a component of anti-
poverty programs as well as research and development
programs implemented during this period. The Elementary and
Secondary Act of the mid 1960's also led to numerous
evaluations. Rossi and Freeman (1982) state that

> "by the late 1960's - in the United States and
> internationally - evaluation research, in the words
> of Wall Street, had become a growth industry" (p. 22).

Like quality assurance, program evaluation received a
major impetus from legislative initiatives. In the United
States, the Community Mental Health Centres (CMHC)
Amendments of 1975 mandated expenditures for program
evaluation at both the federal and local levels. The CMHC
contribution to evaluation research is considerable. A
review of information contained in the Databank of Program
Evaluations from 1969-1979 revealed that approximately 3,000

outcome studies were conducted by CHMC's (Aaronson and Wilner, 1983).

Principles of evaluative research have since been applied in a variety of settings to assess program effectiveness (Tripodi, 1983), monitor programs (Rossi and Freeman, 1982) and determine their efficiency (Thompson, 1980).

QUALITY ASSURANCE: STATE OF THE ART

Defining Quality and Quality Assurance

In her introductory comments to the special issue on
Quality Assurance in Evaluation and the Health Professions,
Barker Bausell (1983) notes that the amount of work done in
the field of quality assurance is overwhelming. These
comments are echoed by Coulton (1982) and Demlo (1983), both
of whom offer comprehensive frameworks for understanding
quality assurance. To move into an examination of the
relevant literature, one must begin with a clear operational
definition of quality and quality assurance. Since the
literature on this topic focuses almost solely on the health
care field, this effort will be directed at defining quality
of medical care. Donabedian (1966), one of the foremost
authorities in his field, attempts to do just that. In his
classic article he states:

> "The definition of quality may be almost anything
> anyone wishes it to be, although it is, ordinarily,
> a reflection of values and goals current in the
> medical care system and in the larger society of
> which it is a part" (p. 167).

In an article written in 1981, this author speaks of quality
as an entity which can be expressed in terms of implicit and
explicit criteria. These criteria can reduce or expand
"quality" but are not full representations of this
characteristic. In 1983 Donabedian presents a formulation
defining quality as "an approved or preferred relationship
between means and ends" (p. 364). While no less nebulous
than the preceding "definitions," he presents the notion of

individualized and social definitions of quality which relate to the value of means and ends for the individual and society at large. Quality of care, for the individual, is a matter of personal choice and is affected only by real variables like inability to pay or gain access to services. Social definitions of quality assign value to the means and the ends and endeavor to provide equity in the process. Social quality is the responsibility of society and the health professions. Quality thus incorporates selected means and ends as well as minimum standards embodied in various approaches to quality. Quality of care, using this formulation is multidimensional.

Quality assurance is an activity devoted to ensuring acceptable means and ends are achieved in accordance with standards established by various organizations and bodies. These standards serve to regulate health care and health care professionals (Gaumer, 1984). Quality assurance can be distinguished from quality assessment in that quality assurance, when necessary, includes action to improve health care services. Quality assessment simply measures quality of care at one point in time (Baker, 1983). Unfortunately the two terms are used interchangeably in the literature even though quality assessment is the behavioral norm (Donaldson and Keith, 1983). Knapp and Miller (1983) suggest that even when intervention occurs in the health care setting, it is usually directed at the patient. Due to its predominance, the term quality assurance will be used in

this report to refer to both the assessment and assurance of quality.

Foci of Quality Assurance

Donabedian (1966) provides what is today the most widely used approach to quality assurance. Not to be confused with definitions of quality (Donabedian, 1983), three major foci for the evaluation of quality of care are structure, process and outcome variables.

Structure Variables

Structure refers to the physical aspects of health care, regulations affecting service provision, characteristics and training of staff, organizational and administrative variables like record systems, and support from external community bodies (Baker, 1983). These structural variables are the relatively stable components that facilitate or hinder the provision of service (Demlo, 1983). The American Hospital Association (1983) guidelines mention the following structural goals of quality assurance programs: "complying with the requirements of the Joint Commission on Accreditation of Hospitals (JCAH) and other accrediting and regulatory agencies"; "instituting a risk management program"; and "enhancing the skills and knowledge of all health care practitioners and administrators" (p. 2). The Canadian Council on Hospital Accreditation (1983) mandated the implementation of quality assurance programs in

hospitals, which alone can be viewed as a structural means for achieving quality of care.

Two aspects of structure will be highlighted in this report: regulations affecting service provision and the training of medical personnel. The importance of regulations, both as positive and negative inputs, cannot be stressed enough. Gaumer (1984) critically discusses the impact of regulation on the health profession, stating that licensure, credentialing, and practice acts restrict occupational choice, limit career mobility and health delivery productivity, and reduce the range of services available to the consumer. Some of these same regulations are presented in a more positive light by Affeldt et. al. (1983). In discussing the JCAH accreditation standards, these authors commend the "effective problem-solving process that systematically identifies important problems" (p. 248) in the provision of care. Regulations, however, can be viewed as prerequisites to quality and establish minimum standards which fit the problem-solving mold noted above. This is to be contrasted with the planning model described by Marshik-Gustafson, Kopher and Terze (1981) which challenges organizations to view quality as a developmental process, ensuring the establishment of goals aimed at high-quality care.

Also included under the structure of care theme is the training and competence of physicians. There are two points in physician careers toward which attention is directed:

during formal education and, to a much lesser extent, once the physician is in practice. The literature focusing on the educational process is considerable. These articles emphasize measurement techniques rather than theoretical approaches (Popham 1978a, 1978b; Stillman et. al. 1978) and argue about the best means to assess health professionals' competence. Central to this debate is the distinction between norm-referenced and criterion-referenced testing.

Norm-referenced testing compares one physician to another and includes questions designed to "weed out" individuals who obtain lower grades than others (McGaghie, 1980). These tests have been criticized on the grounds that they might not be valid; and, when applied to a homogeneous group they may measure only situational variables like fatigue on the day of testing.

Criterion-oriented tests attempt to deal with the problems described above by clearly describing the skill being measured. The description of the skill becomes the indicator against which the trainee's performance is referenced. Popham (1978b) recommends that the indicators should represent "terminal skills" (p. 105) which represent the mastery of a series of skills.

Regardless of the elaborate nature of the evaluation tool, however, this debate can be criticized on two levels. First, the authors do not explain how a behavior comes to be defined as central to professional practice. These decisions are vital and regulate control of health care

services by dominant groups. These authors also operate out of a traditional psychological paradigm which asserts that the individual has sole responsibility for his/her behavior and that his behavior, measured at one point in time, will represent competence.

Peer review does not attempt to address these shortcomings although it does so indirectly, examining physician performance during their practice careers and using criteria rather than norms to set standards. Here the debate centres around the use of explicit versus implicit criteria for making judgements as to levels of care (Donabedian, 1981). The crux of the matter here is whether specification leads to obscurantism or whether individualizing the review of performance leads to invalid judgements.

Due to the dual role of practitioners as part of the health care structure and as agents of service delivery, peer review crosses the arbitrary line between structure and process. It deals with structure when it attempts to discern individual ability to perform. A case example is the Medical Association peer review body. Peer review addresses process when it examines performance leading to global recommendations about service adequacy.

Process Variables

Process variables include the physician-patient relationship, the actual services rendered and the procedures and activities related to service delivery

(Demlo, 1983; Coulton, 1982). Along with structural variables, "process" is one of the means referred to by Donabedian (1983) which is discussed in the previous section. Coulton (1982) defines the parameters of process variables by asking the following question: "Are services being delivered in accordance with accepted beliefs about what constitutes good practice?" (p. 399). This question directs our attention to the process standards of medical care, which constitute the foundation of the quality assurance field.

Standards of professional practice were noted in the discussions of norm versus criterion referenced tests and implicit versus explicit standards. In a workshop given by Barbara Berkman (1986), standards were defined as operational criteria, derived from knowledge, skill and values, which are valid and reliable representations of acceptable levels of care.

Medical audits, utilization reviews, client satisfaction surveys and direct observation are all forms of process focussed quality assurance efforts. Medical audits are generally retrospective assessments of the quality of care provided to a patient group (Demlo, 1983; Coulton, 1982). Repchull (1981) discusses the implementation of audit processes for operating room nurses in several Canadian hospitals. Regardless of the location, all addressed the nursing process and included a comparison of actions against standards. The models available for performing audits are

numerous. Included among them are the Comprehensive Quality Assurance System (Rubin and Kellogg, 1977), the tracer method (Kessner et. al., 1973), and criteria mapping (Demlo, 1983). Criteria mapping is the most complex of the three approaches. This approach maps sequential decision-making in terms of patient findings over time, according to a set of care objectives. Demlo (1983) notes that this process method allows for clinical judgement and patient complexity.

Utilization reviews examine the use of health services, looking for such things as unnecessarily or inappropriately high utilization. While ostensibly linked to concerns for the health of patients, utilization reviews tend to focus on the cost of care. The concurrent review is the most prevalent form of utilization review, examining the patient's stay from his/her point of entry into the system.

Client satisfaction surveys are discussed in some detail in the section of this report entitled "Assessing Program Utility." Although this section identifies consumer satisfaction as a measure of successful program outcome, it can also be used to gain feedback on the service delivery process. In fact, given the tenuous relationship between the health process and health outcomes (Donabedian, 1983) it is necessary to separate these elements from one another in satisfaction ratings. As Baker (1983) notes,

> "much can be learned from dissatisfied patients about what improvements are needed in health care, particularly in light of the difficulty encountered in getting patients to say anything negative" (p. 270).

It is interesting to note the attitude of Rodale (1983), the head of a consumer group fighting for better information about the quality of care. He appears to identify the success or failure of institutions in terms of specific outcome rather than process measures. Outcomes, such as mortality rates, may be easier to measure but unless they are significantly different between institutions, they yield only a portion of information on quality as a whole. Even if significant differences are found, unless the quality of the process is examined closely, it is impossible to explain these differences. The medical menu, as Rodale describes it, should include a list of ingredients. One of the "ingredients" suggested by Lohr (1983) is caring. She notes that "there are probably more deficiencies in these interpersonal elements of care than we would like to think" (p. 5). Consumer satisfaction ratings present an opportunity to "measure" these factors. An example of a questionnaire which incorporates both the "hard" and "soft" elements of care is the Rand Health Insurance Experiment Patient Satisfaction With Care survey, used to evaluate prepaid health plans in the U.S.

Direct observation of process is seldom used in the health care industry (Coulton, 1982). If, as LaDuca (1980) suggests, attention must be directed at the social context of human experience, it follows that direct observation would enable the evaluator to frame his judgements of health practitioners' behavior. The art would be in devising

unobtrusive means of observing health professionals in practice. Baker (1983) contends, however, that even if observation is obtrusive and positively affects performance, it provides a useful measure of performance capacity. Baker notes that direct observation is more likely to be used in training situations.

Additional problems with direct observation are the cost and time required for the studies.

Outcome Measures

Outcome measures have been widely employed in the health field and represent a shift in focus from the practitioner to the alleged product of his/her medical intervention. Lang and Clinton (1983) identify six outcome categories: "Physical health status, mental health status, social and physical functioning, health attitudes/knowledge/ behavior, utilization of professional health resources and patient perception of quality of nursing care" (P. 220). Each of these categories contains numerous variables which address some aspect of outcome. Using physical health status as an illustration, the variables under study include blood glucose, blood pressure, fluid balance, nutritional status, vision and hearing, number of illness episodes, number and severity of preventable complications and healing rate. Each of these variables address only one aspect of health.

Developing a comprehensive outcome measure for any of these six outcome categories is a complex task. Based on

the World Health Organization's conceptual definition of health, Wolinsky and Zusman (1980) have attempted to develop a comprehensive health status measure by combining measures of physical, psychological and social well-being. Their study warrants attention, both in terms of the methodology they employ and their results. These authors began by constructing three separate scales: a physical health scale, a social health scale and a psychological health scale. These scales were submitted to statistical analysis and a single summary measure was developed for each scale. The measures were standardized and compiled to form discrete health states ranging from "normally well" to "seriously ill" (p. 616). The health status measure was then employed to predict different types of health service utilization. In evaluating their comprehensive health status model, Wolinsky and Zusman found that the discrete comprehensive measures were more useful than the single summary measures of health in predicting utilization of services. This does not necessarily reflect the inadequacy of the summary measures, but does raise questions as to their predictive validity.

Despite these problems, the results obtained during the study are encouraging. The rigor and methodological expertise apparent in the report, however, relegate the application of comprehensive outcome measures to future, rather than present, quality assurance efforts. For now, single indicators of health care outcome must be portrayed

as just that, and not as indicators of "health" per se. In addition, more effort must be directed at developing indicators in long term facilities (Zimmer, 1983), both of an outcome and process nature.

More fundamental problems exist with regard to outcome measures. The first of these is whether outcome is, in fact, a valid measure of quality at all (Donabedian, 1966). This relates both to the inadequacies of medical science and the tenuous links between input, process and outcome, as was alluded to earlier. Donabedian (1966) also raises another important point:

> "sometimes an outcome is irrelevant, as when
> survival is chosen as a criterion of success in
> a situation which is not fatal but is likely to
> produce suboptimal health or crippling." (p. 168)

Some excellent indicators of outcome have been developed, despite these problems. The Health Accounting Strategy developed by Williamson (1978) is one of the more positive efforts (Demlo, 1983). This process utilizes the interdisciplinary team to establish priorities for quality assurance. Following the priorization process, possible health care outcomes for the selected topic are identified, additional studies are planned to identify contributory factors, formal efforts are implemented, and the original assessment is repeated to see if the intervention was successful. The merits of this approach are its interdisciplinary nature and its proactive stance.

On the Scope and Limitations of the Field

As the preceding sections indicate, quality assurance is a field of considerable scope and breadth, examining the structure, process and outcome of medical care. Each of these three areas encompasses a range of models and approaches, a variety of data sources, and employ numerous data analysis techniques. Figure 1 graphically presents the process dimension of quality assurance to illustrate this point. As Figure 1 implies, the field is truly multidimensional.

INSERT FIGURE 1

FIGURE 1

A Sample of the Dimensions of Quality Assurance

Quality Assurance/Quality Assessment

I   Structure   Process   Outcome

II   Direct Service   Utilization Review   Client Surveys
       Audit

III   Score Method   Criterion Mapping
       For Nursing Quality
           Assurance

IV   Patient Direct Patient Staff   Physician Medical
       Records Obser. Inter.   Inter.   Map   Records

V   Annual Tabulation,   Summary Analysis Providing
          Summary Report   Individual Case Scores

I   Focus
II   Approach
III   Model
IV   Data Source
V   Analysis/Reporting

(All lists are incomplete, for illustrative purposes only).

Despite the seemingly elaborate nature of the methodology, however, it does have several limitations, some of which were presented in relation to outcome measures. These included problems with validity and the causal linkages which form the basic tenets of quality assurance. In addition, "quality" itself is ill-defined. LaDuca (1980) cogently comments on this issue as it pertains to the competency-based approach to quality assurance. He notes that quality is assumed to be a characteristic that rests in a particular individual or place. LaDuca argues that quality should be conceptualized using a relational model which views quality as context-bound, emerging out of the interaction between provider, patient and situation. In light of these comments, it would appear that substantive progress in the area of quality assurance would be made from an examination of this interaction, rather than expansion of the methodology.

In the 1966 article by Donabedian, he states "a review of the studies of quality shows a certain discouraging repetitiveness in basic concepts, approaches and methods" (p. 193). While the approaches and methods have been expanded and diversified since this article was written, the basic belief system remains intact.

PROGRAM EVALUATION: AN OVERVIEW

A Definition

Program evaluation research is viewed by its partisans
as an effective means to collect and summarize information
for the purpose(s) of policy development and implementation,
program planning and service delivery. The results of the
quantitative assessments that usually characterize program
evaluations are used to develop judgements (Rossi and
Freeman, 1982) to aid policy makers and managers in these
tasks. Given the varied nature of the ends to which program
evaluations will be applied and the diverse settings which
are subject to this approach, it follows that "program
evaluation" will have several meanings.

Evaluation research has been defined by Rossi and
Freeman (1982) as:

> "activity devoted to collecting, analyzing and
> interpreting information on the need for, imple-
> mentation of, and impact of intervention efforts
> to better the lot of humankind by improving social
> conditions and community life" (p. 15).

Rutman (1977) augments this definition, presenting
evaluation research as a process linking inputs to outcomes
using reliable and valid scientific methodology. Weiss
(1973) and Hasenfeld (1983) outline another dimension of
evaluation research, conceptualizing evaluation as an
operation which takes place within a political and economic
context. Collectively these authors have identified four
important elements of evaluation: (1) it is purposeful; (2)
it has a value base; (3) it is a process involving the

application of scientific procedures; and, (4) it occurs within a context. Nutter and Weiden (1985), whose unpublished manuscript addresses the differences and similarities between program evaluation and quality assurance note that "program evaluation is more research, investigation, and exploration oriented" (p. 7). Program evaluation attempts to identify more or less effective and/or efficient means of producing change.

Foci of Evaluations

The nature of an evaluation is determined, in part, by its focus. Rather than discriminate between programs in terms of their service area, program evaluations are designed according to the stage of practice or program development (Rossi and Freeman 1982; Tripodi, 1983). Nielsen and Turner's (1983) discussion of the evolutionary process as it applied to program evaluation carries the notion of evaluation types to its logical extreme and, as such, warrants attention. These authors adopt the evolutionary process from an anthropological perspective as their metaphor. This process implies that as programs and their contexts evolve, so should the evaluation design. Nielsen and Turner (1983) apply this idea to the field of education, describing a unique blend of methods. They recount an evaluation of a reading laboratory program in a U.S. school district which was carried out annually for three years. At the point of implementing the program and after its initial modifications, a naturalistic approach was

adopted to fit the reading laboratory's developmental stages and the needs of decision-makers. In the third year of program development, a more traditional paradigm was employed, utilizing questionnaires and structured interviews to monitor the existing program. Combining naturalistic and traditional approaches over the course of one study sets these authors apart. They also exhibit a utilization-based philosophy which has been developed by Patton (1978) and will be discussed in a later section.

While the evolutionary approach is not widely adhered to; as was noted above, the notion of developing evaluations to "fit" certain classes of programs is not unique. Perhaps the most useful conceptualization of evaluation strategies is presented by Rossi and Freeman (1982) in their comprehensive text. They identify three classes of evaluation research:

> "analysis related to the conceptualization and design of interventions, monitoring of program implementation and assessment of program utility" (p. 33).

Before discussing these classes, it is necessary to define four criteria which are applied to evaluative research in general: efforts, effectiveness, unanticipated consequences and efficiency. "Efforts" refers to the activity required for achieving program objectives (Tripodi, 1983). Efforts include, but are not synonymous with, inputs which address the question: Are services being delivered in an acceptable manner according to established standards? (Coulton, 1982). "Effectiveness" pertains to the extent to which a program is

successful in achieving its goals. Effectiveness is a
traditional focus of program evaluation (Weiss, 1972).
Subsumed under this criteria is output: Are services
delivered in sufficient quantity?; and outcome: Are they
having their intended effect? Not necessarily included are
questions related to process, which may be addressed if
effectiveness criteria are not met or during program
monitoring. "Unanticipated consequences" are unplanned
outcomes resulting from program efforts. "Efficiency"
examines specifically how the products of programs compare
to their costs and generally how well programs operate
(throughout).

Conceptualization and Design

The first class of evaluation research examines the
conceptualization and design of interventions, articulating
an impact model which describes the relationship between
program efforts and intended outcome (Rossi and Freeman,
1982). Evaluative efforts at the early stage of program
development are devoted to describing the causal,
intervention and action hypotheses, the target population
and the delivery system design. The causal hypothesis
operationally defines the cause(s) of the problem. The
intervention hypothesis links the intervention to the causal
hypothesis. The action hypothesis links the intervention to
behavioral outcome(s).

In some respects, this class of evaluative research
resembles the evaluability assessment process described by

Rutman (1977, 1984). The evaluability assessment is

depicted as a formative precursor to a summative outcome

evaluation. According to Rutman (1984),

> "an evaluability assessment establishes the
> extent to which a program is sufficiently well
> defined to consider evaluating it" (p. 28).

His evaluable program model, which establishes the

feasibility of conducting an evaluation, contains the steps

included by Rossi and Freeman (1982) in their first class of

evaluation research activity. It follows, then, that

evaluation activities in the early stage of program

development can facilitate efforts to examine the same

program when it has been in operation for some time. As

Cohen (1982) states:

> "most evaluators, while giving lip service to
> carefully defining programs and objectives,
> build their evaluation upon existing conceptua-
> lizations and information presented to them by
> program managers" (p. 8).

Objective evaluator input in the early stage of program

development can address this criticism a priori.

Program Monitoring

Program monitoring is the second class of research

discussed by Rossi and Freeman (1982). Included under this

heading are studies focusing on program coverage (Rossi,

1978), bias or differential participation in programs

(Dutton, 1978), process studies (Thorner, 1979), and

examinations of delivery system elements like accessibility

(Lebow, 1983). As with the other "classes" of evaluation

research, program monitoring can be adapted to the nature of

the particular program (Rossi and Freeman, p. 86). An important focus of program monitoring as a means of examining established programs is accountability which can include coverage accountability, service delivery accountability, fiscal accountability and legal accountability (Rossi and Freeman, 1982).

Program monitoring is a function of the program audit which is well described by Posovac and Carey (1980). A program audit entails the collection of information which produces a description of the population served and the services rendered, touching on access, process and output as defined by Coulton (1982). Like an evaluability assessment, an audit is a necessary precursor to a study of outcome. An audit can be used to describe the following: (1) the type of services offered; (2) the extensiveness of the program; (3) the numbers served; (4) the clients; and, (5) the providers of services (Posovac and Carey, 1980).

Most useful in program monitoring activities are Management Information Systems (MIS) which facilitate the storage and retrieval of data collected over time. While a discussion of MIS goes beyond the scope of this paper, it is essential to note the central role of available information in the auditing process. Using the health care system as a example, the problem-oriented medical record (POMR) affords the researcher an opportunity to examine demographic patient information; effort, in terms of "the plan"; the range of services provided; and the service providers themselves

(Woody and Mallison, 1973; Kane, 1974). The impact of poor recording has been well documented in the literature (Posovac and Carey (1980). Despite the fact that records and agency files appear conducive to evaluative studies they may be inaccurate, out of date, inappropriate for evaluation and biased (Weiss, 1972). One of the recommendations that comes out of the auditing process may relate to the need for an improved recording system!

Assessing Program Utility

The assessment of program utility encompasses two types of summative or outcome models: the evaluation of program effectiveness and the assessment of efficiency. By far the most predominant in the literature, and encompassing a range of techniques, summative models seek to determine if services are having the desired effects on clients.

Prior to discussing these models in detail, it is necessary to identify some general problems in measuring the effects of programs: (1) "effects" are influenced by circumstances outside the realm of the program; (2) causal models, as described earlier, are poorly developed; and, (3) treatment modalities are often not specified. Aaronson and Wilner (1983) frame the first problem as two questions: "Did the treatment under study affect the change or was it something else?" and "Could apparent differences result from chance alone?" (p. 311). These problems of internal validity are rarely addressed in outcome studies, even though they advocate the rigor of the scientific method.

Thorner (1979) discusses the issue of measurement validity
in relation to health and medical programs. He asserts
these programs are based on the assumption that "the level
of health is related to the level of effort expended in
providing health services" (p. 39). Thorner recommends
three alternative approaches: (1) study only process
elements; (2) study intermediate rather than end goals; and,
(3) substitute a negative measure like mortality for health.
As Weiss (1972) points out, evaluators must meet the needs
of many groups of individuals internal and external to the
organization. They may not be able to select these options.
They must, however, at least address the problems of
internal and measurement validity as methodologists and
identify the limitations of their studies in their final
reports. The critical issue in assessing utility, defined
in terms of outcome is whether the program produces more of
an effect than "no program" or an alternative program (Rossi
and Freeman, 1982). This statement of relative effect must
replace absolute cause-effect claims.

The difficulty establishing causal links can be
attributed, in part, to inadequate social science knowledge.
While behaviorists might scoff at the necessity of
determining the root of the problem, a clearly articulated
program should connect the intervention to its cause. To
add to this dilemma, the intervention itself is often not
specified beyond general terms such as "counselling" or
"complete physical examination." In a review by Aaronson

and Wilner (1983), for example, some of the narrative
descriptions of treatment were "general psychiatric
outpatient care," "general inpatient treatment," and
"comprehensive community psychiatric services" (p. 310).
Chen and Rossi (1983) have succinctly summarized these
shortcomings:

> "The domination of the experimental paradigm
> in the program evaluation literature has unfor-
> tunately drawn attention away from a more
> important task in gaining understanding of social
> programs, namely, developing theoretical models
> of social interventions" (p. 284).

They comment on the poor conceptual foundations of programs
and note the "preposterous sets of 'causal' mechanisms"
(p. 284) accepted as valid statements.

Effectiveness-based models of evaluation employ the
scientific method to measure variables selected as
indicators of achievement or non-achievement of outcome
goals (Weiss, 1972). Multiple measures are preferred over
single measures, as are approximations of the experimental
design. This model can best be described as "evaluative
research" rather than program evaluation. Evaluations of
effectiveness are often presented as the only type of
evaluation (Babbie, 1983; Grinnell, 1981) with formative
evaluation receiving little, if any, attention. Outcome
measures are defined as the dependent variables in these
studies. Independent variables include the organizations
purpose, methods, staffing and characteristics of the client
(Raymond, 1981). Intervening variables are the program
functions, which include clients' frequency of attendance,

and bridging variables, which are the subobjectives of the program. These subobjectives are "steps" to the achievement of program objectives. Raymond (1981), Weiss (1972), Posavac and Carey (1980), to mention a few, all describe research designs appropriate for outcome assessments. Table 1 summarizes these approaches.

TABLE 1

Design Options for Assessing
Program Effectiveness

<u>Pre-Experimental Designs</u>

- Before-and After Study
  of one program

- After-only studies of
  program participants

- After-only study of
  participants and non-
  random controls

<u>Experimental Designs</u>

- Classic
  Experimental

- Posttest-only
  control group

- Two-by-two
  factorial

- Solomon four group
  random assignment
  to groups

- Time Series with random
  assignment to groups

- Crossover

<u>Quasi-Experimental Designs</u>

- Time Series

- Multiple time-series

- Nonequivalent control-
  group or comparison group
  study

- The Patched Up Design*

*Term used by Cook and Campbell (1976). Usually entails
 addition of comparison groups to control for certain
 threats to internal validity, often developed "in process."

Weiss (972) notes that quasi-experimental designs are gaining popularity and have been accepted as practical alternatives to experimental designs. These designs "can produce results that are sufficiently convincing for many practical purposes" (p. 73).

Suchman (1967) presents a mode of "multiplicity of causes and 'interdependence of events'" (p. 84) which has implications for the formulation and design of evaluative research. The conditions portrayed in Figure 2 point to the need for careful design of summative evaluations and the requirement that explanations of effects be described as conditional probabilities only.

FIGURE 2

| Preconditions | Independent Variable | Intervening Events | Dependent Variable | Consequences |

a_1
a_2
a_3
.
.
.
a_n

Program A

b_1
b_2
b_3
.
.
.
b_n

Effect B

c_1
c_2
c_3
.
.
.
c_n
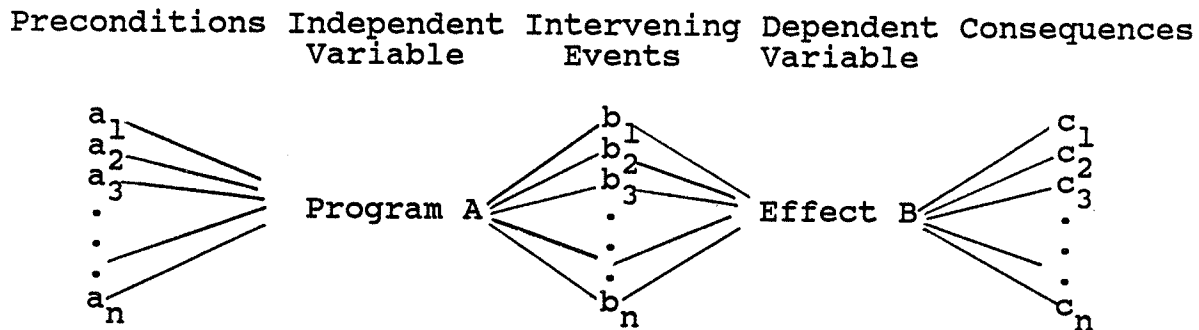
As a closing note to the discussion of effectiveness measures and an introduction to program efficiency, mention must be made of the difficulties in defining outcomes per se. The problems of measurement, referred to as instrumentation, are an area of concern to evaluators (Aaronson and Wilner, 1983). The fortunate evaluator may find standardized tests available to measure the attribute

under study. Patton (1984) asserts, however, that even standardized measures must be accepted in the environment under study if the findings are to be trusted and utilized. Often outcome measures are developed on a trial and error basis and are applied irregularly. Little collaboration between researchers is evident. In one study, a diverse group of outcome criteria was used by several authors to describe a homogeneous target population in terms of its success in achieving similar goals (Aaronson and Wilner, 1983).

Health status is as susceptible to the misuse of indicators as is emotional well-being. Of promise is a model developed by Starfield (1979) which describes the health status of the population using multiple indicators for the purpose of developing a health profile similar to the Minnesota Multiphasic Personality Inventory.

Another issue which pertains to outcome measures is the ownership of these criteria by professional groups. For instance, if "health" is defined only in terms of a physical state, assessed by a medical peer review team, emotional and social health can be de-valued. The medical profession also retains control over standards of care which may come to be assessed only as they pertain to their definition of health. This is especially problematic when tests are unstandardized and norms are not available. Consumer satisfaction measures, which are becoming an important part of evaluation

research (Locker and Dunt, 1978), endeavor to address this issue.

The consumer movement of the late sixties and early seventies increased the role of consumers in the delivery of health and social services. It follows that one of the outcomes of programs should be user satisfaction. In the field of health care, it was also recognized that consumer satisfaction positively affected compliance with treatment and medical follow-up (Larsen and Rootman, 1976). There is little standardization of consumer measures, however, to allow comparisons across programs. Lebow (1983) notes that the emergence of "scientific" consumer satisfaction studies is a recent phenomenon. One of the prime criticisms of employing these measures as the sole indicator of effectiveness, especially in health care, are that services are generally highly rated (Lebow, 1983). The format of questions may be a factor here. Windle and Paschall (1981) note also that consumers may value unique aspects of care. These may not be included in questionnaire designs which by their very nature are inflexible and unable to address all the pertinent issues.

The assessment of efficiency examines program outcomes in relation to their costs and includes cost-benefit and cost-effectiveness analysis. Rossi and Freeman (1982) succinctly state: "cost-benefit and cost-effectiveness analysis can be viewed both as conceptual perspectives and as sophisticated technical procedures" (p. 271).

Conceptually they are based on an economic view of man. The purported advantage for cost-benefit analysis relates to the planning process. Cost-benefit analysis provides decision-making opportunities by quantifying the results of alternative actions in monetary terms. Bootman, Rowland and Wertheimer (1979) describe cost-benefit analysis as it applies to the health field, noting that expenditures for health are composed of investment and consumption components. The process for engaging in cost-benefit analysis is as follows:

"1. Define the project with its current benefits and costs, and to whom these benefits and costs accrue;
2. Express the benefits and costs in monetary terms, and;
3. Compare the benefit streams with the costs to determine the feasibility of the proposed project" (p. 131).

The problem with cost-benefit analysis does not lie in the identification of the costs of programs, although this is problematic in the area of prevention, but in the specification of program benefits in monetary terms. Cost-effectiveness analysis identifies the benefits in terms of units, rather than assigning a dollar value to them. Programs can be compared, using a cost-effectiveness paradigm, in terms of the cost of producing one outcome or set of behaviors. These outputs may include a range of things such as the numbers of lives saved (Bootman, Rowland and Wertheimer, 1979) or an increase in learning for disadvantaged youth (Levin, 1983). While the analysis of cost-effectiveness can be conceptualized as an effectiveness

measure it can also be viewed as a measure of efficiency. Given the fiscal restraints in health and social services, comparisons of programs with similar objectives in terms of cost-effectiveness may be efficiency motivated, aimed at the reduction of service.

On Politics and Utilization

In concluding the overview of program evaluation models and methods, it is necessary to attend to the political aspects of evaluation research which place it firmly in the realm of an array of stakeholders. As a somewhat humbling introduction, Julius Margolis' comments to Carol Weiss (1973) point to this aspect of applied research:

> "you may go through a scientific analysis to
> answer the question of where the airport should
> be built but an altogether different decision
> might finally emerge from the bureaucracy" (p. 6).

This suggests that the agenda of the stakeholders may not be to acquire the types of information an evaluator is able to provide for reasons that may not be apparent to the evaluator! Conversely, the purpose of the evaluation may not be clear to all stakeholders. A third alternative is that evaluation results may be selectively used to support the position of certain stakeholders. A classic example of these problems is the Westinghouse/Ohio evaluation of the Head Start program. Three different perspectives on the initial reason for the evaluation are presented by Datta (1976). The first view suggests that the study was an attempt to find a way to terminate Head Start. The second opinion was that it marked a commitment to evaluation of all programs funded by the Office of Economic Opportunity. A third view identified this initial evaluation as step one of an evaluation plan for the Head Start program.

The evaluation itself is described as fraught with methodological problems, with the final report making

recommendations based on data it did not collect. The Westinghouse report was later used by an advisor to the President to severely cut back on the Head Start program, changing its status from an ongoing demonstration project to an experimental project. Datta (1976) also suggests that this report was influential in reducing the commitment of government to preschool intervention.

Given scenarios like those described above, evaluators are forced to make choices. These choices relate to the functions of evaluation. These functions can be identified as "ritualistic" (Weiss, 1984, p. 159), "operational (or formative)" and "strategic (or summative)" (Wholey, 1986). Ritualistic evaluations are those conducted for reasons other than their alleged purpose. There is no established way of effecting or maximizing utilization of findings and Weiss suggests they will be of minimal utility.

Evaluations which have operational use are directed at improving program performance. These evaluations are termed informational by Weiss (1984). Research which has an operational function is compatible with the suggestions proposed by Patton (1984), Weiss (1972) and others which address the political and utilization aspects of program evaluation. These suggestions include: identifying and involving decision makers in all phases of the evaluation process, assuring face validity of the selected instruments, being clear about what is to be studied, and planning possible uses of the results and a clear dissemination

strategy a priori. It is especially important to apply these recommendations to evaluations with strategic aims and which, by definition, affect the allocation of resources. Chen and Rossi's (1983) commentary regarding the need for a theory-driven approach to evaluation is most appropriate in this instance. They argue that evaluators must begin with theories about how organizations work and how social problems are caused. It follows that well-grounded evaluations will reduce the "political" problems associated with the strategic function and increase the potential for utilization.

TOWARD A COMPREHENSIVE ASSESSMENT MODEL

The few attempts to reconcile quality assurance and program evaluation have been less than successful, with the authors exhibiting a hesitancy to pursue more than terse comparisons (Baker, 1983; Nutter, 1985). Baker (1983) emphasizes the differences between these approaches, in terms of their evolution and level of data aggregation. Quality assurance, he contends analyzes information on an individual level while program evaluation focuses on group data. This distinction appears too simplistic given the range of methods employed in the two fields.

Nutter and Weiden (1985) emphasize quality assurance's preoccupation with standards. This term is indeed predominant in the quality assurance literature (Coulton, 1982; Demlo, 1983). These authors proceed to suggest that

program evaluation is best employed to determine if a program is producing its intended outcomes while quality assurance should concentrate on the satisfaction of standards. This argument confuses the process and outcome aims of both quality assurance and program evaluation, assigning the responsibility for outcome assessments to program evaluators.

Assuming quality assurance is aimed at maintaining and advancing quality of care and the purpose of program evaluation is to provide information to assist with planning and service delivery, it appears both can operate in tandem, without duplicating each others' intent. One must also recognize that implicit in "comparison" is evaluation and implicit in "planning" and "service delivery" are standards of care.

Table 2 presents quality assurance and program evaluation as complementary approaches which, in combination, provide a comprehensive assessment of program functioning. These methods are organized according to three stages in the life of an organization. The target for application of the model is the community health centre. Community mental health centres have been subjected to pressures to integrate quality assurance and program evaluation (Baker, 1983). The selection of a community health centre is an effort to acknowledge this problem and set the stage for the section which follows.

TABLE 2

A Sequential Model for the Application of Two Approaches

Phase I   Program Design

    1. Establish Impact Model   PE

    2. Define Minimum and Maximum Standards for   QA
         Intervention Effect

    3. Establish Structural Standards   QA
        (e.g., Need for Information System)

    4. Design Structural Standards to Reflect   QA
         Quality of Care to Clients/Patients

    5. Design Structures Based on Management Needs,   PE
        as it Relates to Causal Model

    6. Test Program for Refinement Requirements   PE

Phase II   Implementation

    1. Conduct Process Studies in Terms of Standards   QA
        of Care

    2. Conduct Studies on Coverage, Access, Bias,   PE
        Expenditures

    3. Record Review Focussing on Adequacy of Recor-   QA
        ding, Content of Certain Procedures
        (e.g., Process of Completing CPE)

    4. Record Review to Examine Range of Activities,   PE
        Clients Served, 'Fit' Between Design and
        Instrumentation

    5. Client Surveys to Study Quality of Physician-   QA
        Patient Interaction

    6. Client Survey Re: Access, Comparison Between   PE
        Program and Other Programs

    7. Establish Utilization Patterns in Terms of   QA
        Disease Types

    8. Establish Utilization Patterns in Terms of   PE
        Program Intent

Phase III   Institutionalized Program

1. Utilization Studies, Comparing Actual Client   QA
   "Career" to Preferred Standards for Use of
   Services

2. Examine Health Outcomes in Terms of Provin-   QA
   cial, National Norms

3. Examine Services Provided in Terms of Overall   PE
   Objectives and Impact Model

4. Describe Quantity of Services Provided   PE

5. Peer Review of Unusual Patterns of Service   QA
   Provision

PART II

THE PRACTICUM EXPERIENCE

PRACTICUM OBJECTIVES

The Practicum objectives were to examine the applications of Program Review techniques in the Medical Program of a community health centre; to explore the evaluability assessment as a pre-evaluation tool; and to assist the Program by providing useful information for program planning. For the purposes of the practicum, Program Review can be defined as a descriptive analysis of program components including, at minimum, a review of records, observational data, client interviews and information collected from staff and management.

Rossi and Freeman (1982) describe program review objectives in their chapter on program monitoring and accountability, although they do not formally identify "program review" per se. Using the term "implementation monitoring" (p. 125), they identify the importance of providing established programs with information on program coverage, the degree to which a program is reaching its intended population, and program process, which addresses the actual services that are delivered.

Majchrzak (1982) provides a conceptual framework for the selection of program review as the appropriate means to these ends. She notes that program evaluation reflects three aspects of the organization itself: input, process and output. The need for certain types of information

reflects the developmental stage of the organization itself. The input stage is synonymous with the implementation stage of the organization. Input data refers to the number and type of clients that enter the system. The process stage is the intermediate phase between innovation and stabilization. Process information is an expansion of input data enabling decision-making about the number and type of clients using services and describes movement through the system. During the output stage the organization is stabilized. Output data examines program impact on clients and external systems.

Although the author does not explicitly state this, chronology appears unrelated to the stages in organizational development. The practicum, in part, is an adaptation of the objectives of a program review to the perceived stage of the medical program's development, taking into consideration the sequential nature of program evaluation activities (Rutman, 1977).

The program review addresses the input and process dimensions of the program-in-process. Input data was collected as a precursor to the analysis of process information.

THE SETTING

Klinic Community Health Centre provides a range of health and social services to the Winnipeg community. Crisis intervention, sexual assault counselling, community

services to a predominantly elderly population, and medical services are all offered out of this one location.

Klinic, Inc. was established in 1971 to meet the needs of young people in the core area of Winnipeg who were reluctant to use traditional health service organizations. During the years when experimenting with hallucinogenic drugs was at its peak, Klinic provided city wide help to drug users in a non-judgemental manner, establishing itself as an alternative storefront resource for transients, teenagers and core area residents. Many of the service recipients had medical problems that needed attention.

The Medical Program at Klinic, which is the target for this review, was established in response to these needs for medical care. Initially its clients were single women with unplanned pregnancies, women requiring contraceptive advice and men and women concerned about the possibility of having sexually transmitted diseases. The Medical Program provided counselling and diagnostic and therapeutic intervention; often all in the first visit due to the transient nature of the clientele. In response to the longer-term needs of this population, continuous primary health care services were offered to those clients wishing to make follow-up appointments.

As was noted above, the Medical Program is one of several programs offered out of Klinic. Klinic also offers a Community Services Program which focuses on the elderly and a Counselling Program which offers a 24 hour crisis

service including the Sexual Assault Program for the City of
Winnipeg, individual counselling, group therapy and
counselling sessions. Two additional programs are the
Volunteer Program, which trains and recruits the large
volunteer pool for the different programs, and the
Administrative Program, which provides support and
maintenance services to all Klinic programs. Figure 2
illustrates the program structure at the time of this review
in relation to the other programs at Klinic. From Figure 2
the relationship between the Medical Program and Community
Services becomes apparent. The structural overlap includes
shared clinical supervision and overall coordination.

FIGURE 2

Structure of the Medical Program in Relation
to Klinic Structure

Board of Directors

Executive Director

Volunteer Program

Counselling Program

Administrative Program

Health and Community Services

Health Services Co-ordinator

Medical Program

Community Services

Physician-Medical
Co-ordinator
(.5 Time)

Medical
Assistants   M.D.   Nurse
(1.3)   Practitioner
                      (1.8)

Public   Nurse   Community
Health   Practitioner Workers
Nurse

- - - - - - - Volunteers
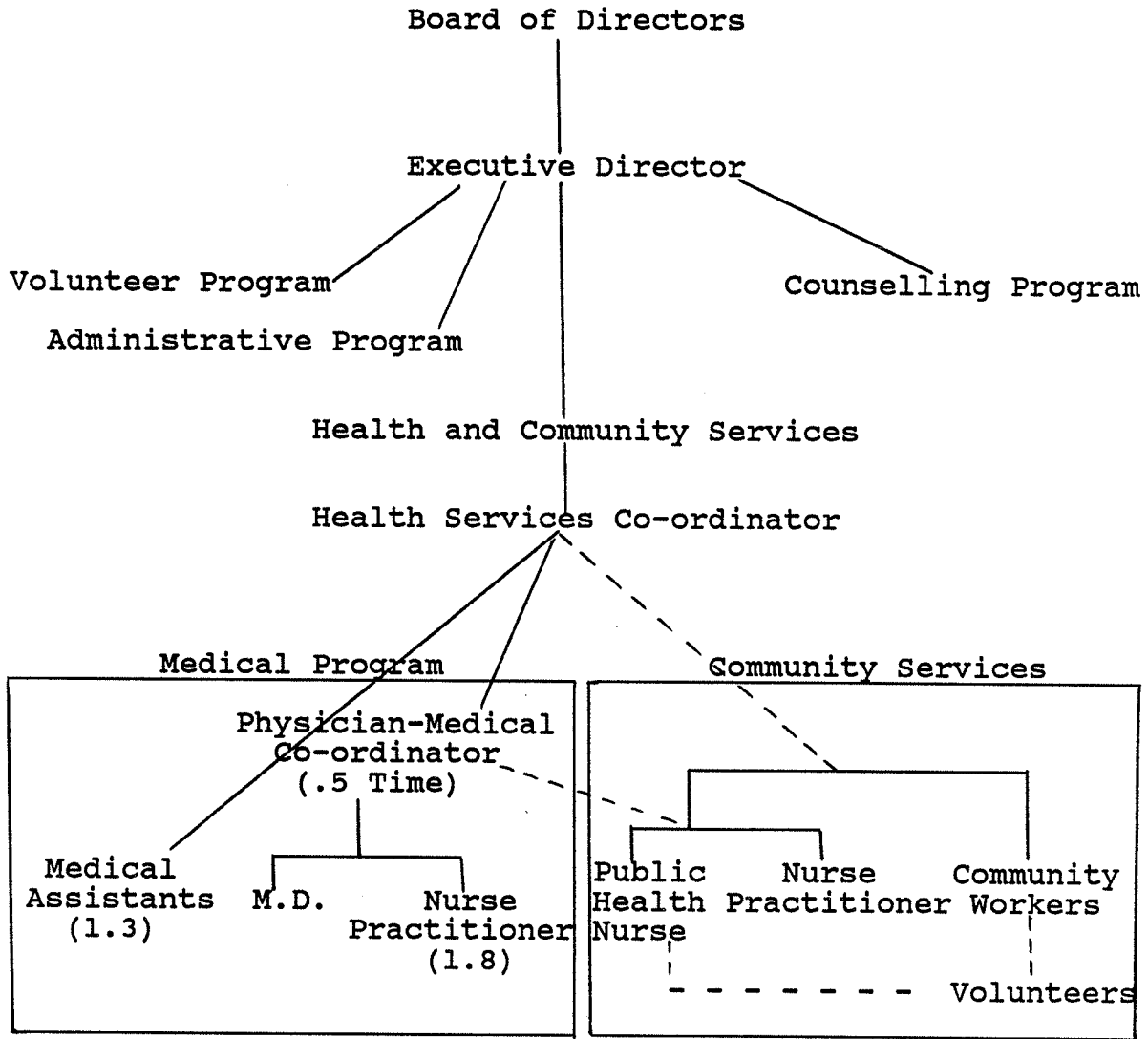
The staff complement is also illustrated in Figure 2. The functions of these positions were outlined in a 1983 report by Dr. Lewis C. Rose, with the exception of the Physician-Medical Co-ordinator position which was developed since the Rose report was written. Based on his description, supplemented by information from Program Personnel, they are as follows:

Health Services Co-ordinator:

Administers the program on behalf of the Executive Director. This person is responsible for staffing, planning and organizing the program, and for promoting further education and training of the Staff. She is also responsible for maintaining and updating job descriptions of her Staff and for budgeting for the Medical Program.

Physician-Medical Co-ordinator:

Supervises program staff on clinical matters. The Co-ordinator is responsible for the day-to-day operations of the program and assists the Health Services Co-ordinator in planning for the program and in establishing its direction. He also performs the functions associated with the "Physicians" classification.

Physicians:

Provide primary medical care to their patients and refer patients with problems outside their competence to specialists or other professionals. They attend patients in Klinic and make housecalls on their patients. One of the physicians had recently acquired admitting privileges to St.

Boniface Hospital immediately prior to this Review and admits patients (primarily obstetrical) to this hospital. The physicians assist the nurse practitioner in caring for her patients and accept patients transferred from the nurse practitioner where necessary.

Nurse Practitioners:

Nurse Practitioners are registered nurses with advanced University preparation, enabling them to provide primary health care services. They can assess patients with minor primary health care problems, provide well patient physical examinations, initiate routine investigations and provide health teaching, information, counselling and referral options to patients. They work in a collegial manner with physicians and consult them when pharmaceutical or medical treatment is indicated.

Medical Assistant:

Assists the physicians and nurse practitioner with the care of the patients. She assembles laboratory specimens for transmission to the lab and performs simple lab tests herself. She prepares and stocks the examination rooms, orders supplies and negotiates for pharmaceutical samples. She counsels people with sexually transmitted diseases and completes the necessary reports. She makes appointments for patients with consultants and makes follow-up calls where necessary.

<u>Intake Workers</u>:

Answer all incoming calls and either deal with them or refer them to the appropriate worker. 'They make appointments for patients or provide information about the walk-in clinic. They pull and file patient charts, sort mail and lab reports as they are received. They receive patients as they arrive at Klinic. They report directly to the Assistant Director of Klinic.

The system employed by the program to maximize the patient flow and use of personnel is a modified circus system. The physician and nurse practitioner each see one patient, with the first practitioner to finish moving on to see a third patient. The rooms are then filled again quickly with patients. This system was instituted in February 1983, following the recommendation of Dr. Rose.

Medical records are kept manually on all patients using the services and are centralized in the reception area. In addition, a daily log is kept by the Staff, noting the patients' principle diagnoses. In 1980-1981 part of this information was entered into a computer which is connected with the mainframe computer at the University of Manitoba. Routine entries of information from the medical program into the computer ceased in 1981.

A final component of the "setting" are the funding arrangements of the Medical Program and Klinic as a whole. Base funding for Klinic is secured through the Manitoba

Health Services Commission. Additional grants are secured

by the individual programs in their attempts to respond

to community needs. In terms of securing grants for direct

service programming the Medical Program is somewhat at a

disadvantage, since their additional "programs" may be

extensions of medical services already funded at acceptable

levels according to M.H.S.C.

PROCESS OF ENTRY

Evaluation research is a political process (Weiss, 1983) beginning at the point of introduction to the agency or organization. It is therefore essential to develop a shared understanding of the purpose for the evaluation (Posovac and Carey, 1980), as well as the assumptions and limitations of the evaluation design. The process of developing this consensus must begin before the evaluation is undertaken (Wholey, 1977). As Berk and Rossi (1976) point out, involving all the interested parties in the early stage of evaluation designs can also positively affect the utilization of findings.

On February 8, 1984, my principle advisor and I met with the Executive Director and Assistant Director to discuss the feasibility of conducting a Program Review of the Medical Program and gain their consent to conduct an evaluability assessment of the Program. The evaluability assessment process was required to determine, from a research perspective, the nature and level of evaluation possible in this setting.

A formal request was presented to the Management group the following week. The Health Services Co-ordinator and Physician-Medical Co-ordinator agreed to meet with me once the request had been approved.

"Groups that have a stake in the outcome of an evaluation should be made aware of the ways evaluation results can be useful to them. For example, a monitoring evaluation can provide project managers information that facilitates staff supervision and project modification" (Rossi and Freeman, 1982).

This proviso was attended to in the early meetings. An attempt was also made to go beyond this proviso, by encouraging the Program managers to develop the agenda for the evaluation within the constraints established by the findings of the evaluability assessment.

From these early negotiations it was apparent that an "effectiveness" focussed evaluation was not preferred by Management, who assumed on the basis of their own observations that the unit was already performing well. While not conclusively proven due to the nature of the design, many of the preliminary findings of the Program review supported these observations.

The willingness of the system to engage in an assessment process was also evident, even at this early stage. Any hesitancy on the part of Program managers was as much a function of the student-evaluator's reluctance to prematurely provide an evaluation design as it was a function of their reluctance to engage in the process.

What emerged from these meetings can be termed "informal approval" which I contend is as important as formal consent. Specific information about the Medical Program also surfaced during these initial meetings. Of significance was the shared perception that the Medical

Program was "in transition". The issues related to this perception centered around the identification of the primary targets of service and the content of care provided by the Medical Program. With regard to the latter issue, a distinction was made between reproductive health care services and primary health care services. These themes were dominant in future discussions with personnel and had a considerable impact on the evaluation design. The emergent nature of the Program also precluded an outcome or summative evaluation, as defined by Suchman (1967).

EVALUABILITY ASSESSMENT

Wholey (1977) provides an excellent rationale for conducting an evaluability assessment, noting that "it provides criteria for deciding how much and what types of information to seek in the evaluation" (p. 41). As Rutman (1977) points out evaluations of program effectiveness assume that certain preconditions are met in the program. The program must be clearly defined, have measurable objectives and have hypotheses linking activities to outcomes. The evaluability assessment establishes the presence or absence of these preconditions. It also serves to establish parameters around the value of the information that can feasibly be extracted from an evaluation, thus maximizing utilization of the final product. The evaluability assessment can assist in directing the agency or program toward summative or formative research, with the former focusing on outcome measures as already noted, and

the latter representing a measure of efficiency. The findings of the evaluability assessment can also act as a working agreement between relevant parties or interest groups involved in the evaluation, setting the stage by clearly defining the program and the constraints to evaluation that might exist.

Wholey (1977) has identified five steps involved in conducting an evaluability assessment. The first step he refers to is "bounding the problem/program" (p. 43) to determine what the program actually consists of or the unit to be analyzed. Collecting program information is the second stage in the process, followed by the development of a program model which accurately describes the program and its activities. Analyzing the program model is Wholey's fourth step, determining how useful the program model is for evaluative purposes. Presenting the conclusions drawn after completing the fourth step to management completes the evaluability process according to Wholey (1977).

Rossi and Freeman (1982) outline a method similar to that employed by Wholey (1977), adding the "how to" advice regarding the tasks of interviewing program personnel and conducting site visits to gain a sense of how the program actually operates. The Wholey (1977) and Rossi and Freeman (1982) approaches to the evaluability assessment formed the basis for the pre-evaluation of the Medical Program. Although the evaluability assessment has been identified as a series of steps, it is important to note that these steps

are not strictly sequential. The evaluator may, for
example, be involved in a "later" step in the process only
to discover that a change in the "results" of a former step
may be required. This change, in turn, may impact on other
steps in the process. Figure 3 depicts a model for an
evaluability assessment which was developed for the purpose
of the practicum. It describes the process which led to the
design employed in the Program Review.

FIGURE 3

An Evaluability Assessment Model

ENTRY

IDENTIFY USERS OF THE EVALUATION

BECOME FAMILIAR WITH THE SETTING

PREPARE STATEMENT OF INTENT

DETERMINE RESOURCES FOR STUDY

PREPARE PROGRAM DESCRIPTION

DEVELOP PROGRAM MODEL

DETERMINE WHAT IS EVALUABLE   DETERMINE WHAT IS DESIRED

REVIEW LITERATURE

FORMULATE DESIGN

DEVISE DISSEMINATION STRATEGY
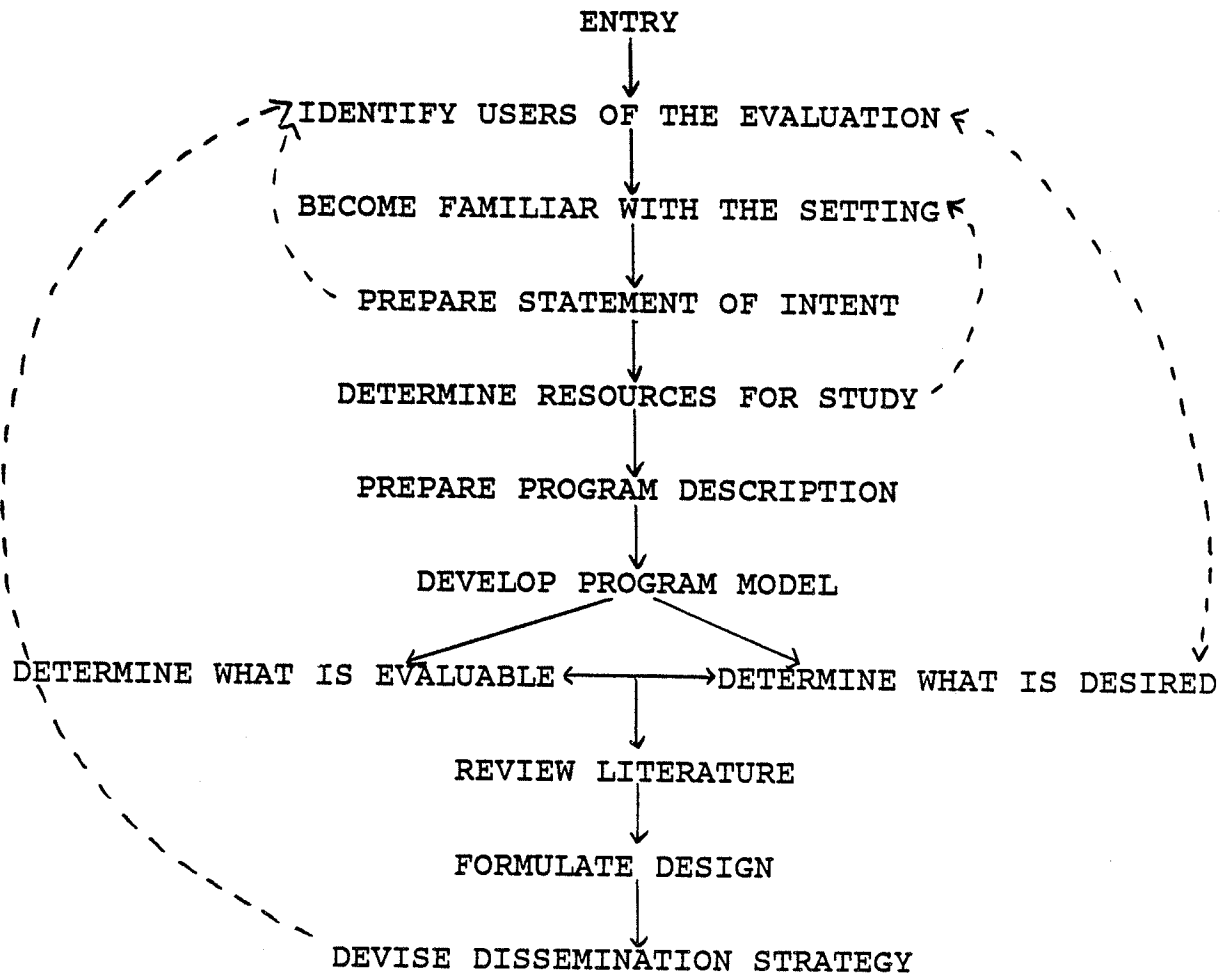
Entry was discussed in the preceding section.
Identifying the users of the evaluation was helpful for two
reasons: (1) it familiarized the evaluator with the
implications the evaluation might have for the Program; and,
(2) it allowed for the identification of key decision makers
and the way in which changes might be made, given the
findings of the evaluation, Hasenfeld (1983) observes that
different groups representing diverse interests may try to
influence the evaluation at different points in time. This
caution was not necessary in this instance. Identifying
potential users did assist in preparing a strategy for
dissemination and facilitate the design.

The users identified at this time included the
Physician-Medical Co-ordinator, the Health Services
Co-ordinator, the Staff of the Program, the Administrative
Program, the Executive Director, the Board of Directors and
the University of Manitoba. This latter group of "users"
was important to identify in that their inclusion changed
the final report from a private to public document.

Three levels of decision-making were identified during
this Phase: Management, Board, and Staff. It was essential
to identify Staff as a decision-making body given the nature
of Klinic itself and its participatory management approach.

A statement of intent had already been presented at the
point of entry, as a response to a request from the
Executive Director. A commissioned evaluator may have
insisted on acquiring additional information prior to

submitting this statement. Regardless, a statement of intent at this point in the evaluability assessment was merely a general statement as to the purpose of the evaluability assessment itself. A useful function of formulating this statement was to gain access in a uniform manner to program personnel and give them a sense of the type of information that might be required during the Program Review.

The statement of intent is not to be confused with the purpose of the evaluation, which cannot be determined until the evaluability assessment is complete. The purpose is finalized into an evaluation proposal or "evaluation plan" (Rossi and Freeman, 1982, p. 77).

Establishing resources for conducting the evaluation is the fourth step in the evaluability process. In this instance, staff time, office space and computer time were the principle resources.

Access is another issue that was addressed at this point. Access to the physical setting, medical records and Staff was acquired. Sensitivity to Staff feelings about evaluation is of importance, even during the evaluability assessment. Posovac (1980) notes that there are several sources of resistance to evaluation. These include concerns that an evaluation might jeopardize the program, fears that creativity will be prevented - possibly through operationalizing work processes, a concern that the quality of service may be overlooked by an insensitive evaluator, a

concern regarding information misuse, and a concern that the evaluation wastes funds or resources that could be better used in the program. An additional source of resistance is what Posavac (1980) refers to as self-styled experts or people who feel they know more about evaluation than the evaluator.

A related issue which can be anticipated, especially in evaluating a Medical Program is the objection of some individuals to "outside" versus inside or self evaluations. This issue is addressed, in part, by Donabedian (1981) in his essay on explicit versus implicit criteria of effectiveness of health care. As Donabedian (1981) notes, explicit or standardized criteria are potentially an instrument of control, and have been viewed as such by groups of physicians. Implicit criteria are viewed as the norm by many physicians, with quality of care issues related back to their own professional body. Locker and Dunt (1978) also comment on the "objective" value assigned to provider assessments of health care vis-a-vis patient assessments. If found to be present, resistance by the physicians could have affected the decision to evaluate the program or the focus of the evaluation, should quality of care be defined as a program component that is sufficiently articulated and amenable to evaluation from a research perspective. Another important advantage of gaining staff cooperation during the evaluability assessment is that it increases the likelihood

of developing an accurate program model from which to develop the final evaluable model.

Familiarity with the setting provides information regarding the operations and constraints of the program. In the case of the Medical Program, the setting was believed to be a definite constraint on the number and types of services offered. In a 1983 report, Dr. Lewis Rose noted that if one additional room was available now, it would permit one practitioner to run an efficient general clinic, while an additional practitioner (nurse or physician) did counselling, routine physical examinations or some other form of low volume activity. Dr. Rose recommended doubling the space available to the program, adding such important elements as examining rooms, additional waiting and storage space, and a toilet. Familiarity with the setting is especially important in an efficiency type evaluation where "throughput" is the focus. In this instance it also provided such basic information as the location of files and general atmosphere, all of which were relevant to the evaluation.

Preparing a program description, according to Rossi and Freeman (1982) is based on "formal documents, such as funding proposals, published brochures, administrative manuals, annual report, minutes, and completed evaluation studies" (p. 76). The documents reviewed for this purpose are listed in the Reference section of this report. The purpose of the program description is to link program

objectives to program components, identifying how the

Program actually operates.

Problems with the development of a program description

were immediately apparent. Based on the written information

acquired from Klinic and interviews with the Executive

Director and the Health Services Co-ordinator, the following

objectives were derived:

1. To provide comprehensive primary health care to
    the catchment area;
2. To provide holistic health care;
3. To provide reproductive health care to the
    community of need;
4. To move the community towards "wellness";
5. To improve the health of service users; and,
6. To maintain client satisfaction with service and
    the method of service provision

These objectives are linked to program elements in Figure 4.

The list is not exhaustive and could have been supplemented

in further discussions with Management and Staff. This

program model or "rhetorical model" (Rutman, 1977)

establishes potential casual links or hypotheses which

define the program. It becomes apparent in examining these

objectives that objectives 1, 2 and 3 are throughput or

delivery system issues whereas objectives 4 and 5 are

effectiveness issues. The sixth objective could fit into

either category (Locker and Dunt, 1978).

FIGURE 4

PROGRAM MODEL

PROGRAM ELEMENTS   INTERMEDIATE OBJECTIVES   OBJECTIVES

                                    T$_1$ T2

PRIMARY HEALTH CARE SERVICES ———→OFFER RANGE OF ——————————→INCREASE COMMUNITY ————→COMPREHENSIVE PRIMARY
                                    SERVICE TO USERS   RESIDENTS USE OF SVCES   HEALTH CARE FOR COMMUNITY

REPRODUCTIVE HEALTH CARE SERVICES   →MOVE COMMUNITY TOWARDS
                                                                                          "WELLNESS"

                                                                                          →REPRODUCTIVE HEALTH CAR
PHYSICAL LOCATION ——————————→USE OF SERVICE BY COMMUNITY   TO COMMUNITY OF NEED
                                    RESIDENTS

CLIENT PATHWAY   HIGH RATE OF SERVICE——→ EARLY DIAGNOSIS &
    —PROGRAM IMAGE   USE BY YOUTH & GAY   TREATMENT OF REPRODUCTIVE →CLIENT SATISFACTION
    —LENGTH OF TIME PER PATIENT   COMMUNITY   HEALTH CONCERNS
    —CIRCUS SYSTEM   EFFICIENT DELIVERY OF- - ->EFFICIENT TREATMENT OF
                                    PRIMARY HEALTH CARE   REPRODUCTIVE HEALTH
                                    SERVICES   PROBLEMS
IDEOLOGY OF THE STAFF————————————————————————————————————→ HOLISTIC HEALTH CARE

DIAGNOSTIC SERVICES ——————————→ DEVELOP TREATMENT PLAN ——→PATIENT FOLLOWS————————→IMPROVE HEALTH OF THE
                                                            THROUGH WITH PLAN   USERS

T=Time

Two issues must be noted upon examination of Figure 4:
(1) the pathways leading to "success" in achieving the
objectives are poorly developed; and (2) the objectives
themselves are not necessarily congruent.   Donabedian
(1966) cogently criticizes outcome studies that produce
irrelevant findings, an almost certain product of pursuing
these objectives on a singular basis.   Without well-defined,
consistent objectives, furthermore, a summative research
design has little chance of success, from both research and
utilization-based perspectives. The stakeholders,
furthermore were not interested in a design of that nature.

From the conclusions reached during the evaluability
assessment process, a formative Program Review model was
advocated.   The Program Review proposal was presented to the
staff of the Medical Program in May, 1984.   The Staff were
supportive of my plan to proceed immediately.

CONDUCTING THE REVIEW

The specific purposes of the Program Review are
outlined in the final report to Klinic, included in Appen-
dix A.   The Review itself was composed of four principle
tasks:

1.   Problem Oriented Record Review (P.O.R.R.)

2.   Client Survey

3.   Observation of the Program

4.   An Exercise to Determine Program Objectives

Each of these tasks, and the findings of the Review are
outlined in detail in the final report.   This section will

focus on some of the difficulties encountered during the review process; specifically, conceptualizing and operationalizing the variables employed in the P.O.R.R.; securing client participation in the Client Survey; observing program elements; and, completing the objective setting exercise.

The use of the clinical or medical records for health care assessment has been well documented (Demlo, 1983; Coulton, 1982; Baker, 1983). The Problem Oriented Medical Record, as described by Woody and Mallison, 1973), has four basic data components: a demographic information base, a complete problem list with numbered and titled problems, an initial plan; and, progress notes which correspond to each problem. The progress notes are usually organized in a SOAP format which includes a Subjective statement of the problem acquired from the client/patient, an Objective statement provided by the practitioner, an Assessment, and a Plan. The medical records at Klinic, for the most part, employ this system. The SOAP format is more widely adhered to by Staff for process recording than the complete Problem Oriented Medical Record approach. The P.O.R.R. included a review of demographic data and the identification of the medical problems diagnosed by Program physicians and nurse practitioners. Collecting the demographic data was straightforward. It quickly became apparent, however, that additional training was required to group all diagnoses

within the reproductive health care and primary health care categories.

Stillman et al. (1978) discuss the use of practical instructors to evaluate complete physical examinations. While the exercise described by these authors differed in focus, the process they recommend was used in addressing the categorization problem. They suggest the following: (1) develop a checklist of items essential to a CPE; and, (2) train the evaluators in the use of the checklist.

In developing a checklist, all diagnoses from January 1, 1984 to May 1, 1984 were listed. Those diagnoses that were obviously in the reproductive health care category or the primary health care category were appropriately grouped as such. The Health Service Co-ordinator and the Medical/ Physician Co-ordinator assisted the writer in grouping the remaining diagnoses.

It is important to note that the validity of the categories was determined by the Program itself. While this reduces the reproducibility of the design, it makes the findings meaningful to the Program, and, I suggest, increases the potential utilization of the information contained in the final report.

The sample for the Client Survey was severely constrained by the nature of the setting. Due to the value placed on total confidentiality by Klinic, the Client Survey was limited to consumers who entered the premises for a one week period. The reliance on available subjects is

criticized by Babbie (1973) in his excellent book on survey methods which discusses this and other non-probability sampling approaches. As a result, the information obtained should be viewed with caution and interpreted as the feedback from these clients only, who may or may not represent Medical Program clients as a whole.

Baker (1983) observes that watching the practice of care providers is the most direct way of obtaining information on the quality of care. Given the discrepancy between the information contained in the Medical records and actual practice, he states that direct observation can act as a reliability check in a descriptive study such as this one. Baker tempers his enthusiasms for direct observation, however, by defining it as an obtrusive measure which may affect performance. He further notes that reliability is not adequately addressed unless two observers are utilized. The physical space constraints of the setting and the very nature of many clients' presenting problems precluded the direct observation of all program elements. This method was employed to assess entry of clients to the Program, the constraints of the physical setting and the workload. Although measurement reliability was not tested, a checklist was devised to address the issue of reliability wherever possible. The findings, furthermore, were presented to Klinic in a manner which identified these limitations.

Determining the program objectives was a priority for the Program Co-ordinators. Clear-cut objectives are also a

prerequisite to a summative evaluation of effectiveness
(Rutman, 1977) and form a first step to the assurance of
quality of care (Repchul, 1981). Although a serious effort
was made by Program Staff and Management, a final consensus
was not reached in this area. The importance of
establishing a program focus was duly noted by all those
involved in the objective-setting exercise who indicated a
willingness to pursue this topic following the completion of
the initial session.

DISSEMINATING THE RESULTS

Posovac and Carey (1980) observe that a common
complaint of evaluators is: "They never read the report!
Those who did read it did nothing about the recommenda-
tions!" (p. 271). While this, in fact, may be true some of
the responsibility must be assumed by the evaluator who must
examine her/his role in the evaluation process.

Weiss (1972) observes that some evaluators do not
perceive their role as action oriented, emphasizing instead
the collection of data and analysis of the results. She
identifies a minority of evaluators who perceive their role
"as encompassing the 'selling' of their results" (p. 113).
To increase the feasibility of this 'selling' process it is
essential to solicit maxixmum involvement of all stake-
holders in the design of the study, as was noted earlier.
Dissemination thus becomes the final stage of a process
initiated at point of entry to the organization.

A draft of the final report was presented to the same Program personnel that were party to the development of the initial proposal. The report was discussed in this context, and feedback on the process employed by the student evaluator was solicited from those present.

Copies of the final report were distributed to the Co-ordinator of Health Services and the Physician/Medical Co-ordinator. The Executive Director also received a copy.

A presentation of the findings was subsequently made to the Klinic Board of Directors, upon request of the Board Chairperson.

PART III

SELF-EVALUATION

The practicum provided me with the opportunity to
develop social work skills in the following areas:
formative program evaluation, the conduct of evaluability
assessments and small group dynamics. Since this practicum
was completed I have moved comfortably into evaluations of
social service organizations, all of which have employed a
similar process to that developed in the Medical Program
Review. As a consequence of the practicum experience and
the literature review completed for this purpose, I am now
very aware of the context-bound nature of evaluation, and
will strive to maintain the flexibility required to adapt to
new social and health care delivery systems and settings.
Given that the fields of program review and quality
assurance are evolving it will be necessary to continue to
study to keep abreast of the innovations in these areas,
both in terms of the approaches and methodology employed
therein.

Self-evaluation can occur on three levels. The first
level is comprised of a brief overall rating of the
experience, as was provided above. The second level
addresses the usefulness of the evaluation, from a
methodological and utilization-based perspective. The final
level of self-evaluation relates to the comments presented
in the preface which address the need for a "theory-driven
approach" (Chen and Rossi, 1983).

The limitations of the methodology are discussed in detail in the body of the final report and in the preceding sections. Suffice to say that the study was of an exploratory-descriptive cross-sectional nature and lacked the rigor of a quasi-experimental or experimental design.

Brown and Braskamp (1980) present a fifty-item checklist to determine the usefulness of evaluations. The items identified in this checklist, which appears as Appendix B, are: Determining the Evaluator's Role, Understanding the Organizational Context, Planning the Evaluation, Conducting the Evaluation, and Communicating the Evaluative Information. Their tongue-in-cheek guidelines for interpreting the results range from the "no effect" to the "considerable effect" points of a continuum. This approach to self-evaluation was successfully utilized by Vaughan (1985) who concluded that her study "produced an enduring report for the health centre's use" (p. 47).

In applying this checklist to the practicum, I concluded that the adopted process "fit" well with a majority of the items described by Brown and Braskamp. Additional effort could have been directed at the following:

- determining appropriate share of the responsibility for utilization

- specifying activities related to an educational role as well as a data-gathering, information-providing role

- understanding the policy-making process of the organization

- determining which decisions and policies are made as a result of the evaluation

- assessing the implications of decisions based on the evaluation that affect personnel

- determining the likely source of resistance to negative evaluation results

- using several media for making formal presentations.

Despite these shortcomings, the practicum would be rated highly according to the checklist criteria.

This conclusion brings us to the third level of evaluation described above, which relates to the adequacy of the theoretical approach and not the methodological considerations or the utilization-based bias which have been discussed to this point.

Chen and Rossi (1983) note the importance of the theory-driven approach to evaluation which they define as the theoretical specification of how a program can be expected to work. The prosaic theories they are concerned with identify a priori "how human organizations work and how social problems are generated" (p. 285). While the evaluability assessment completed during the practicum produced a program description, this description ignored what Chen and Rossi refer to as exogenous variables. These variables, which may be related or unrelated to the treatment process, could have been defined and included in a model through the application of theory, describing the plausible goals that exist apart from policy or personal opinion. Using LaDuca's (1980) formulation as an example, physician competence has been assumed to be a principle determinant of the quality of health care. Exogenous

variables related to competence must be identified through the application of theory to elucidate the relationship between competence and performance, thereby directing or re-directing the relationship between process and outcome and the nature of the design itself. The need for theory which transcends the methodological considerations of program evaluation and quality assurance, and the lack of such theory, imposed the most serious limitations on this study. The discovery of the need for a theory which unites context, process and outcome was also the most rewarding aspect of the practicum experience.

REFERENCES

Quality Assurance

Affeldt, John E.; Roberts, James S.; Walczak, Regina M. "Quality Assurance, Its Origin, Status and Future Direction - A JCAH Perspective," Evaluation and The Health Professions: Vol. 6, No. 2, June 1983, 245-255.

American Hospital Association. "Guidelines, Quality Assurance Management in a Hospital," American Hospital Association: 1983.

Baker, Frank. "Quality Assurance and Program Evaluation," Evaluation and the Health Professions: Vol. 6, No. 2, June 1983, 149-160.

Baker, Frank. "Data Sources for Health Care Quality Evaluation," Evaluation and the Health Professions: Vol. 6, No. 3, September 1983, 263-281.

Barker Bausell, R. "Quality Assurance, An Overview," Evaluation and the Health Professions: June 1983, 139-141.

Berkman, Barbara; Nutter, Richard; Weiden, Ted. Proceedings from a workshop entitled, "The Rapproachment of Quality Assurance and Program Evaluation," Canadian Evaluation Society Conference. Spring 1986.

Barkdoll, Gerald. "Evaluating the Evaluators," Evaluation and the Health Professions: Vol. 1, No. 3, October 1978, 71-84.

Boissoneau, Robert A. and Edwards, Mark Q. "Multiple Rater Performance Appraisals: Solutions for Hospital Personnel," Hospital and Health Services Administration: March/April 1985, 54-66.

Brenner, Lawrence H. and Jessee, William F. "Delays in Diagnosis: A Problem for Quality Assurance," Quality Review Bulletin: November 1983, 337-344.

Brown, David E.; Levy, James D.; Sarmiento, May. "Patient-Oriented QA Activities," Quality Review Bulletin: January 1984, 19-22.

Clark, Ewen M. and Forbes, J.A. Evaluating Primary Care. London: Billing and Sons Limited, 1979.

Clemenhagen, Carol. "Summary of Quality Assurance Activities, Canada," Vital Signs - M.H.O. Inc., February 1986, 6-7.

Cohen, Lawrence and Stricker, George. "Mental Health Quality Assurance," Evaluation and the Health Professions: Vol. 6, No. 3, September 1983, 327-338.

Coulton, Claudia J. "Quality Assurance for Social Service Programs: Lessons From Health Care," Social Work: September 1982, 397-402.

Demlo, Linda K. "Assuring Quality of Health Care, An Overview," Evaluation and the Health Professions: Vol. 6, No. 2, June 1983, 161-196.

Donabedian, Avedis. "Quality Assessment and Monitoring, Retrospect and Prospect," Evaluation and the Health Professions: Vol. 6, No. 3, September 1983, 361-375.

Donabedian, Avedis. "Advantages and Limitations of Explicit Criteria for Assessing the Quality of Health Care," Milbank Memorial Fund Quarterly/Health and Society: Vol. 59, No. 1, 1981, 99-107.

Donabedian, Avedis. "Evaluating the Quality of Medical Care," Milbank Memorial Fund Quarterly: Vol. 44, 166-206.

Donaldson, Molla S.; Keith, Karla J. "Planning for Program Effectiveness in Quality Assurance," Evaluation and the Health Professions: Vol. 6, No. 2, June 1983, 233-244.

Duram, Gladys S. "On the Scene: Risk Management in Health Care." Aspen Systems Corporation, 1980, 19-35.

Edmunds, Marilyn Winterton. "Evaluation of Nurse Practitioner Effectiveness: An Overview of the Literature," Evaluation and the Health Professions: Vol. 1, No. 1, Sring 1978, 69-82.

Engel, John D. "The Assessment of Competence Comments on this Special Issue," Evaluation and the Health Professions: Vol. 3, No. 3, September 1980, 251-252.

Garrard, Judith; Keyes, Margaret A.; Verby, John E. "The Patient Encounter Method: A Systematic Approach to the Evaluation of Clinical Education," Evaluation and the Health Professions: Vol. 1, No. 4, December 1978, 157-174.

Gaumer, Gary L. "Regulating Health Professionals: A Review of the Empirical Literature," Milbank Memorial Fund Quarterly/Health and Society: Vol. 62, No. 3, 1984, 380-401.

Getzen, Thomas. "Market and Evaluation Roles in Quality Assurance," Evaluation and the Health Professions: Vol. 6, No. 3, September 1983, 299-310.

Guba, Egon G. and Lincoln, Yvonna S. "A Comparison of Quality Criteria for the Conventional and Emergent Paradigms," Unpublished manuscript, 1986.

Hemenway, David. "Thinking About Quality: An Economic Perspective," Quality Review Bulletin: November 1983, 321-327.

Hogan, John. "Planning for Evaluation in a Community Health Agency," in National League for Nursing, Community Health Agency Evaluation. New York: 1976, 9-10.

Kakacek, Keith. "Effective Risk Management," CA Magazine: March 1984, 28-33.

Kennedy, James Ron. "Risk Management for Allied Health Departments," Quality Review Bulletin: June 1984, 175-180.

Kessner, D.M.; Kalk, C.E.; Singer, J. "Assesing health quality - the case for tracers," New England Journal of Medicine: Vol. 298, 381-386.

Knapp, Rebecca and Miller, M. Clinton III. "Analytic Procedure for Evaluating Health Care," Evaluation and the Health Health Professions: Vol. 6, No. 3, September 1983, 345-362.

LaDuca, Anthony. "The Structure of Competence in Health Professions," Evaluation and the Health Professions: Vol. 3, No. 3, September 1980, 253-288.

Lang, Norma M. and Clinton, Jacqueline, F. "Assessment and Assurance of the Quality of Nursing Care," Evaluation and the Health Professions: Vol. 6, No. 2, June 1983, 211-231.

Lange, Brian. "Research Designs Appropriate for Service Agencies," Evaluation and the Health Professions: Vol. 2, No. 2, June 1979, 155-160.

Lohr, Kathleen N. "Quality Assurance Tools for Health Administrators," The Rand Paper Series: The Rand Corporation, Santa Monica, California: November 1983, 25.

Luke, Roice D.; Krueger, Janelle C.; Modrow, Robert E. <u>Organization and Change in Health Care Quality Assurance</u>. Rockville, M.D.: Aspen System Corporation, 1983.

Lynch, Abbyann. "The personalized quality assurance program," <u>Health Management Forum</u>: Spring 1984, 67-74.

Marshik-Gustafson, Judith; Kopher, Susan; Terze, Marguerite. "Planning is the key to successful QA programs," <u>Hospitals</u>: June 1981, 67-73.

McGaghie, William C. "The Evaluation of Competence: Validity Issues," <u>Evaluation and the Health Professions</u>: Vol. 3, No. 3, September 1980, 289-320.

McLachlan, Gordon (Ed.). "A Question of Quality? Roads to Assurance in Medical Care," Reviewed in <u>Evaluation and the Health Professions</u>: Vol. 2, No. 4, December 1979, 487-488.

McLean, A. and Winchell, J.R. "New Q.A. guidelines raise new questions," <u>Health Care</u>: February 1984, 20-21.

Mehnert, Thomas. "The Reassessment Process: Key to a Meaningful Quality Assurance Program," <u>Quality Review Bulletin</u>: April 19, 1985, 127-131.

Nichols, A. Christine and Wirginis, Maryann, B. "Linking Standards of Care with Nursing Quality Assurance - The SCORE Method," <u>Quality Review Bulletin</u>: February 1985, 57-63.

Opatz, Joseph P. "Wellness is a Cost-Containment Strategy," <u>International Risk Control Review</u>: Vol. 5, No. 2, Winter 1986, 41-42.

Popham, W. James. "Measurement Requisites for Competency Assurance in the Health Professions," <u>Evaluation and the Health Professions</u>: Vol. 1, No. 1, 1978a, 9-15.

Popham, W. James. "Competency Verification in the Health Professions Via Limited Focus Measurement," <u>Evaluation and the Health Professions</u>: Vol. 1, No. 3, October 1978b, 101-109.

Prescott, Patricia A. and Driscoll, Laura. "Nurse Practitioner Effectiveness: A Review of Physician-Nurse Comparison Studies," <u>Evaluation and the Health Professions</u>: Vol. 2, No. 4, December 1979, 387-418.

Reinhardt, Uwe E. "Quality Assessment of Medical Care: An Economist's Perspective," <u>Quality Review Bulletin</u>: September 1983, 252-257.

Repchull, Laurie. "Put OR Audits Into Operation," <u>Health Care</u>: October 1981, 12-15.

Rodale, Robert. "The Evaluation of the Quality of Health Care, A Lay Perspective," <u>Evaluation and the Health Professions</u>: Vol. 6, No. 2, June 1983, 143-148.

Rubin, L. and Kellogg, M.A. "The Comprehensive Quality Assurance System," in Giebink, G. and White, N. (Eds.), <u>Ambulatory Medical Care Quality Assurance</u>, 147-167.

Ryge, Gunner and De Vincenzi, Ronald G. "Assessment of the Clinical Quality of Health Care," <u>Evaluation and the Health Professions</u>: Vol. 6, No. 3, September 1983, 311-326.

Sanazaro, Paul J. "Determining Physicians' Performance," <u>Evaluation and the Health Professions</u>: Vol., 6, No. 2, June 1983, 197-210.

Schulberg, Herbert C. and Baker, Frank. (Eds.). <u>Program Evaluation in the Health Fields, Volume II</u>. Human Science Press: New York, 1979, 1-34.

Selig, Andrew Lee; Reber, Paul; Phanidis, Judith; Robertson, Grace. "Social Workers as Evaluators, A Case Study of a Program for Consumer Feedback in a Psychiatric Hospital," <u>Social Work in Health Care</u>: Vol. 6, No. 2, Winter 1981, 67-77.

Shortell, Stephen M. "High-Performing Healthcare Organizations: Guidelines for the Pursuit of Excellence," <u>Hospital and Health Services Administration</u>: July/August 1985, 7-35.

Squires, Nicole-Marie. "Western Canada Wants Healthy Politics," <u>Health Care</u>: February 1980, 20-23.

Stillman, Paula L.; Ruggill, Jane S.; Sabers, Darrell. "The Use of Practical Instructors to Evaluate a Complete Physical Examination," <u>Evaluation and the Health Professions</u>: Vol. 1, No. 1, Spirng 1978, 49-54.

Sykes, Russell B. "Risk Management: Insuring Against All Odds," <u>CA Magazine</u>: December 1984, 42-47.

Thompson, Mark S.; Palmer, Heather R.; Rothrock, Janet K.; Strain, Rose; Brochman, Laura H.; Wright, Elizabeth A. "The Cost of Quality Assurance in Medicine," <u>Evaluation and the Health Professions</u>: Vol. 6, No. 3, September 1983, 283-297.

Tulchinsky, Theodore H. "An Exploratory Study of Methods of Evaluating the quality of Medical Care in a Canadian Prepaid Group Practice Plan," An Essay for the Master of Public Health Degree: 1968.

Turner, Gerald P. and Mapa, Joseph. "Quality Assurance: A New Approach," Dimensions: March 1984, 12-14.

Unknown Author. "Application of Group Dynamics to Effective Nursing Review," Quality Review Bulletin: December 1983, 371-373.

Unknown Author. "Professionals Debate Mandatory Measures," Health Care: March 1980, 37-41.

Vu, Nu Viet. "Medical Problem-Solving Assessment: A Review of Methods and Instruments," Evaluation and the Health Professions: Vol. 2, No. 3, September 1979, 281-307.

Williamson, J.W. "Formulating priorities for quality assurance activity," Journal of the American Medical Association: 1978, Vol. 239, 631-637.

Willimson, John W. and Associates. Teaching Quality Assurance and Cost Containment in Health Care. California: Jossey-Bass Publishers, 1982.

Wolinsky, Frederic D. and Zusman, Marty E. "Toward Comprehensive Health Status Measures," The Sociological Quarterly: Vol. 21, Autumn 1980, 607-621.

Zimmer, James G. "Quality of Care Assessment in Long-Term Care Facilities," Evaluation and the Health Professions: Vol. 6, No. 3, September 1983, 339-344.

Program Evaluation

Aaronson, Neil K. and Wilner, Daniel M. "Evaluation and
    Outcome Research in Community Mental Health Centres,"
    Evaluation Review: Vol. 7, No. 3, June 1983, 303-320.

Abt, Clark C. The Evaluation of Social Programs. Beverly
    Hills: Sage Publications, 1979.

Arkava, Morton I. and Lane, Thomas. Beginning social work
    research. Toronto: Allyn and Bacon, Inc., 1983.

Attkisson, C. Clifford and Hargreaves, William A. "A
    Conceptual Model for Program Evaluation in Health
    Organization" in Schulberg, Herbert C. and Baker,
    Frank (eds.). Program Evaluation in the Health Fields,
    Vol. II. New York: Human Science Press, 1979.

Babbie, Earl R. Survey Research Methods. California:
    Wadsworth Publishing Company, Inc., 1973.

Babbie, Earl. The Practice of Social Research.
    California: Wadsworth Publishing Company, 1983.

Baker, William V. "Evaluation in Saskatchewan: A Working
    System," A Paper presented at the Canadian Evaluation
    Society Conference, Spring, 1986.

Ballantyne, Peri. "Developing Models for Evaluating Multi-
    Modal Programs: Determining Evaluability," A Paper
    presented to the Canadian Evaluation Society
    Conference, Spring, 1986.

Bennett, E.M. and Trute, Barry (eds.). Mental Health
    Information Systems: Problems and Prospects. Studies
    in Health and Human Services. New York: Edwin Mellen
    Press, 1983.

Berk, R.A. and Rossi, P.H. "Doing Good or Worse:
    Evaluation Research Politically Re-examined," Social
    Problems: Vol. 23, February 1976, 337-349.

Bootman, J. Lyle; Rowland, Clayton; Wertheimer, Albert I.
    "Cost-Benefit Analysis," Evaluation and the Health
    Professions: Vol. 2, No. 2, June 1979, 129-154.

Boyd, Lawrence H.; Hylton, John H.; Price, Steven V.
    "Computers in Social Work Practice: A Review," Social
    Work: September 1978, 368-371.

Brown, R. and Brakamp, L. "Summary: Common themes and a
    checklist," in Braskamp, L. and Brown, R. (eds.).
    Utilization of evaluative information. San Fransisco:
    Jossey-Bass, 1980.

Campbell, Donald T. and Stanely, Julian C. Experimental and
    Quasi-Experimental Designs for Research. Chicago:
Rand
    McNally College Publishing Company, 1963.

Chea, Mary Wong, "Research on Recording," Social Casework:
    March 1972, 177-180.

Chen, Huey-Tsyh and Rossi, Peter H. "Evaluating With Sense,
    The Theory-Driven Approach," Evaluation Review, Vol. 7,
    No. 3, June 1983, 283-302.

Cohen, Alan M. "Program Evaluation Processes and the
    Generation of Appropriate Data for Decision-Making,"
    Paper presented at the Canadian Evaluation Society
    Conference, May 1980.

Connor, Ross F. "The Art of Implementation," in Rutman,
    Leonard (ed.), Evaluation Research Methods. Beverly
    Hills: Sage Publications, 1984, 219-236.

Datta, Lois-Ellen. "The Impact of the Westinghouse/Ohio
    Evaluation on the Development of Project Head Start:
    An Examination of the Immediate and Longer-Term Effects
    and How They Came About," in Abt, Clark C. (ed.), The
    Evaluation of Social Programs. Beverly Hills: Sage
    Publications, 1979, 129-182.

Deutscher, Irwin. "Toward Avoiding the Goal-Trap in
    Evaluation Research," in Abt, Clark C. (ed.), The
    Evaluation of Social Programs. Beverly Hills: Sage
    Publications, 1979, 249-268.

Dutton, Diana B. "Explaining the Low Use of Health Services
    by The Poor: Costs, Attitudes or Delivery Systems,"
    American Sociological Review: Vol 43, June 1978, 348-
    368.

Fowler, Floyd J. Jr. Survey Research Methods. Beverly
    Hills: Sage Publications, 1984.

Greene, James Y.; Weinberger, Morris; Mamlin, Joseph H.
    "Patient Attitudes Toward Health Care: Expectations of
    Primary Care in a Clinic Setting," Social Science and
    Medecine: Vol. 14A, 133-138.

Grinnell, Richard M. Social Work Research and Evaluation.
    Illinois: F.E. Peacock Publishers, 1985.

Grinnell, Richard M. Social Work Research and Evaluation.
    Illinois: F.E. Peacock Publishers, 1981.

Gross, P.F. "Urban Health Disorders, Spatial Analysis, and the Economics of Health Facility Location," International Journal of Health Services: Vol. 2, February 1972, 63-84.

Gruber, M. (ed.). Management Systems in the Human Services. Philadelphia: Temple University Press, 1981.

Hassenfeld, Yeheskel. Human Service Organizations. New Jersey: Prentice Hall Inc., 1983.

Hill, John G. "Cost Analysis of Social Work Service," in Polansky, Norman (ed.), Social Work Research. Chicago: The University of Chicago Press, 1960, 223-246.

Horst, Pamela; Nay, Joe N.; Scanlon, John W.; Wholey, Joseph. "Program Management and the Federal Evaluator," in Schulberg, Herbert and Baker, Frank, (eds.). Program Evaluation in the Health Fields, Vol II. New York: Human Science Press, 1979.

Kahn, Alfred J. "The Design of Research," in Polansky, Norman (ed.), Social Work Research. Chicago: The University of Chicago Press, 1960, 48-73.

Kane, Rosalie, "Look to the Record," Social Work: July 1974, 412-416.

Kaplan, Abraham. The Conduct of Inquiry. Pennsylvania: Chandler Publishing Company, 1964.

Kaufman, Roger and Thomas, Susan. Evaluation Without Fear. New York: New Viewpoints, 1980.

Kennedy, Mary M. "The Role of the In-House Evaluator," Evaluation Review: Vol. 7, No. 4, August 1983, 519-541.

Kiresuk, Thomas J. and Lund, Sander. "Goal Attainment Scaling: Research, Evaluation and Utilization," in Schulberg, Herbert and Baker, Frank (eds.). Program Evaluation in the Health Fields, Vol. II. New York: Human Science Press, 1979, 214-237.

Kuropatwa, Ralph. "Evaluation As Treatment: The Case of the I.P.P.," Paper presented at the Canadian Evaluation Society Conference, Spring 1986.

Larsen, D.E. and Rootman, I. "Physician role performance and patient satisfaction," Social Science and Medicine: Vol. 10, 1976, 29-32.

Lebow, Jay L. "Client Satisfaction with Mental Health Treatment," <u>Evaluation Review</u>: Vol. 7, No. 6, December 1983, 729-759.

Levin, Henry M. <u>Cost-Effectiveness, A Primer</u>. Beverly Hills: Sage Publications, 1983.

Locker, David and Dunt, David. "Theoretical and Methodological Issues in Sociological Studies of Consumer Satisfaction with Medical Care," <u>Social Science and Medicine</u>: Vol. 12, No. 4A, July 1978, 283-292.

Love, Robert E.; Caid, Charlene J.; David, Abraham. "The User Satisfaction Survey: Consumer Evaluation of an Inner City Community Mental Health Centre," <u>Evaluation and the Health Professions</u>: Vol. 1, No. 5, March 1979, 42-54.

Lusby, Sarah and Rudney, Bernice. "One Agency's Solution to the Recording Problem," <u>Social Casework</u>, December 1973, 586-590.

Majchrzak, Ann. "Organizational Context of Program Evaluation in Community Mental Health Centres," <u>Evaluation and the Health Professions</u>: Vol. 5, No. 2, September 1982, 303-333.

Mark, Melvin M. and Cook, Thomas D. "Design of Randomized Experiments and Quasi-Experiments," in Rutman, Leonard (ed.), <u>Evaluation Research Methods</u>. Beverly Hills: Sage Publications, 1984, 65-120.

Neff, Joya Lee. "An Evaluation Format for Community Health Agencies," in National League for Nursing, <u>Community Health Agency Evaluation</u>. New York: 1976, 13-15.

Nielsen, Lore and Turner, Susan Douglas. "Program Evaluation as an Evolutionary Process," <u>Evaluation Review</u>: Vol. 7, No. 3, June 1983, 397-405.

Nutter, Richard W. and Weiden, Theodore D. "A Reconciliation of Program Evaluation and Quality Assurance," Unpublished manuscript: November 1985.

Patton, M.Q. <u>Creative Evaluation</u>. Beverly Hills: Sage Publications, 1981.

Patton, M.Q. <u>Utilization-Focused Evaluation</u>. Beverly Hills: Sage Publications, 1978.

Posovac, Emil J. and Carey, Raymond C. <u>Program Evaluation, Methods and Case Studies</u>. New Jersey: Prentice-Hall Inc., 1980.

Rocheleau, Bruce and Mackesay, Thomas. "What, Consumer Feedback Surveys Again?" Evaluation and the Health Professions: Vol. 3, No. 4, December 1980, 405-419.

Ross, Catherine E. and Duff, Raymond, S. "A Nonrecursive Causal Model of the Health Care Delivery System," The Sociological Quarterly: Vol. 23, Summer 1982, 403-420.

Rossi, Peter H. and Freeman, Howard E. Evaluation - A Systematic Approach. Sage Publications: Beverly Hills, 1982.

Rutman, Leonard. "Some Thoughts on Federal Level Evaluation," The Canadian Journal of Program Evaluation: Vol. 1, No. 1, 1986, 19-28.

Rutman, Leonard. Evaluation Research Methods. Beverly Hills: Sage Publications, 1984.

Rutman, Leonard. "Evaluability Assessment" in Rutman, Leonard (ed.), Evaluation Research Methods. Beverly Hills: Sage Publications, 1984, 27-38.

Rutman, Leonard. Evaluation Research Methods: A Basic Guide. Beverly Hills: Sage Publications, 1977.

Scriven, Michael. "Payoffs from Evaluation," in Abt, Clark C. (ed.), The Evaluation of Social Programs. Beverly Hills: Sage Publications, 1979, 217-224.

Stanfield, Barbara. "Measurement of Outcome: A Proposed Scheme," in Schulberg, Herbert and Baker, Frank (eds.). Program Evaluation in the Health Fields, Vol. II. New York: Human Science Press, 1979, 205-213.

Suchman, Edward A. Evaluative Research. New York: Russell Sage Foundation, 1967.

Thompson, Mark S. Benefit-Cost Analysis for Program Evaluation. Beverly Hills: Sage Publications, 1980.

Thorner, Robert M. "Health Program Evaluation in Relation to Health Programming," in Schulberg, Herbert and Baker, Frank (eds.). Program Evaluation in the Health Fields, Vol. II, New York: Human Science Press, 1979, 39-52.

Tripodi, Tony. Evaluative Research for Social Workers. New Jersey: Prentice-Hall Inc., 1983.

Tripodi, Tony; Fellin, Phillip; Meyer, Henry J. The Assessment of Social Research. Illinois: F.E. Peacock Publishers Inc., 1983.

Trochim, William M.K. Research Design for Program Evalua-
     tion. Beverly Hills: Sage Publications, 1984.

Trute, Barry; Tefft, Bruce; Scuse, David. Human Service
     Information Systems: How to Design and Implement Them.
     New York: Edwin Mellen Press, 1985.

Vaughan, Anne E. "Automated Management Information Systems
     in Human Services: Data Applications in a Community
     Health Centre," Report of a Practicum Presented to the
     Faculty of Graduate Studies, University of Manitoba,
     November 1985.

Veeder, Nancy W. "Health Service Utilization Models for
     Human Services Planning," Journal of the American
     Institute of Planners: Vol. 41, No. 3, March 1975,
     101-109.

Weiss, Carol H. "Increasing the Likelihood of Influencing
     Decisions," in Rutman, Leonard (ed.), Evaluation
     Research Methods. Beverly Hills: Sage Publications,
     1984, 159-190.

Weiss, Carol H. "Where Politics and Evaluation Research
     Meet," Evaluation: Vol. 1, No. 3, 1973, 37-45.

Weiss, Carol H. Evaluation Research. New Jersey:
     Prentice-Hall Inc., 1972.

Wholey, Joseph. "Evaluation and Utilization in the United
     States," The Canadian Journal of Program Evaluation:
     Vol. 1, No. 1, 1986, 11-18.

Wholey, Joseph S. "Evaluability Assessment," in Leonard
     Rutman (editor), Evaluation Research Methods: A Basic
     Guide. Beverly Hills: Sage Publications, 1977,
     Chapter 2.

Windle, C.; Paschall, N. "Client participation in CMHC
     program evaluation: increasing incidence, inadequate
     involvement," Community Mental Health Journal: Vol 17,
     66-76.

Woody, Mary and Mallison, Mary. "The Problem-Oriented
     System for Patient-Centered Care," American Journal of
     Nursing, July 1973, 1168-1175.

Wortman, Paul M. (ed.). Methods for Evaluating Health
     Services. California: Sage Publications, 1981.

Klinic Documents

Community Services - Program Direction, Spring 1983.

Klinic Community Health Centre - Present Programs and Future
Potential, June 1983.

Klinic's Direction - Changes and Additions to the P and P
Committee's Paper of April 14, 1980.

Klinic's Direction, DRAFT, September 11, 1980.

Klinic Inc. Planning Documents: April 1980, December 1982,
March 1983, June 1983.

Planning and Priorities Committee, Report to the Board,
April 1980.

Proposal for the Development of the Medical Program at
Klinic, December 1982.

Rose, Lewis C. Klinic - A Study of the Medical Program of
Klinic Community Health Centre, February 1983.

Tarry and Associates, Management Consultants. Assessment of
the Community Services Programs of Klinic, Inc.,
February 1979.

APPENDIX A

PROGRAM REVIEW

OF THE

MEDICAL PROGRAM

KLINIC, INC.

by

Linda L. Campbell
B.A. B.S.W.

in partial fulfillment of the
requirements for a Master of
Social Work Degree

PROGRAM REVIEW

OF THE

MEDICAL PROGRAM

KLINIC, INC

TABLE OF CONTENTS

SECTION 1

INTRODUCTION

In May 1984, to fulfill part of the requirements of a Master of Social Work degree for the University of Manitoba, a formal proposal to conduct a Program Review of the Medical Program was made by Linda Campbell to the management team of Klinic, Inc., This formal proposal marked the completion of an evaluability assessment which was initiated in Febuary of 1984 and involved a review of Medical Program planning documents, site visits and meetings with the Coordinator of Health and Community Services and the Coordinator of the Medical Program.

The major themes which emerged out of the evaluability assessment and which influenced the development of the formal proposal were:

- the need for accurate current information on the Medical Program in terms of its client population and the nature of their presenting health problems;

- the need for clarification regarding client's perceptions of the Medical Program; specifically addressing the areas of accessibility and client assumptions about the services offered by the Medical Program; and;

- the need for an explicit statement of Program objectives, the development of which would facilitate Program planning and enable a more thorough evaluation of Program effectiveness.

The specific purpose of the Program Review were as follows:

- to provide staff and management with information on outputs or the services actually being delivered to clients and a profile of the clients being served by the Medical Program;

- to document client's perceptions of the Medical Program in terms of
  its focus and methods of service delivery; and,

- to assist the Program in developing a statement of current objectives.

The Program Review was conducted in four phases: (1)
Problem Oriented Record Review; (2) Medical Program Client Survey;
(3) Direct Observation of Program Activities, and (4) Program Objectives
Setting Exercise. Each of these phases is reviewed individually in Sections
3, 4, 5 and 6. Section 2 is reserved for the conclusions and recommendations
which reference the appropriate Sections in the body of the report. It is
separated into four subsections relating to each of the four phases noted
above.

CONCLUSIONS AND RECOMMENDATIONS

2.1 Problem Oriented Record Review

On the basis of the 631 file review of the Problem Oriented Record (P.O.R.)
the Medical Program can be reported to serve a variety of individuals, many of
whom are concentrated in a small number of the categories that were examined.
Using the modal, or most frequently observed, category of each variable the
following description of a Medical Program client was obtained:

The most typical client is a single woman aged 21-25 years who has never
married, lives in the R3C postal zone, has no children and lives with
immediate family members. This woman is most likely to have heard of
Klinic through a friend or relative and to have come to Klinic on the
basis of that referral. She will have visited Klinic from 1-3 times in
the past year and is more likely to have received reproductive health
services than primary health services in her last visit. Among those
services, she is most likely to have received veneral disease assessment
and/or treatment and lab tests. With the exception of the referral for
lab tests, it is unlikely that she was referred out of Klinic for any
services.

The above description can be expanded upon by considering the variation in
some of the data collected. The age of clients ranged from 1 to 79 years although
the majority were concentrated in the 15-35 year categories. The number of visits
in the one year period under study also varied considerably - from one visit to
41 visits.

The form of the distribution of each variable is also important. The postal
code variable, for example is bimodal. The most frequently mentioned postal codes

were both in the geographic catchment area. Clients in this area comprised 27.7% of the total sample.

The nature of service is more evenly distributed than might be assumed by the above description. While 56.3% of the clients sampled received reproductive health care services on their last visit, 40% received primary health care services.

Other segments of the data which are pertinent in the context of the other phases of the Program Review are:

- catchment area clients differ along key dimensions from clients living out-side of the catchment area. Catchment area clients are generally less educated, more likely to be living away from immediate family and less likely to be employed. A higher proportion of catchment area clients are male.

- 20.5% of the clients sampled have dependent children while only 3% of the sample are under 14 years of age. This suggests that clients' children are receiving health care services elsewhere or are not receiving any services.

- there is very little overlap between Programs at Klinic and very few clients are referred to or from other Programs.

- few clients are referred outside of Klinic for social services while 21.2% are referred out for specialized Medical Services.

As part of the P.O.R. Review the actual recording process was evaluated. The recording in the P.O.R. by Medical Program staff is generally detailed and compre-hensive. The entries, unfortunately do not all follow a standardized format. Some practititioners utilize the S.O.A.P. format routinely and others do not use it at all. A standardized method of recording in the P.O.R. is consistent with the Medical Programs team approach to health care practice and would be advan-tageous for practice and evaluation purposes. A standardized method of recording

should be employed by all staff who use the P.O.R. regardless of their Program affiliation.

Additional recommendations which reference the appropriate Section and page numbers in the body of the report are:

1. The nature of the client contact should be coded in the P.O.R. indicating if it is an office visit, a home visit, a lab report or a telephone call (Section 3, p.10).

2. Client address changes should be noted and dated in one specific section of the P.O.R. (Section 3, p.14).

3. The Problem summary sheet should be used routinely by all Klinic staff. This may involve re-training the staff from the other Programs on the correct use of the P.O.R. (Section 3, p.16).

4. The telephone and front desk referral process should be reviewed and a protocol developed which would ensure that referrals were being made to services or programs that are sensitive to Klinic's clients. Client feedback on the use of these resources could also be solicited from time to time to ensure that clients were satisfied with the services they received (Section 3, p.22).

5. Entries in the P.O.R. should be coded by Program name while retaining their problem oriented focus. This may mean simply writing "M.P." for Medical Program after each entry is signed or heading each entry with the Program name. This is especially important given the Medical Program's use of casual staff for vacation and illness relief and the number of volunteers employed in other Programs (Section 3, p.22).

2.2. The Client Survey

The clients who responded to the Client Survey closely resembled those sampled in the P.O.R. Review in terms of their age and sex.

Generally clients appeared satisfied with the Medical Program. Despite the fact that 35.6% of the Survey respondents felt embarrassed, scared, nervous, ambivalent or uncomfortable when they initially came to the Medical Program, 100% stated they would use the Program again.

The Medical Program was also rated highly on the variables "personal", "caring", "confidential" and "available". An overwhelming majority (96.5%) of the respondents saw the Medical Program as a place that takes an interest in them as a whole person.

Many of the respondents were currently being seen by another health practitioner (35.8%). A majority identified a private physician as the most frequently used "other medical service" (64.5% of the clients who answered this question). Most clients were unable to accurately identify the services provided by the Medical Program other than those they had already received.

Of those clients who dropped in, many appeared unaware of their option of making an appointment. Of those who dropped in, 88.2% indicated they would make an appointment with the Medical Program "if they knew the could".

A small but significant number of Survey respondents had misinformation about the staff employed by the Program. The Medical Program was seen by 16% of the clients as "a clinic that uses mainly student doctors". This may be related to the opinion of 12.1% of the respondents who identified the Medical Program as less capable that the other medical service they had used the most.

It would appear that clients could benefit from information about the services offered by the Medical Program, clients' option of making appointments with the practitioner of their choice, and the staff that are employed by the Program.

Only 19 of the 106 clients who completed the Survey form made program or service recommendations. The most frequently made recommendations focused on birth control and nutrition. A more specific list of potential programs and services could be distributed to clients by management for program planning purposes.

Additional recommendations which relate to the contents of Section 4 are:

6. Clients currently using another medical service should be asked to indicate which of the specific services they are receiving outside of Klinic would they like to be receiving from the Medical Program. This could provide additional information on clients' perceptions of the Medical Program and on its image vis a vis other medical services. (Section 4, p.28).

7. As was suggested above, clients should be made aware of the range of services provided by the Medical Program staff. (Section 4, p.28).

8. Clients should be re-educated regarding the option of making appointments with the Medical Program and with individual practitioners (Section 4, p.29).

9. The perception of the Medical Program as "less capable" should be addressed by Program staff and management to determine what part of this perception is based on image, client misconceptions, etc. (Section 3, p.31)

10. Prior to engaging in program planning, the health needs of current clients should be assessed directly. (Section 4, p.31).

2.3   Observation of Program Activities.

The flow of clients through the Medical Program was observed to be a function of the number of staff employed by the Program and the space provided for service delivery. A reception area crowded during peak periods, too few examining rooms given the number of practitioners employed at any one time, and limited washroom facilities all effected client flow through the Program. The multiple functions of the front desk staff also generated minor delays, despite their efforts to respond quickly to waiting clients.

Additional areas of observation which management may want to address are:

- billing and record keeping for "one-shot" pregnancy tests;

- the functions of the Medical Assistants which are not included in their

  job description and;

- file (P.O.R.) control.

Recommendations which follow from the Observation exercise are:

11. It would benefit clients and staff by having one additional support
staff person attached directly to the Medical Program. The function of this
person could be to act as receptionist for Medical Program clients, control and
monitor the use of P.O.R.'s and attend Medical Program meetings - providing
feedback to the Program on their Intake process (Section 5, p.33).

12. Health education literature, focussing on some of the areas mentioned
by clients in the Client Survey could be made available to waiting clients
(Section 5, P.34).

13. The Medical Assistant's job description could be reviewed to encom-
pass the full range of tasks performed in this position (Section 5, P.35).

14. To reflect the Medical Program's emphasis on the whole person, all
services of a social or emotional support nature should be documented in the
P.O.R. (Section 5, p. 35).

15. A file should be kept of all clients who use Klinic for its pregnancy
testing service, to allow for follow-up of its frequent users (Section 5, P.35).

15. Single clients over 18 should be automatically billed through
M.H.S.C. for pregnancy testing. All other clients could be asked if they would
be willing to supply their M.H.S.C. number for billing purposes (Section 5,
P.35).

17. Greater control should be developed of the P.O.R.'s. All files not
in the filing cabinets should be signed out or recorded as missing. All files
should be returned to the front desk at the end of each day (Section 5, p.17)

2.4   Medical Program Objectives.

The explicit statement of Program Objectives, developed with Program Staff and Management individually and collectively, encompasses curative and perventive aspects of health care and relects the Program's goal of providing accessibile services to special needs groups.

While there was a general staff consensus regarding the majority of objectives, there was varying emphasis on involvement with the geographic catchment area. Some staff members felt that the principle Program objectives should support a catchment area focus. Others wished to retain a community of need focus and their geographically distributed client population. All agreed that additional social and medical support services should be made available to existing and prospective clients of the Medical Program.

Specific goals for the Program that were put forth by Medical Program personnel involved extensions of services currently being offered and service additions including the development of programs for select client groups. It was recognized that supports within Klinic would have to be in place before many of these goals could be realized. Some of the supports mentioned were time allocated for program planning and research, a better relationship between Klinic Programs and additional facilities.

Some recommendations, intended to assist the Program in meeting their objectives are:

18.   The target for service should be clearly specified by the Medical Program (Section 6, p.39).

19.   A program focussed effort directed at current clients living in the geographic catchment area could be initiated, combining the goals and objectives of the various members of the Medical Program. If this program was offered to community residents in addition to current clients it could act as a measure of community response to a health oriented outreach program without unduly straining current resources. (Section 6, p.40).

SECTION 3

PROBLEM ORIENTED RECORD REVIEW

3.1 Introduction

     The Problem Oriented Record (P.O.R.) Review examined the medical records
of clients seen in the Medical Program during the period of May 1, 1983 - April
30, 1984. The final sample size was 631 clients selected at random with a random
start from among those clients whose names appeared on the Medical Program Log
during that period. The sampling ratio was 1/10 P.O.R.'s. Since the Log was used
as the sampling frame, those clients receiving medical services from the Community
Services Program were not included in the sample unless they also visited the
Medical Program at Klinic during the one year period. In addition, those clients
who names appeared on the Log more than once from May 1, 1983 - April 30, 1984 had
a greater likelihood of being included in the sample. To ensure that individual
P.O.R.'s were reviewed only once, each P.O.R. was marked as it was examined. A
replacement P.O.R. was substituted for those P.O.R.'s that were sampled more than
once in two additional random sampling exercises.

     Each P.O.R. was examined using the Client Data Retrieval Form (refer to
Appendix A), which was pre-coded to facilitate computer analysis. Two separate
checks on reliability were made during the P.O.R. Review. In each instance, 5
study numbers were selected at random from among those already assigned to
clients. These were linked to client numbers and the corresponding P.O.R.'s were
scored again by the same rater. Only two questions were scored inconsistently.
The first question, number of visits to the Medical Program from May 1, 1983 -
April 30, 1984 was scored inconsistently in 1 of 10 cases. This was, in part, due
to the difficulty distinguishing between an office visit and a telephone call.
(See Recommendation No. 1). The second question that was scored inconsistently
was the total number of primary health care diagnosis. This was scored incon-
sistently in 1 of 10 cases. To maximize the consistency of scoring in this area,
a detailed list of health care diagnosis falling into categories of reproductive
health care and primary health care were devised in consultation with Medical

Program management. This list was referred to for the duration of the P.O.R.
Review and will be discussed in subsection 3.2.1.

3.2   Results of the P.O.R. Review.

The data was analyzed at two levels: (1) using the total sample and (2) by
breaking down the total sample into two groups, (a) those individuals living in
the geographic catchment areas and (b) those living outside of the geographic
catchment area. The geographic catchment area was defined as the area from Main
Street west to Raglan Road, and from Portage Avenue south to the Assiniboine
River.

3.2.1 Total Sample Results.

The age distribution of the total sample, depicted in Figure 1 is as
follows:

```
                          I
                  1     --+
               0-14    I I 19                          Fig 1
                        --+
                        I
                  2     ----------------+
               15-20   I            125 I
                        ----------------+
                        I
                  3     -----------------------+
               21-25   I                   201 I
                        -----------------------+
                        I
                  4     ------------------+
               26-30   I             139 I
                        ------------------+
                        I
                  5     ---------+
               31-35   I     67 I
                        ---------+
                        I
                  6     --------+
               36-50   I    55 I
                        --------+
                        I
                  7     --+
               51-65   I I 17
                        --+
                        I
                  8     -+
         66 AND OVER   II 7
                        -+
                        I
                        +
         MISSING 99    I 1
                        +
                        I
                     I........I........I........I........I........I........I
                     0        80      160      240      320      400
                                      FREQUENCY

                            NUMBER OF CLIENTS
```

Age In Years
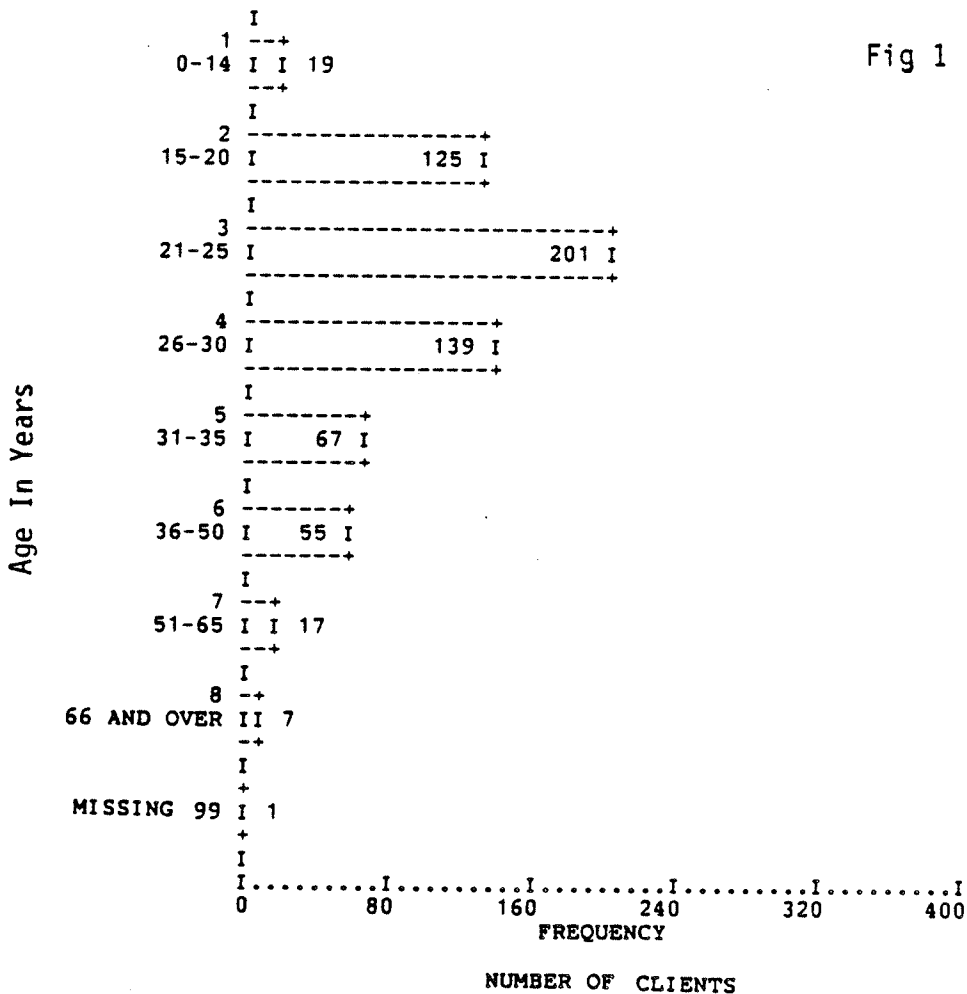
As can be seen from Figure 2, the majority of clients were born between 1947 and 1967 with a mean age of 27 years. The largest group of clients were born in 1962 and are 22 years of age.

CLIENT DATA RETRIEVAL FORM INFORMATION   Fig. 2
FREQUENCIES: AGE

COUNT   MIDPOINT   ONE SYMBOL EQUALS APPROXIMATELY 8.00 OCCURRENCES

```
    0        2
    2        7
    1       12
    7       17   *
    3       22
    5       27   *
    7       32   *
    9       37   *
   11       42   *
   42       47   *****
   82       52   **********
  146       57   ******************
  215       62   ****************************
   79       67   **********
    3       72
    2       77
   14       82   **
    0       87
    0       92
    3       97
    0      102

              I....+....I....+....I....+....I....+....I....+....I
              0        80       160       240       320       400
                        HISTOGRAM FREQUENCY
```
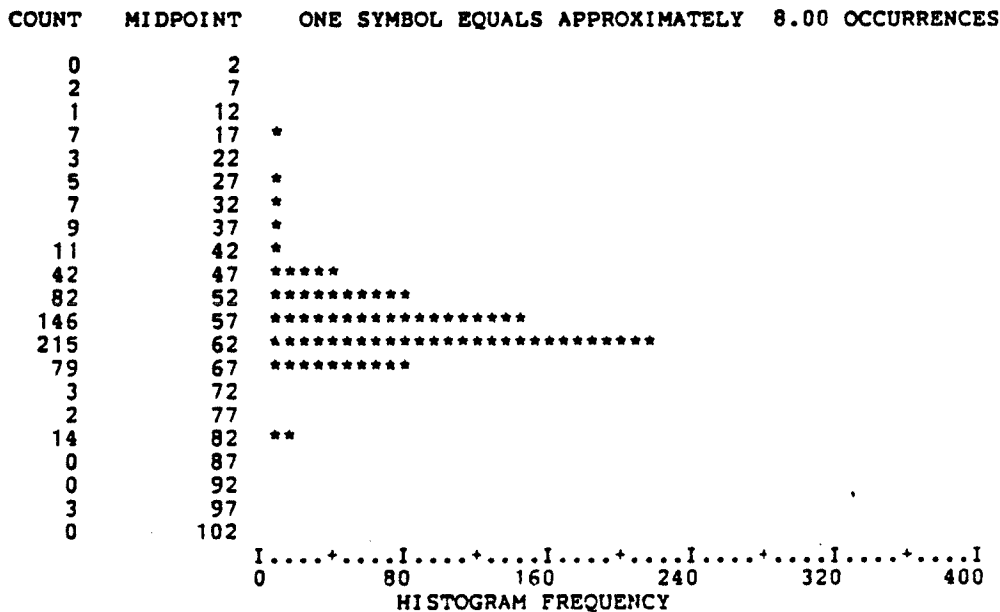
VALID CASES   631   MISSING CASES   0

Count = # of Clients

Midpoint = Median Age

In the total sample, 28.4% of the clients were male and 71.5% were female.

A total of 175 clients or 27.7% live in the catchment area, identified using postal codes where possible and home addresses for those clients living in the R3G postal zone which is only partly in the catchment area. Only 17 postal codes out of the 631 cases were identified as missing. In order to ensure the accuracy of this measure, the addresses and postal codes were taken from the registration information form K:01 or from the most recent lab report form if the information contained on the two forms differed. Figure 3 provides a detailed picture of the geographic distribution by postal code areas of the sample client population. Not included in Figure 3 are the number of clients living outside the Greater Winnipeg Area and out of province. Twenty or 3.4% of the clients sampled live outside of the Greater Winnipeg Area. Five clients or 1% of the total sample population live outside of Manitoba.

FIGURE 3

CLIENT SAMPLE DISTRIBUTION BY POSTAL CODE AREAS
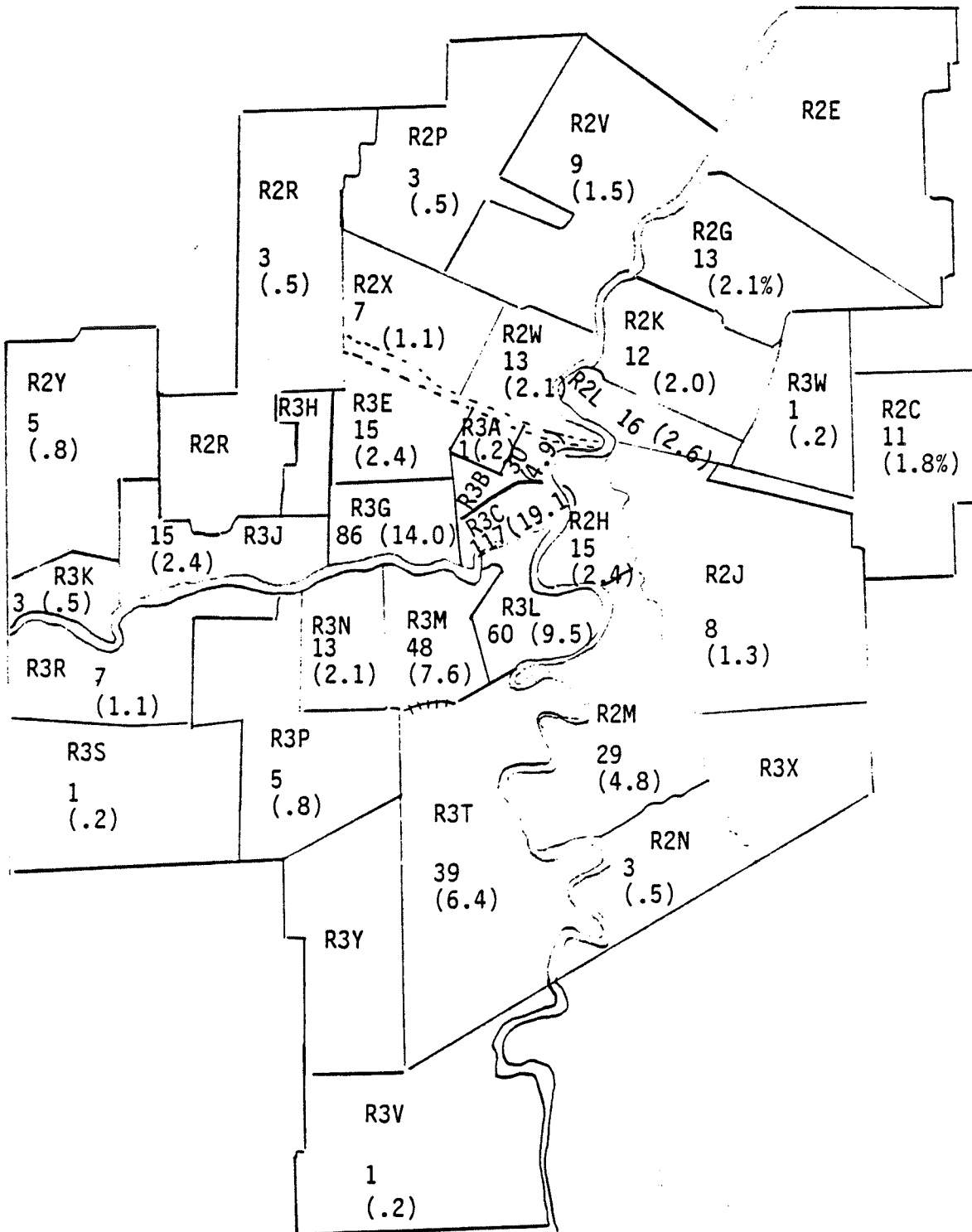
NOTE: In each postal code zone there are two numbers. The first number represents the actual number of clients living in that area. The second number indicates the percentage these clients represent of the total client sample.

It is important at this point to highlight the discrepancies found between the information contained in form K:01 and in the remainder of the P.O.R. The address and postal code variables which usually appeared on form K:01 and in the remainder of the P.O.R. serve as case examples of these discrepancies and raise questions as to the reliability of the data taken solely from form K:01 as a measure of current client status. In a significant number of cases, the addresses and postal codes on form K:01 and on the most recent lab reports differed. In addition, clients may have moved 4 or 5 times since form K:01 was completed. No standardized mechanism for recording changes to the original K:01 data were found in the P.O.R. Review (See Recommendation No. 2).

Labour force attachment, education, current relationship status, dependent children at home, certification and living arrangements, were all taken directly from form K:01 and therefore should not necessarily be viewed as current, depending on when the client filled out the form. The numbers and percentages of clients in each category of each variable are listed in Appendix B. The modal category for the variable of labour force attachment was "employed full time" with 37.8% of the people responding to that question being in that category. It should be noted, however, that 139 clients or 22% of the responses were missing.

The majority of clients or 53.7% had completed grades 9-12. When the missing cases are excluded from the analysis this percentage become 60.3% of the actual responses.

The majority of clients or 58.5% indicated they had never married in contrast to the 16.8% who are married or living as married.

Only 15.5% of the sample population indicated they have children. Missing data accounted for 24.2% of the variation in response.

The modal category for certification was "none" (29.2%). High school certification ranked third with 24.9% of the responses falling in this category. Approximately one quarter or 26.8% of the responses were missing.

The largest group of individuals or 41.8% indicated they were living with immediate family members. Twenty percent of the respondents failed to identify their living arrangements on form K:01.

In response to the questions "How did you hear of Klinic"? and "Why did you come to Klinic"? a small number of people checked more than one answer. A total of 3 possible responses were included in this analysis. The frequency of responses to each category have been summarized below:

(a)   How did you hear of Klinic?

Category	No. of Responses in Category
Friend or Relative Using Klinic Services	289
Klinic Staff member or Volunteer	34
Public Relations Pamphlets, Advertisements	94
Newspaper Articles, Television Interviews	30
Other Agency or Professional	53
Missing	155

(b)   Why did you come to Klinic?

Category	No. of Responses in Category
Referred by Klinic Staff or Volunteer	19
Referred by Another Agency or Professional	49
Recommended by Friend of Relative	203
Looking for "Alternate Health Care"	73
Services Aren't Available Elsewhere	16
Confidentiality of Services	124
Convenient Location	86
Missing	116

Notably, a significant number of clients were made aware of Klinic or were

recommended to Klinic by a friend or relative.

One variable which the study attempted to tap was the source of referral to
the Medical Program in those cases where the client indicated that they had heard
of Klinic through a staff member or volunteer or were referred to Klinic by a
staff member or volunteer. In 99.5% of the cases it was impossible to accurately
determine which of the other Klinic Programs made the initial referral to the
Medical Program. (See Recommendation No. 3). In part this was due to inadequate
use of the blue Problem summary sheet.

The next variable examined was the number of visits made to the Medical
Program from May 1, 1983 to April 30, 1984. This number was acquired by
reviewing the entries made in the P.O.R. for that period. Only office visits in
which clients were seen by Nurse Practititioners, Physicians, or the Medical
Assistant were recorded. Entries coded "LAB" were not included as visits. Where
there was no coding by Medical Program staff identifying the nature of the entry,
a content analysis was made to ascertain whether or not the client was present.
If it could be determined that the client was present, the entry was coded as an
office visit. The number of visits in a one year period ranged from 1 to 41.
Over half of the clients sampled, however, visited the Medical Program 3 times or
less in the one year period. A complete breakdown of the frequencies for this
variable appears in Appendix B. A summarized version appears in Figure 4. The
males were slightly over-represented in the 1 and 2 visit categories and under-
represented in the 3-4 and 5-8 visit categories, suggesting that men are more
likely to use the Medical Program on a 1 and 2 visit basis than are women.

The variable "most recent principle diagnosis" was divided into 3 cate-
gories: (1) reproductive health care diagnosis/services (2) primary health care
diagnosis/services and (3) both reproductive and primary health care
diagnosis/services. The diagnosis/services and codes used in the daily log formed
the basis for the preliminary category breakdown. Those diagnostic and service
codes beginning with a "V" were reviewed with Program management for inclusion in
the reproductive health care category. This included such diagnosis and services
as sexually transmitted disease assessment and treatment, birth control coun-

Fig. 4

CLIENT DATA RETRIEVAL FORM INFORMATION
FREQUENCIES: NUMBER OF VISITS

VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
	0	1	.2	.2	.2
1 VISIT	1	119	18.9	18.9	19.0
2 VISITS	2	118	18.7	18.7	37.7
3-4 VISITS	3	157	24.9	24.9	62.6
5-8 VISITS	4	146	23.1	23.1	85.7
GE 9 VISITS	5	90	14.3	14.3	100.0
	TOTAL	631	100.0	100.0	

```
            I
            +
        0 I 1
            +
            I
        1 --------------------------------+
1 VISIT I                        119 I
            --------------------------------+
            I
        2 --------------------------------+
2 VISITS I                       118 I
            --------------------------------+
            I
        3 ------------------------------------+
3-4 VISITS I                            157 I
            ------------------------------------+
            I
        4 ----------------------------------+
5-8 VISITS I                          146 I
            ----------------------------------+
            I
        5 ----------------------+
GE 9 VISITS I               90 I
            ----------------------+
            I
            I.........I.........I.........I.........I.........I
            0        40        80       120       160       200
                             FREQUENCY
```
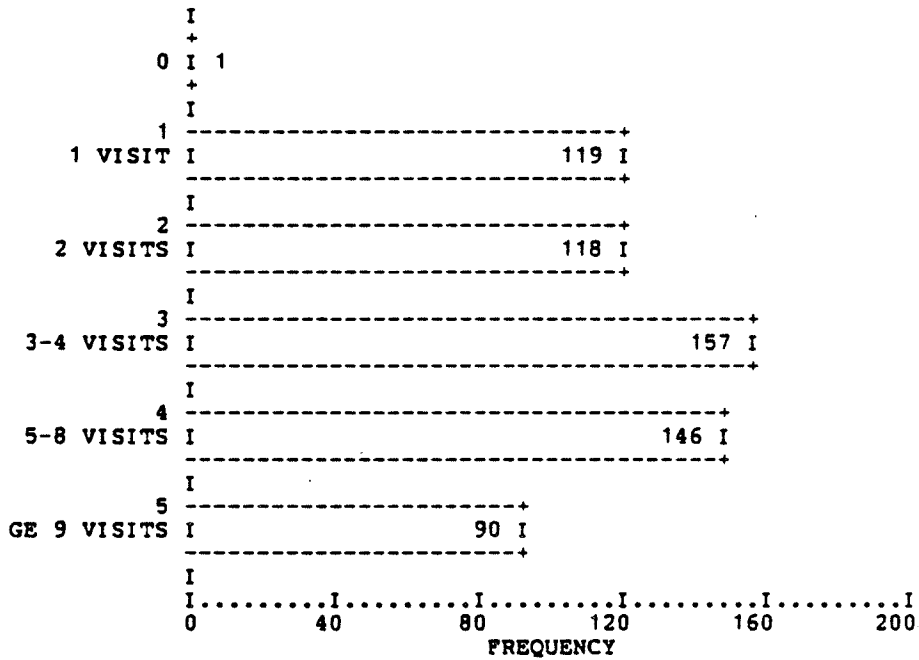
VALID CASES   631   MISSING CASES   0

selling and complete physical examinations for the purpose of determining birth control suitability. For a more complete list of reproductive health care diagnosis see Appendix C. Services and diagnosis of a general health care nature were included in the primary health care category.

For those cases where more than one diagnosis or service was provided in a single visit, the log was used to assist the evaluator in selecting the principle diagnosis/service from among those identified in the P.O.R. Where a reproductive and primary health care diagnosis and/or service were noted in the P.O.R. and on the daily log, category 3 was employed indicating both types of diagnosis and services were the main types provided to the client.

For the total sample population, 56.3% of the most recent principle diagnosis were reproductive health care related, 40% were primary health care related and 3.3% were considered to be both reproductive and primary health care related. Missing data accounted for .4% of the variation.

When secondary diagnosis and services are included in the analysis this breakdown remains relatively similar with reproductive health care services being rendered in 55.4% of the cases and primary health care services accounting for 44.5% of the total diagnosis and services provided. Using the most recent visit as an index, approximately 27% of the clients received more than one diagnosis or service.

The variables of "total reproductive health care diagnosis and services" and "total primary health care diagnosis and services" were recoded into thirds for ease of interpretation. These variables summarized all the diagnosis and services received by clients from May 1, 1983 - April 30, 1984, and included both principle and secondary diagnosis. Due to the difficulty found in assessing whether or not one particular diagnosis was new or recurrent, each diagnosis was counted as a new diagnosis each visit. This was justified on the basis that the service rendered in relation to the diagnosis was a discrete service. The exception to this rule was prenatal clients. They were identified as having one reproductive health care diagnosis during their entire prenatal period. The postnatal visit was coded as

a separate reproductive health care service. Figures 5 and 6 illustrate the
breakdown of the total number of services in the reproductive and primary health
care categories. Each bar represents 33.3% of the cumulative frequencies in each
category.

Fig. 5

CLIENT DATA RETRIEVAL FORM INFORMATION
FREQUENCIES: TOTAL REPRODUCTIVE HEALTH CARE

VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
NO RHC	1	149	23.6	23.6	23.6
1-3 RHC SVCES	2	276	43.7	43.7	67.4
4-14 RHC SVCES	3	206	32.6	32.6	100.0
	TOTAL	631	100.0	100.0	

```
                         I
               1 -------------------+
          NO RHC I            149 I
                 -------------------+
                         I
               2 -----------------------------------+
     1-3 RHC SVCES I                            276 I
                 -----------------------------------+
                         I
               3 ------------------------------+
   4-14 RHC SVCES I                  206 I
                 ------------------------------+
                         I
                 I.........I.........I.........I.........I.........I
                 0        80       160       240       320       400
                                   FREQUENCY
```

VALID CASES   631   MISSING CASES   0

- 19 -
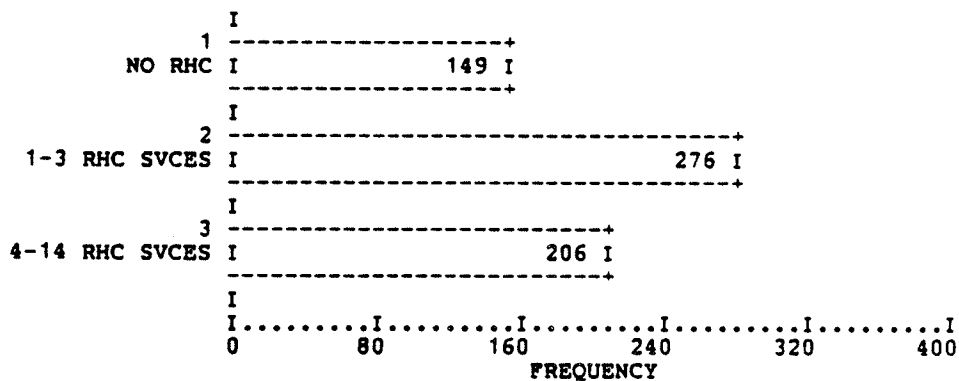
FIG.6

CLIENT DATA RETRIEVAL FORM INFORMATION
TOTAL PRIMARY HEALTH CARE DIAGNOSES

.

VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
NO PHC	1	213	33.8	33.8	33.8
1-2 PHC SVCES	2	210	33.3	33.3	67.0
3-41 PHC	3	207	32.8	32.8	99.8
	9	1	.2	.2	100.0
		-------	-------	-------	
	TOTAL	631	100.0	100.0	

```
          I
     1    -----------------------------+
 NO PHC  I                          213 I
          -----------------------------+
          I
     2    -----------------------------+
1-2 PHC SVCES I                     210 I
          -----------------------------+
          I
     3    -----------------------------+
3-41 PHC I                          207 I
          -----------------------------+
          I
          +
    48   I 1
          +
          I
          I.........I.........I.........I.........I.........I
          0        80       160       240       320       400
                              FREQUENCY
```
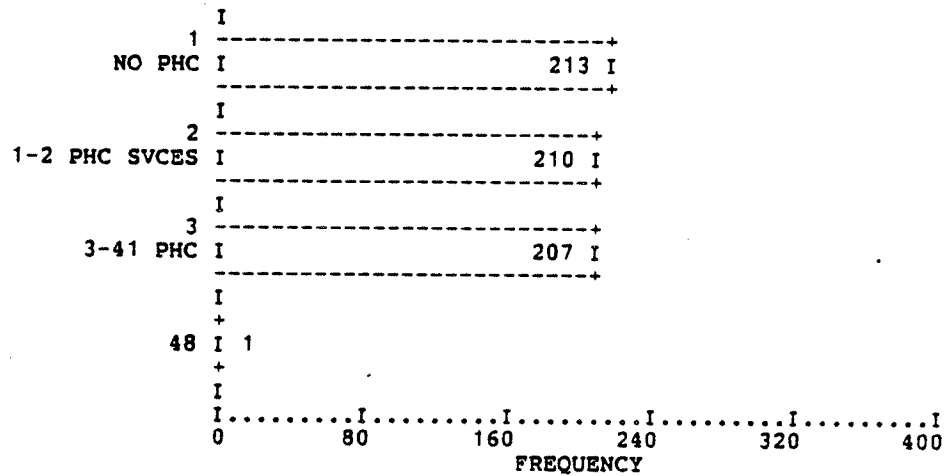
VALID CASES   630   MISSING CASES   1

The next 6 variables addressed separate speciality areas of service provision; specifically, fertility control services, contraceptive advice, sexually transmitted disease assessment/treatment, depression assessment/treatment, prenatal care and eating disorder assessment/treatment/monitoring. "Fertility control" included the provision of contraceptives and/or the assessment of client suitability for the various contraceptive methods. A full 33.2% of the clients sampled received fertility control services. "Contraceptive advice" was recorded only for those who received counselling on birth control measures and did not receive an examination, a prescription for oral contraceptives or a birth control device in the same visit. This variable was selected as a measure of preventive health care practices and was a service provided to 7.8% of the client sample. Sexually transmitted disease (STD) assessment and/or treatment was provided to 68.6% of the total sample. This figure includes those clients who were routinely tested for STD as part of their complete physical examination. Only 4.1% of the clients sampled were treated for depression, the only mental health measure highlighted in the study. Thirty-four or 5.4% of the sample received prenatal services from May 1, 1983 to April 30, 1984. Eight clients in the sample were treated or monitored for eating disorders. This included bulemia and anorexia nervosa.

The final section of the Problem Oriented Record Review addressed the area of referrals from the Medical Program to external services and to other Programs in Klinic. The most frequent measured reason for referral was for lab tests, x-rays and ultrasound with 534 or 84.8% of the clients sampled being referred out for these services. Of those people referred out for lab tests, 80.1% also received STD assessment and treatment, suggesting that a significant majority of the lab tests were STD related.

The next most frequently made referrals were for specialized medical services. 21.7% of the clients samples were referred to other physicians for consultation or specialized medical services. Only 1.3% of the clients samples were referred to social services for assessment or follow-up. This figure may underestimate the number of referrals made to social services, however, due to the fact that not all such referrals are entered into the P.O.R. according to Program Staff. (See Recommendation No. 14). Only one client was referred to Women's Health Clinic in the one year period in this study. Again, this figure may not

reflect the actual number referred. Some referrals may in fact take place over the phone or prior to a P.O.R. being opened on a client, both of which would be missed in a review of this nature (See Recommendation No. 4).

Referrals to Programs in Klinic were made for 24 or 3.8% of the Medical Program clients. Of those clients referred to other Klinic Programs, only 1 client or .2% was referred to Community Services during the one year period. Twenty-three clients or 3.6% were referred to the Counselling Program during that time. An additional 12 clients or 1.9% were known to Community Services and additional 14 or 2.2% were known to the Counselling Program in the period under review. In these 26 medical records it was difficult to ascertain when the client was referred and with which program the initial contact was made. (See Recommendation No. 5). These cases were included in the analysis only to document the extent of overlap between Programs.

3.2.2 Subsample Results - Geographic Catchment Area Data.

Separate frequencies were run for those individuals residing in the catchment area. As was noted previously, 175 clients or 27.7% of the total sample live in the catchment area. Only in those instances where the catchment area data differed from the total sample by greater than or equal to 2% have the results been included in this report. A summary of the differences found between the catchment area subsample and the total client sample are included in Appendix D.

Clients were also divided into two groups: (a) those residing in the geographic catchment area; and, (b) those residing outside of this area. Crosstabulations were then computed for all the variables to examine the frequencies of their joint occurrence in each of these two groups. Chi square tests were performed to examine the significance of the relationship between place of residence (catchment area/outside catchment area) and the other variables examined in the Program Review.

Using the chi square test of independence in which no expected frequency was less than 5 and the level of significance was less than or equal to .05, the following variables were found to be related to place of residence:

Variable	Level of Significance	
Education	.002 with 2 degrees of freedom (df)	
Relationship Status	.05	df=2
Living Arrangements	.0000	df=4
How client heard of Klinic	.03	df=1
Why client came to Klinic	.0000	df=5
Total number of visits	.01	df=4
Most Recent Principle Diagnosis	.0002	df=2
Total number of Reproductive Health Care Diagnosis/Services	.0003	df=2
Total number of Primary Health Care Diagnosis/Services	.0004	df=3
Veneral Disease Assessment and/or Treatment	.004	df=1
Client Sex	.002	df=1

Catchment area clients were more likely than clients living outside of the areas to be less educated, to have been married, to be living common law or be separated, divorced or widowed. They were less likely to be living with immediate family. Catchment area clients were more likely to have heard of Klinic through a friend or relative and to have come to Klinic on the basis of that referral or because of Klinic's location. Catchment area clients were over-represented in the "greater than 9 visit" category and under-represented in the "1 and 2 visit" categories. They were more likely than clients living outside of the catchment area to receive primary health care services from the Medical Program. Catchment area clients were less likely to have received veneral disease assessment and/or treatment. They were also more likely to be male.

SECTION 4

CLIENT SURVEY

4.1   Introduction.

A total of 106 clients of the Medical Program completed the Client Survey,
which was distributed to every individual aged 12 years and over who visited the
Medical Program in a one week period. Clients anonymity was assured in the
introduction to the survey and clients were given the option of receiving the
survey results, thus supporting the position of Klinic vis a vis its client
body.

For a two day period, prior to the distribution of the final client sur-
vey, an open ended questionarire was given to clients to pre-test their respon-
ses to certain items. The final survey was significantly modified based on
client responses to the pre-test. The pre-test and the final client survey are
provided in Appendix A.

Twenty-two of the total number of clients aged 12 years and over who
visited the Medical Program in the one week period did not complete the Client
Survey. Of this number 6 clients refused to complete the survey, 5 had already
filled out the survey earlier in the one week period, 10 were missed or returned
their survey form prior to its completion due to the client being called in to
see a practitioner, and 1 was a sexual assault client who was not asked to
complete the survey due to her emotional state.

4.2   Results of the Survey

The age of the survey respondents varied from 12 years to 66 years, with
the largest number of clients in the 21 years of age category. The mean or
average age was 25.562 years with a standard deviation of 8.204. Figure 7 shows
the age distribution of the survey respondents. As figure 7 illustrates, the

ages of the respondents are concentrated in the 17 to 31 years categories, a
tighter concentration than that found in the P.O.R. Review.

MEDICAL PROGRAM CLIENT SURVEY   Fig. 7
FREQUENCIES: CLIENT AGE

VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
0-14	1	1	.9	.9	.9
15-20	2	24	22.6	22.6	23.6
21-25	3	36	34.0	34.0	57.5
26-30	4	27	25.5	25.5	83.0
31-35	5	9	8.5	8.5	91.5
36-50	6	5	4.7	4.7	96.2
51-65	7	2	1.9	1.9	98.1
66 AND OVER	8	1	.9	.9	99.1
MISSING DATA	9	1	.9	.9	100.0
	TOTAL	106	100.0	100.0	

```
                 I
            1 -+
      0-14 II 1
            -+
                 I
            2 -----------------------------+
     15-20 I                          24 I
            -----------------------------+
                 I
            3 --------------------------------------+
     21-25 I                                    36 I
            --------------------------------------+
                 I
            4 --------------------------------+
     26-30 I                              27 I
            --------------------------------+
                 I
            5 -----------+
     31-35 I          9 I
            -----------+
                 I
            6 ------+
     36-50 I     5 I
            ------+
                 I
            7 ---+
     51-65 I  I 2
            ---+
                 I
            8 -+
 66 AND OVER II 1
            -+
                 I
            9 -+
MISSING DATA II 1
            -+
                 I
            I.........I.........I.........I.........I.........I
            0        8        16       24       32       40
                              FREQUENCY
```
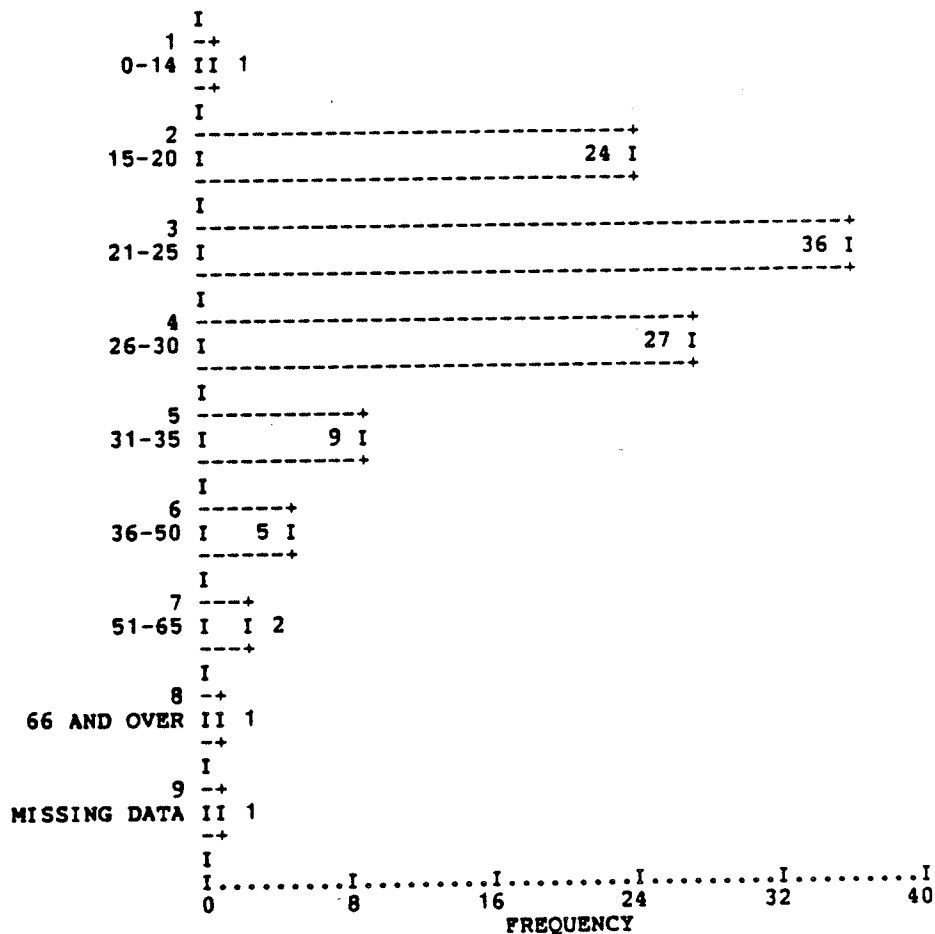
The second variable, measuring the distance in blocks or miles clients lived from Klinic, indicates that 29 of the 106 clients live 1/2 a mile or less from Klinic, 22 clients live 1-2 miles from Klinic, 13 live 3-4 miles from Klinic, 18 clients live 5-6 miles from Klinic, 8 live 7-15 miles from Klinic and 8 live more than 15 miles from Klinic.

Eighty-four or 79.2% of the respondents were female. Twenty-two or 20.8% were male. Given that the clients who refused to complete the survey were predominantly male (4 out of 6), these figures closely resemble those summarized in the proceeding section.

The largest group of clients, or 30.2%, were visiting the Medical Program for the first time in the past year. Although the survey did not tap this directly, many of these clients appeared to be new clients of the Program, based on their responses to other items on the questionnaire.

An additional third of the clients visited the Medical Program 1-3 times in the last year. The remaining third visited the Program from 4-24 times in that period. The average number of visits in the last year was 3.39. Figure 8 graphically depicts the distribution of the number of visits in the last year.

(SEE FIGURE 8)

FIG.8

MEDICAL PROGRAM CLIENT SURVEY
FREQUENCIES: NUMBER OF VISITS

NO. OF VISITS IN LAST YEAR

VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
	0	32	30.2	32.0	32.0
	1	14	13.2	14.0	46.0
	2	11	10.4	11.0	57.0
	3	9	8.5	9.0	66.0
	4	12	11.3	12.0	78.0
	5	4	3.8	4.0	82.0
	6	4	3.8	4.0	86.0
	7	2	1.9	2.0	88.0
	9	1	.9	1.0	89.0
	10	3	2.8	3.0	92.0
	12	3	2.8	3.0	95.0
	15	1	.9	1.0	96.0
	16	1	.9	1.0	97.0
	20	2	1.9	2.0	99.0
	24	1	.9	1.0	100.0
	99	6	5.7	MISSING	
	TOTAL	106	100.0	100.0	

```
COUNT  MIDPOINT   ONE SYMBOL EQUALS APPROXIMATELY   .80 OCCURRENCES

  0      -3.0
  0      -1.5
 32       .0    *********************************************
 25      1.5    *********************************
  9      3.0    **********
 16      4.5    *******************
  4      6.0    *****
  2      7.5    ***
  1      9.0    *
  3     10.5    ****
  3     12.0    ****
  0     13.5
  1     15.0    *
  1     16.5    *
  0     18.0
  2     19.5    ***
  0     21.0
  0     22.5
  1     24.0    *
  0     25.5
  0     27.0
              I....+....I....+....I....+....I....+....I....+....I
              0        8        16       24       32       40
                       HISTOGRAM FREQUENCY

VALID CASES    100     MISSING CASES     6
```
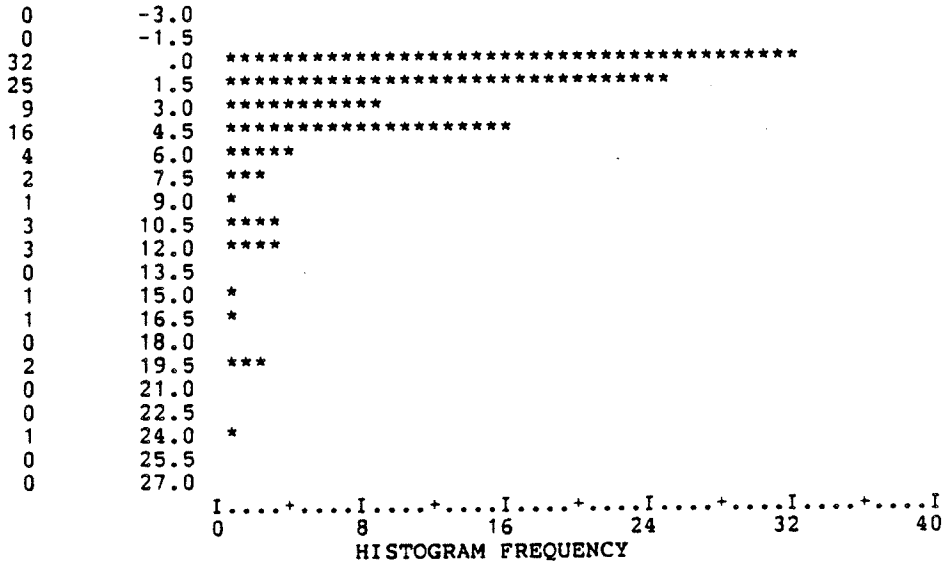
Over one third of the respondents (35.8%) are currently seeing another doctor or health practitioner outside of Klinic. (See Recommendation No. 6).

In response to the open-ended question regarding the type of service clients have received from the Medical Program clients named a range of services including routine check ups, veneral disease treatment, pediatric services, blood work, pregnancy counselling, gynaecological services. The most frequently mentioned medical service was the complete physical examinations or "physical", noted in 31.1% of the cases.

Most clients did not respond when asked to name some of the other services they thought were provided by the Medical Program. Several mentioned services provided by other Programs in Klinic like counselling and 24 hours crises services (See Recommendation No. 7).

When asked to identify how they felt when they first came to Klinic, the majority of clients, felt comfortable. A complete breakdown of responses to this item is as follows:

	No. of Client Responses
comfortable	56
embarrassed	11
relaxed	16
scared	21
other	11
Total	115

As the total indicates, some clients checked two responses to this item. Those responses included in the "other" category were 4 responses of "nervous", 2 of "uneasy", 2 or "uncomfortable", 1 or "ambivalent", 1 of "ill", and 1 of "thankfull for free services".

The majority of clients (54.2%) indicated that the last time they visited the Medical Program they had seen a Doctor Twenty-one or 25.3% indicated they had seen a Nurse Practitioner. One fifth (20.5%) were unsure of whom they had seen. 57.5% asked to see the same person for this visit and an overwhelming 81.3% said they prefer to see the same person each time they come to the Medical Program.

Sixty-six or 62.3% of the respondents usually make an appointment with the Medical Program. Twenty-eight or 26.4% usually drop in. Of those clients who do drop in, 88.2% would make an appointment if they knew they could. (See Recommendation No. 8).

The time spent waiting to see a Practitioner varies from 0-90 minutes. The most frequently mentioned time spent waiting was 15 minutes with 19.4% of the clients stating they waited this length of time. The mean time spent waiting was 21.3 minutes with a standard deviation of 18.727. A sizeable majority (57.5%) felt that the time spent waiting was acceptable. Fourteen clients (13.2%) felt the wait was too long. Fifteen clients (14.2%) were unable to respond, since this was their first visit to the Medical Program. Sixteen (15.1%) did not answer the question.

The next 8 items addressed client perceptions of the Medical Program and its staff, dealing with some of the areas that staff identified as sources of confusion for clients. Missing data accounted for an average of 33% of the responses and was excluded from the figures reported herein.

It should be apparent that in the following figures, the same person may identify the Medical Program in terms of several of its components. It is also apparent that some clients are unsure of the services offered by the program and unaware of the qualifications of its staff.

Approximately half of the clients who responded (47.9%) indicated they felt the Medical Program was "mostly for local community residents". This figure is interesting given that less than one third of the clients sampled live in the catchment area.

Approximately half of the Client Survey respondents (47.8%) felt the Medical Program was a V.D. clinic.

A majority, or 78.9% of clients, felt that the Medical Program teaches clients how to take care of themselves.

28.3% of clients who responded, indicated that they see the Medical Program as a clinic that uses mainly student doctors. This item, however, had the largest amount of missing data. When the figure is adjusted to account for missing data the 28.3% of respondents is reduced to 16% of the total client sample.

Most of the clients (96.5%) see the Medical Program as a place that takes an interest in clients as a whole person.

Approximately 3/4 of the respondents (77.6%) see the Medical Program as a Birth Control Clinic.

An overwhelming majority (95.8%) feel the staff are well trained. Most of the clients surveyed (80.6%) feel the Medical Program is a family practice clinic.

Most of the clients sampled have used another medical service (77.4%). This figure takes into account the missing data. The most commonly used service is the Private Physician, with almost half (46.2%) of the clients indicating that they have used this type of medical service. The next most frequently used service was the emergency department, with another clinic being the third most frequently used service mentioned. A total of 13.2% and 11.3% mentioned each of these two respective services.

Those clients who had used another service, when asked to compare that service to the Medical Program, generally ranked the Medical Program very favourably on the variables "personal", "caring" and "available". On the

variable "capable", however, 59.1% of those clients who answered the question, indicated it was as capable as the other services they had used, 12.1% indicated it was less capable and 28.8% found it more capable (See Recommendation No. 9). Regarding the confidentiality of the Medical Program, 39.7% of the clients who responded felt the Medical Program was as confidential as other services, 2.9% felt it was less confidential and 57.4% felt it was more confidential.

Of those clients who responded to question 20 "Does Klinic's Medical Program meet your health needs?" 96.4% indicated that it does. Only 3 clients indicated it did not. Twenty-two clients failed to answer this question.

All of the clients who answered questions 21 and 22 indicated that they would send a friend to the Medical Program and that they would use the Medical Program again. Twenty-one clients (19.8%) and eighteen (17.0%) clients did not respond to these respective items.

The final two survey items, asking clients to identify additional health illness problems or health education programs they thought the Medical Program should consider, received few responses. Eight clients responded to both survey items. Six clients responded to item 23 which asked clients to identify other health or illness problems that the Medical Program should look at. Five clients responded with program suggestions or comments about the services offered by Klinic's Medical Program. These comments are summarized in Table 1. The most frequently mentioned topics were birth control and nutrition and the need for programs in those areas.

Despite the low response rate to these questions, a direct assessment of the need to examine the problem areas or develop any of the program areas noted in Table 1 may be useful. It is possible that the open-ended nature of the questions as well as their placement at tne end of the survey contributed to the limited number of responses they received (See Recommendation No. 10).

TABLE 1

CLIENT SURVEY RESPONSES TO QUESTIONS 23 AND 24

Question 23: "What other health or illness problems do you think the Medical
Program should look?

- problems with the elderly, geriatrics
- day care for children
- needs indentified by client body
- childrens' needs
- physical and emotional problems associated with puberty
- nutritional problems - client based & community based
- chiropractic related conerns
- cold
- holistic health
- existing problems should be dealt with more extensively
  by developing in-house lab services
- prenatal classes
- dental problems
- local health needs

Question 24: "Are there any health education programs you feel should be offered
by the Medical Program?

- counselling and self help programs for the elderly
- nutrition and keeping fit programs
- services for practicing homosexuals
- holistic (herbal etc.) preventive advice
- prenatal classes
- birth control classes
- education programs related to puberty
- general preventive information on nutrition cancer detection
- teenage birth control
- drug abuse
- involvement in high school programs related to sexual abuse,
  child abuse, family life education.

SECTION 5

OBSERVATION OF PROGRAM ACTIVITIES

5.1   Introduction

        The purpose of the observation exercise was to document the flow of clients
through the Medical Program. The exercise was carried out for one week
concurrently with the Client Survey, placing the evaluator in a quasi participant
observer position. The method used in the observation exercise was to observe
clients from the front desk area and simply record the process as it occurred.
The limitations of this method are: (a) the absence of a detailed observation
schedule reduces the reliability of the conclusions; and (b) the physical location
of the observer situated behind the front desk, limits the conclusions that can be
drawn from this exercise. Despite these constraints several recommendations were
generated from the observation process, making the data important to the Program
Review as a whole.

5.2   Results of the Observation Exercise

        Clients first contact with the Medical Program was through the front desk
staff. This staff person(s) was not always able to attend to the clients
immediately due to her multiple functions as receptionist, file clerk, appointment
scheduler, referral agent and typist. Depending on the number of incoming
telephone calls, clients waited at the front desk from 0-4 minutes. (See
Recommendation No. 11).

        Clients were usually sent to the waiting room after they had made their
presence known at the front desk. Client perceptions of time spent in the waiting
room was reviewed in Section 3. The maximum time that clients were observed to
spend in the waiting room during the one week period was 60 minutes. This lengthy
waiting time occurred during a busy "walk in" period and does not reflect the

average waiting time for the Medical Program which was approximately 15-20 minutes. This estimate was consistent with the average time reported by clients in the Client Survey. The time spent waiting was occupied by reading the magazines, etc. available in the waiting room, by filling out the Client Survey form or by just sitting in a chair (See Recommendation No. 12)

Clients were then usually seen by a Doctor or a Nurse Practitioner who, after reviewing their P.O.R., called the client into the examining room. On occasion the client was sent directly from the reception desk to the washroom for a urine sample but this was the exception and not the rule. The "circus system", recommended by Dr. Rose, was not observed to be in place during the observation period. Given the number of Doctors and Nurse Practitioners working on an average day and the limited number of examining rooms, this system does not appear workable at this time.

When the practitioners had finished seeing clients, clients either left Klinic directly or returned to the front desk to make a follow-up appointment. Those clients making follow-up appointments were generally aware of the reason for the follow-up which assisted the front desk staff in scheduling these appointments appropriately. Every effort was made by front desk staff to attend to these clients immediately although once again staff were constrained by their multiple roles. Clients were routinely asked to state their preferences for a particular practitioner. Appointments were generally scheduled at times that were convenient to clients. The one difficulty occurred when front desk staff attempted to schedule lengthy appointments (e.g. for a complete physical examination) for clients with part time practitioners. Some of the clients who were faced with this situation agreed to see whomever was available. Other clients chose to wait for their preferred practitioner. On several occasions this wait was beyond the length of time suggested by the Physician or Nurse Practitioner.

5.3   Additional Comments

Several additional observations which were made in conjunction with the P.O.R. Review and the Observation exercise have been included below in point form.

1.   The Medical Assistants' activities appeared to extend beyond those duties included in their job description. Some of the counselling and referral functions should be noted in the P.O.R. to document the full range or services provided to clients of the Medcial Program (Recommendation No. 13 and 14).

2.   Pregnancy tests are not always permanently recorded and Manitoba Health Services Commission billing forms are often not completed for individuals coming to Klinic solely for that purpose. This creates at least two potential problems: (a) any additional revenue that may be generated by billing for these tests is lost to Klinic; and (b) there is no way of tracking or contacting individuals who come to Klinic for frequent testing and may benefit by contraceptive advice or other preventive services (See Recommendation No. 15 and 16).

3.   One of the tasks which consumes front desk staff time is locating files which are missing from the file cabinets. There are at least eight separate places where P.O.R.'s may be found at any one time. Files are also kept in individual offices overnight which generates problems for the Medical Program Staff during the day and the Crisis Line staff during the evenings. Many of the files which were found to be missing were not signed out to staff people (See Recommendation No. 17).

SECTION 6

PROGRAM OBJECTIVES

6.1   Introduction.

The task of specifying program objectives enables a Program to clearly identify its desired outcome(s) and establish criterion of its effectiveness or success. The objective setting exercise addressed individual and group perceptions of Program objectives, providing individual staff members with the opportunity to express their views and allowing staff as a group to begin to deal with the issues of Program objectives and direction.

Individual staff members were requested to complete a brief form which asked them to list the current objectives of the Medical Program, identify how these objectives could be measured, indicate what direction they thought the Program should be taking and identify some specific goals for the Program. (See Appendix A).

Nine staff members completed the form, many of them in considerable detail. These individual responses were then summarized and presented for discussion in a Medical Program meeting. On the basis of this discussion a preliminary Statement of Objectives was drafted. This preliminary draft was presented in a subsequent Medical Program meeting for discussion and modification. The final draft of Medical Program Objectives appears in Table 2.

6.2   Results.

The individual staff members responses to the request that they list the current Program objectives fell into one of three groups. The largest group contained those individuals who stated that the main objective of the Medical Program was to provide first contact or primary health care services to clients of the Medical Program, thereby retaining the Programs's "community of need" focus.

TABLE 2

FINAL DRAFT: MEDICAL PROGRAM OBJECTIVES

1.   To provide first contact or primary medical care to clients of the Medical
      Program. This includes: assessing the health needs of clients, providing
      diagnostic and treatment services to clients and coordinating services with
      referral sources. Medical care will be provided first to clients who
      have been seen before in the Medical Program and second to new or
      prospective clients.

2.   To provide services that are accessible, especially to single mothers, low
      income individuals and families, the elderly, youth, women and the gay
      population. Program components that relate to accessibility are: walk in
      times, evening hours and the communication skills of the Staff.

3.   To increase clients understanding of health and illness. The assumption
      underlining this objective is that increased understanding of health and
      illness will enable early detection and/or prevention of illness thereby
      promoting health.

4.   To offer a range of alternative health services which differ from those
      offered within a traditional practice model.

5.   To expand maternal/child care services, increasing the number of clients
      seen in this area and developing the support services needed to
      accommodate this increase.

6.   To support the practice preferences of the staff currently employed by
      the Medical Program thereby reducing staff turnover.

7.   To increase the participation of the Medical Program at the Board and
      and Management level.

8.   To continue to accept referrals from Community Services providing home
      visits to their clients when necessary.

The second largest group was composed of those individuals who identified the main objective of the Medical Program as providing comprehensive primary health care services to the catchment area.

The minority position, held by only one individual, was that the objective of the Medical Program was to provide focused health care services in the area of reproductive health care. Although this view is significant in that it reflects a different service thrust, given that it is the position of only one individual it will not be considered in this discussion.

The obvious difference in the objectives identified by the two largest groups of Staff members is their intended targets of medical service. While this difference is important and will be discussed in more detail later in this section it is also essential to highlight the similarities, reflected in the elements of health care associated with the objectives noted by members of each group. These similarities have been summarized under the following headings which related directly to recommendation in Section 2:

(1) Curative: all staff members mentioned a diagnostic/treatment aspect of health care.

(2) Preventive: preventive health care was mentioned directly or indirectly by all staff members. This included health education programs, self-help techniques and life-skills programs and supports.

(3) Accessibility: in addition to providing primary health care, all staff members felt the Medical Program had to be available, as operationalized by walk-in times and sensitivity to special needs groups.

(4) Health Provider Attitudes: this element relates to the framework or manner in which services are provided and reflects the values of the staff. Included under this heading is recognition of the physical,

social, emotional and cultural components of the individual and a belief in the patient's right to participate in their health care.

(5) Referral: this element was noted by several staff members who stressed collaboration and consultation between a variety of health professionals.

The element mentioned only by members of the group which had a catchment area focus was "Outreach" which included home visits to the elderly and community medical services to special needs groups is the catchment area.

The difference in the intended targets of service by the two groups continued during the discussion in the Medical Program meeting. As Table 2 indicates, however, attempts were made to reconcile this difference. The opinion expressed by members of both groups can be placed on a continuum, with those who would like to be primarily involved in the catchment area at one extreme and those who would like to retain their city wide client base at the other. Many staff members appear comfortable with a middle position. As was indentified in Recommendation No. 18, clearly identifying a target for service should be a management priority.

The question addressing the ways of measuring the objectives was responded to on an item by item basis related to the individual objectives identified by staff members. Each objective identified in Table 2 should be linked to a program component and a means of measurement to determine the effectiveness of the Program as a whole. Although the scope of this review does not extend into the area of measuring Program effectiveness, an example of the type of analysis needed to prepare for such an evaluation is included in Table 3 using objectives 1-4 from Table 2. (Table 3 appears at the end of this section).

Proposals for Program direction were also split into those favouring an expansion into the geographic catchment area and those favouring a more varied service approach to current clients. The former group mentioned expanding home services to geriatrics and adopting a closer working relationship (team approach) with community services to deal with local health needs. In the latter group, the

majority mentioned an extension of the family practice model including obstetric and pediatric services, with an emphasis on low income and native families. A need to move in the direction of offering additional support services to existing and prospective clients was mentioned by people favouring the catchment area focus and the community of need focus (See Recommendation No. 19).

Specific short term goals have been summarized under the following heading:

(1) extensions of services currently being offered

(2) additions to services currently being offered

(3) supports to points (1) and (2)

(1) Extensions of services currently being offered

- upgrade pediatric services

- increase the number of prenatals seen per year

- develop the post-natal follow-up services

(2) Additions to services currently being offered

- prenatal and parenting classes and/or support groups

- health education programs for specific patient groups eg smoking sensation, relaxation, nutrition, teen sexuality, birth control

- develop a follow-up program for pediatric services and train staff

- develop a counselling component of the Medical Program

(3) <u>Supports to points (1) and (2)</u>

- more efficient use of patient appointment time

- reasonable # of visits per week per practitioner
  to ensure accessibility

- being open more nights per week to ensure accessibility

- increased input from allied professionals directly with
  the Medical Program

- integration with community services (maximize team approach
  to health care)

- new building with lab and X-ray facilities

- more support between Programs

- more time allocated for research and program development

TABLE 3

Preliminary Work-up : Measuring Program Effectiveness

OBJECTIVE	PROGRAM COMPONENT	MEASUREMENT
1. Providing primary medical care	- actual service provided e.g. CPE detailed in terms of the steps involved	- file audit of a quality assurance nature - per review
Providing medical care first to clients	- ? how is this ensured - ? what formal or informal system supports this objective	
2. To provide accessible services	- walk in times - evening hours	- client satisfaction - client survey re: client preferences ratio of
	- fitting clients into appointment schedule	- number of clients squeezed in compared to number turned away

NOTE: Accessibility includes (A) clients knowledge of services; (B) clients understanding of how to use services; (C) availability of services; and (D) resources to meet demands of (A) and (B)

3. To increase clients   - breast self examination   - before and after
   understanding of   study (given to
   health and illness   clients before
                                                      and after
                                                      teaching).
   - time series study
     to see if Medical
     Program clients
     are more aware of
     preventive health
     care

4. To offer a range of   - comparison of
   alternative health   Medical Program
   services   services to
                                                    services offered
                                                    at randomly
                                                    selected clinics

APPENDIX A

DATA COLLECTION FORMS USED

IN PROGRAM REVIEW

CLIENT DATA RETRIEVAL FORM

	Coding Instructions	Code

ME: _____
  SURNAME   GIVEN NAME

IENT NUMBER: _____

UDY NUMBER ASSIGNED TO CLIENT | Coding Instructions (3 cols.) | Code
  $\overline{1}$ $\overline{2}$ $\overline{3}$

TE OF BIRTH | year (2 cols.) | $\overline{4}$ $\overline{5}$

| month (2 cols.) | $\overline{6}$ $\overline{7}$

ST RECENT ADDRESS: _____

STAL CODE | first three digits (3 cols.) | $\overline{8}$ $\overline{9}$ $\overline{10}$

BOR FORCE ATTACHMENT | as coded on registration form K:01 | $\overline{11}$

UCATION | as above | $\overline{12}$

RRENT RELATIONSHIP STATUS | as above | $\overline{13}$

PENDENT CHILDREN AT HOME | as above | $\overline{14}$

RTIFICATION | as above | $\overline{15}$

/ING ARRANGEMENTS | as above | $\overline{16}$

V CLIENT HEARD OF KLINIC | as above | $\overline{17}$

(CLIENT CAME TO KLINIC | as above | $\overline{18}$

REFERRED TO MEDICAL PROGRAM BY KLINIC
\FF, WAS STAFF PERSON FROM: | 0 not applicable
1 Community Services
2 Counselling
3 Volunteer Program
4 Administration
9 Not Known | $\overline{19}$

IBER OF VISITS TO THE MED. PROGRAM
)M MAY 1, 1983 - APRIL 30, 1984 | (2 cols.) | $\overline{20}$ $\overline{21}$

;T RECENT VISIT: PRINCIPLE DIAGNOSIS | 1 reproductive health care (R.H.C.)
2 primary health care (P.H.C.)
3 both R.H.C. & P.H.C. | $\overline{22}$

ST RECENT VISIT: # OF SECONDARY R.H.C. DIAGNOSES (2 cols.)		$\overline{23}$ $\overline{24}$

ST RECENT VISIT: # OF SECONDARY R.H.C. DIAGNOSES   (2 cols.) $\overline{23}$ $\overline{24}$

ST RECENT VISIT: # OF SECONDARY P.H.C. DIAGNOSES   (2 cols.) $\overline{25}$ $\overline{26}$

COND MOST RECENT VISIT: # OF R.H.C. DIAGNOSES   (2 cols.) $\overline{27}$ $\overline{28}$

COND MOST RECENT VISIT: # OF P.H.C. DIAGNOSES   (2 cols.) $\overline{29}$ $\overline{30}$

TAL # OF R.H.C. DIAGNOSES (MAY 1, 1983 - APRIL 30, 1984) (2 cols.) $\overline{31}$ $\overline{32}$

TAL # OF P.H.C. DIAGNOSES (MAY 1, 1983 - APRIL 30, 1984) (2 cols.) $\overline{33}$ $\overline{34}$

ECIFIC SERVICES RECEIVED BY CLIENTS:

FERTILITY CONTROL   1 yes 2 no $\overline{35}$

CONTRACEPTIVE ADVICE   1 yes 2 no $\overline{36}$

V.D. ASSESSMENT/TREATMENT   1 yes 2 no $\overline{37}$

DEPRESSION ASSESSMENT/TREATMENT   1 yes 2 no $\overline{38}$

PRENATAL CARE   1 yes 2 no $\overline{39}$

EATING DISORDERS - ASSESSMENT/ TREATMENT/MONITORING   1 yes 2 no $\overline{40}$

CLIENT REFERRED OUTSIDE KLINIC FOR:

LAB TESTS   1 yes 2 no $\overline{41}$

SPECIALIZED MEDICAL SERVICES   1 yes 2 no $\overline{42}$

SOCIAL SERVICES   1 yes 2 no $\overline{43}$

CLIENT REFERRED TO WOMEN'S HEALTH CLINIC FROM MAY 1, 1983 - APRIL 30, 1984   1 yes 2 no $\overline{44}$

CLIENT REFERRED TO OTHER PROGRAMS WITHIN KLINIC   1 yes, COMM. SERVICES 2 yes, COUNSELLING 3 no 4 known to C.S. 5 known to Counselling $\overline{45}$

X

$\overline{46}$

N.B.   0 = NOT APPLICABLE
9 = NOT KNOWN

PRE-TEST

CLIENT SURVEY

<u>Instructions</u>

This survey is part of a study aimed at improving the services offered by the Medical Program at Klinic. Filling out this form is voluntary. Your answers are confidential and will remain anonymous. Your name will not appear anywhere on this form. Please answer all the questions you can. Your answers are important for the Program.

<u>Questions</u>

1. How old are you? _____

2. Do you live in the area? Yes ( )   No ( )

3. What sex are you? Male ( )   Female ( )

4. How did you get here today?_____

5. How did you find out about the Medical Program? _____
   _____

6. If you found out about it from someone else, what did they tell you about the Program? _____
   _____

7. When you think of the Medical Program, what comes to mind? _____
   _____

8. When you think of Klinic, what comes to mind?_____
   _____

9. Can you name some of the services you believe the Medical Program provides?   _____
   _____
   _____

10. Can you name some of the services you think Klinic provides?
    _____
    _____
    _____

11. Did you find it easy to approach the Medical Program the very first time? Yes ( )   No ( )

12. If you did not find it easy, why not?_____
    _____

13. Do you usually see a Doctor when you visit the Medical Program?
    Yes ( )   No ( )

14. Do you usually see a Nurse Practitioner when you visit the Medical Program?   Yes ( )   No ( )

15. Have you seen both a Doctor and a Nurse Practitioner from the Medical Program?   Yes ( )   No ( )

16. Did you know that you could make an appointment with a particular Doctor or Nurse Practitioner from the Medical Program?
    Yes ( )   No ( )

17. If you have been seen by both a Doctor and a Nurse Practitioner, are there any differences in the way you are treated by members of each group?   Yes ( )   No ( )

18. If so, what are those differences? _____
    _____

19. Have you ever used any other kind of medical service? Yes ( )   No ( )

20. If you have, what kind?   _____
                                   _____
                                   _____

21. Are the other service(s) different in any way from the Medical Program?   Yes ( )   No ( )

22. If so, how are they different?_____
    _____

23. Have you ever been to see another Doctor or Nurse Practitioner?
    Yes ( )   No ( )

24. If you have, did they treat you any differently than you have been treated by the Staff of the Medical Program? Yes ( )   No ( )

25. If yes, in what way did they treat you differently? _____
    _____

26. Do you think that some people are more likely to use the Medical Program than other people?   Yes ( )   No ( )

27. If yes, what types of people are most likely to use the Medical Program? _____
    _____

    Why do you think that is? _____
    _____

28. Do you see the Medical Program as a program mostly for local community residents? Yes ( )   No ( )

29. What do you like most about the Medical Program? _____

_____

30. What do you like least about the Program? _____

_____

31. Does the Medical Program meet your health needs? Yes ( )   No ( )

32. What other areas or problems would you like to see the Medical Program look at?   _____

_____

_____

33. Would you use the Medical Program again? Yes ( )   No ( )

34. Would you send a close friend to the Medical Program? Yes ( )   No ( )

_____

Please comment on this questionnaire. Did you find it:

                    too short   ( )
                    too long   ( )
                    confusing   ( )
                    just fine   ( )

Other comments: _____

_____

- -

If you would like a copy of the results of this survey, please write your name and address below, tear it off and hand it to anyone at the front desk.

                    _____
                    _____
                    _____
                    _____

MEDICAL PROGRAM
CLIENT SURVEY

Instructions

This survey is being conducted by a Master's student for the Medical Program at Klinic. The purpose of the survey is to find out what you think about the Program and the services it offers. Filling out this form is voluntary. In no way would your unwillingness to fill out this form affect the services you receive from the Medical Program. Your answers are confidential and will remain anonymous. Your name will not appear anywhere on this form. Please answer all the questions you can. By filling out this form you will be helping us to better meet your health needs.

Questions

1. How old are you? _____

2. How far away do you live from Klinic?   In blocks _____

                                           In miles _____

3. What sex are you? Male _____   Female _____

4. How many times have you visited Klinic's Medical Program in the past year? _____

5. Are you seeing another doctor or health practitioner outside of Klinic at this time?   Yes _____   No _____

6. What services have you received from Klinic's Medical Program in the past year?
   _____
   _____
   _____

7. What other services do you think the Medical Program provides?
   _____
   _____
   _____

8. When you approached Klinic for the first time, did you feel:

   comfortable   _____
   embarrased   _____
   relaxed   _____
   scared   _____
   other _____

9. The last time you came to Klinic's Medical Program did you see:

   a Doctor   _____
   a Nurse Practitioner   _____
   am not sure   _____

10. Did you try to get in to see the same person this time? Yes _____ No _____

11. Would you like to be able to see the same Staff person each time you visit the Medical Program? Yes _____ No _____

12. Do you usually drop in without an appointment? Yes _____ No _____

13. If you do, would you make an appointment if you knew that you could?
Yes _____ No _____

14. How long do you usually spend waiting to see a Doctor or a Nurse Practitioner at Klinic? _____

15. Is that: too long _____

O.K. _____

16. Do you see the Medical Program as:

- mostly for local community residents   Yes _____   No _____

- a V.D. clinic   Yes _____   No _____

- a place that teaches you how to take care of yourself   Yes _____   No _____

- a clinic that uses mainly student doctors   Yes _____   No _____

- a place that takes an interest in you as a whole person   Yes _____   No _____

- a Birth Control Clinic   Yes _____   No _____

- a place with a well trained Staff   Yes _____   No _____

- a family practice clinic   Yes _____   No _____

17. Have you ever used any other kind of medical service like another clinic, a private Doctor or an emergency department? Yes _____ No _____

18. Which of these other services have you used the most? _____

19. Compare Klinic's Medical Program to the other service you say you have used the most.

Is Klinic's Medical Program:

more personal _____   less personal _____   the same _____

more capable _____   less capable _____   the same _____

more caring _____   less caring _____   the same _____

more confidential _____   less confidential _____   the same _____

more available _____   less available _____   the same _____

20. Does Klinic's Medical Program meet your health needs? Yes _____ No _____

21. Would you send a close friend to the Medical Program? Yes _____ No _____

22. Would you use the Medical Program again?   Yes _____   No _____

23. What other health or illness problems do you think the Medical Program should look at? _____

24. Are there any health education programs you feel should be offered by the Medical Program? _____

- -

Thank you for filling out this questionnaire. If you would like a copy of the results of this survey, please write your name and address below, tear it off and hand it to anyone at the front desk.

_____

_____

_____

_____

TO: MEDICAL PROGRAM STAFF
FROM: LINDA CAMPBELL

        AS PART OF THE PROGRAM REVIEW CURRENTLY BEING CONDUCTED, THE STAFF
OF THE MEDICAL PROGRAM ARE BEING ASKED TO GIVE SOME THOUGHT TO PROGRAM
OBJECTIVES AND DIRECTION. THIS EXERCISE IS THE FIRST PART OF A TWO PART
EXERCISE DESIGNED TO HELP THE PROGRAM CLARIFY ITS OBJECTIVES FOR THE
PURPOSE OF BEING ABLE TO GUAGE ITS EFFECTIVENESS IN THE FUTURE.
        YOUR INDIVIDUAL ANSWERS TO THE QUESTIONS BELOW WILL BE GROUPED
TOGETHER AND SUMMARIZED. THE GROUPED RESPONSES WILL BE PRESENTED
FOR DISCUSSION IN A MEDICAL PROGRAM METTING IN AUGUST.
        PLEASE ANSWER THE QUESTIONS IN AS MUCH DETAIL AS POSSIBLE. I
WILL BE COLLECTING THE FORMS IN ONE WEEK TO ENABLE ME TO AGGREGATE THE
RESPONSES.
        THANK YOU IN ADVANCE FOR YOUR COOPERATION. PLEASE FEEL FREE TO
CONTACT ME AT 257-6337 IF YOU HAVE ANY QUESTIONS REGARDING THIS FORM
OR THE PROCESS IN GENERAL.

QUESTIONS

1. Please list the current objectives of the Medical Program.

2. Can you think of how these objectives could be measured?

3. What direction do you think the Program should be taking?

4. Can you identify some specific goals for the Program?

APPENDIX B

FREQUENCIES - P.O.R. REVIEW

CLIENT DATA RETRIEVAL FORM INFORMATION

EMPLOY   LABOR FORCE ATTACHMENT

VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
FULL-TIME	1	186	29.5	37.8	37.8
PART-TIME SEASONAL	2	59	9.4	12.0	49.8
UNEMPLOYED	3	104	16.5	21.1	70.9
UNPAID HOMEMAKER	4	15	2.4	3.0	74.0
FULL-TIME STUDENT	5	104	16.5	21.1	95.1
DISABLED	6	11	1.7	2.2	97.4
RETIRED	7	5	.8	1.0	98.4
NO WORK AVAILABLE	8	8	1.3	1.6	100.0
	9	139	22.0	MISSING	
	TOTAL	631	100.0	100.0	

VALID CASES   492   MISSING CASES   139

EDUC   EDUCATION

VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
NONE	1	6	1.0	1.1	1.1
GRADES 1-4	2	6	1.0	1.1	2.1
GRADES 5-8	3	31	4.9	5.5	7.7
GRADES 9-12	4	339	53.7	60.3	68.0
TECHNICAL TRAINING	5	38	6.0	6.8	74.7
UNIVERSITY	6	142	22.5	25.3	100.0
	9	69	10.9	MISSING	
	TOTAL	631	100.0	100.0	

VALID CASES   562   MISSING CASES   69

CLIENT DATA RETRIEVAL FORM INFORMATION

LIVINGAR   LIVING ARRANGEMENTS

VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
IMMEDIATE FAMILY	1	264	41.8	52.3	52.3
WITH OTHER REL	2	23	3.6	4.6	56.8
WITH FRIENDS	3	69	10.9	13.7	70.5
BOARDING	4	32	5.1	6.3	76.8
ALONE	5	117	18.5	23.2	100.0
	9	126	20.0	MISSING	
	TOTAL	631	100.0	100.0	

VALID CASES   505   MISSING CASES   126

VISIT#   NUMBER OF VISITS TO M.P.

VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
	0	1	.2	.2	.2
	1	119	18.9	18.9	19.0
	2	118	18.7	18.7	37.7
	3	96	15.2	15.2	52.9
	4	61	9.7	9.7	62.6
	5	48	7.6	7.6	70.2
	6	43	6.8	6.8	77.0
	7	33	5.2	5.2	82.3
	8	22	3.5	3.5	85.7
	9	22	3.5	3.5	89.2
	10	14	2.2	2.2	91.4
	11	8	1.3	1.3	92.7
	12	11	1.7	1.7	94.5
	13	5	.8	.8	95.2
	14	3	.5	.5	95.7
	15	2	.3	.3	96.0
	16	2	.3	.3	96.4
	17	3	.5	.5	96.8
	18	3	.5	.5	97.3
	19	4	.6	.6	97.9
	20	2	.3	.3	98.3
	21	2	.3	.3	98.6
	22	1	.2	.2	98.7
	24	2	.3	.3	99.0
	26	1	.2	.2	99.2
	27	1	.2	.2	99.4
	28	1	.2	.2	99.5
	34	1	.2	.2	99.7
	37	1	.2	.2	99.8
	41	1	.2	.2	100.0
	TOTAL	631	100.0	100.0	

VALID CASES   631   MISSING CASES   0

CLIENT DATA RETRIEVAL FORM INFORMATION

RELATION   CURRENT RELATIONSHIP STATUS

VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
MARRIED	1	58	9.2	10.4	10.4
SEPARATED	2	45	7.1	8.1	18.5
DIVORCED	3	29	4.6	5.2	23.7
WIDOWED	4	9	1.4	1.6	25.3
LIVING AS MARRIED	5	48	7.6	8.6	33.9
NEVER MARRIED	6	369	58.5	66.1	100.0
	9	73	11.6	MISSING	
	TOTAL	631	100.0	100.0	

VALID CASES   558   MISSING CASES   73

- -

KIDS   DEPENDENT CHILDREN AT HOME

VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
YES	1	98	15.5	20.5	20.5
NO	2	380	60.2	79.5	100.0
	9	153	24.2	MISSING	
	TOTAL	631	100.0	100.0	

VALID CASES   478   MISSING CASES   153

- -

DEGREE   CERTIFICATION

VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
NONE	1	184	29.2	39.8	39.8
HIGH SCHOOL	2	157	24.9	34.0	73.8
TRADES PAPERS	3	14	2.2	3.0	76.8
TECH OR VOC	4	34	5.4	7.4	84.2
UNIVERSITY	5	52	8.2	11.3	95.5
PROFESS CERTIFICAT	6	21	3.3	4.5	100.0
	9	169	26.8	MISSING	
	TOTAL	631	100.0	100.0	

VALID CASES   462   MISSING CASES   169

APPENDIX C

REPRODUCTIVE HEALTH CARE DIAGNOSIS

The following diagnoses were derived from a review of all the diagnoses appearing in the Medical Program Log from January to May 1984. Lists of reproductive health care related diagnoses and primary health care diagnoses which were developed during this Log Review were modified in consultation with Program management to produce the list below.

Not all reproductive health care diagnoses appear on this list. Individual diagnoses were assessed on a case by case basis in certain instances. A "sore", for example, was interpreted in terms of the medical plan and laboratory tests associated with it.

DIAGNOSIS AND/OR ABBREVIATION

Amenorrhea
amniotic fluid leakage
atrophic vagine
atypical pap
Balanitis
BCP
BCP advice, contraceptive advice
BCP check
BCP - morning after pill
Candidiasis
Cervical Cap fit/check
Cervicitis
Chlamydia
CPE for birth control
CPE and pap
Condylomata (penile and vaginal only)
Crabs (pubic lice)
Diaphram fitting
Dysmenorrhea
erection failure

false labor
false pregnancy test
FU Diaphram
FU epesiotomy infection
FU self exam (FU breast exam)
GC contact, syphillis contact
GC follow-up, GC and Cx follow-up
GC screen (V.D. screen, check, repeat VDRL
G. vag., G. vag. follow-up
Herpes
Impotence
Infertility
Irreg menses
IUCD insertion
IUD FU, IUD expulsion
lesions (penile, genital, labia only)
Miscarriage, incomplete S/A
multiple miscarriages
pelvic and pap, pelvic exam
Pregnancy, pregnancy test
premature ejaculation
Premenstrual Syndrome
post partum exam, 6 week check
prenatal
R.H. factor
rubella immunization (for adult women)
spotting
S.T.D.
Syphillis
T.A. referral, work-up, follow-up
Vaginitis, vaginal infection, vaginal bleeding
V.D.
warts (vaginal and penile)
yeast infection

APPENDIX D

COMPARISON OF CATCHMENT AREA SUBSAMPLE

TO TOTAL CLIENT SAMPLE

FREQUENCIES

Catchment Area Subsample and Total Sample

Study Variable	Frequencies - Catchment Area	Frequencies - Total Sample
Average (mean) age category	28	27
Sex: Male	36.6%	28.4%
Female	62.9%	71.5%
labor force attachment		
employed full/part time	43.3%	49.8%
unemployed	25.2%	21.1%
full time student	15.7%	21.1%
disabled	4.7%	2.2%
retired	3.9%	1.0%
education		
grades 5-8	10.8%	5.5%
technical training and		
university	27.0%	32.1%
current relationship status		
living as married	12.1%	8.6%
never married	58.4%	66.1%
certification		
none	44.5%	39.8%
professional certification	2.5%	4.5%
living arrangements		
immediate family	32.3%	52.3%
with frients or relatives	26.1%	18.3%
boarding	12.3%	6.3%
alone	29.2%	23.2%
How client heard of Klinic		
friend or relative	69.4%	60.5%
public relations	11.6%	4.8%
Why client came to Klinic		
confidentiality	10.4%	20.0%
location	23.9%	12.2%
Average (mean) number		
of visits to program	5.9	4.8
Most recent visit		
principle diagnosis		
reporductive health care	42.9%	56.3%
primary health care	53.1%	40.1%

Study Variable	Frequencies – Catchment Area	Frequencies – Total Sample
Second most recent visit numbers of primary health care diagnosis		
no primary health care diagnosis	53.1%	59.7%
1 primary health care diagnosis	39.4%	31.9%
Average (mean) number of reproductive health care diagnosis	2.9	2.9
Average (mean) number of primary health care diagnosis	4.4	3.1
Veneral disease assessment/ treatment	60.0%	68.6%
lab tests	81.7%	84.8%
Known to Community Service	4.6%	1.9%

APPENDIX B

UTILIZATION ENHANCEMENT CHECKLIST

UTILIZATION ENHANCEMENT CHECKLIST[1]

Directions: There are fifty items listed below which focus on self-analysis, understanding the organizational context, planning and evaluation, the evaluation process, and communication. You may wish to rephrase some of the items to fit your particular situation or to add items. The checklist can serve as a guideline as you conduct an evaluation or as a self-examination after you complete an evaluation. To serve these multiple purposes, all items are written in the present tense.

A. Determining the Evaluator's Role

1. Assess level of personal congruence with the program's general goals and consider withdrawing if the incongruity may result in unnecessary conflicts.

2. Determine extent of personal commitment to the importance of conducting an evaluation of this program.

3. Analyze degree to which personal values and opinions about the program are publicly advocated by the evaluator.

4. Determine appropriate share of the responsibility for utilization.

5. Specify acitivities related to an educational role as well as a data-gathering, information-providing role.

6. Make sure that consulting skills are sufficient to meet the demands and complexities of the evaluation for the program.

7. Ensure that sufficient technical skills, time resources, and personnel are available to conduct a utilization-focused evaluation.

8. Establish congruence between personal role perception (data-gatherer, consultant, expert, recommender, change agent) and audience expectations.

9. Determine willingness to spend time with program staff in activities that are not directly related to the evaluation (for instance, informal lunches).

10. Establish a sense of credibility and trust with the program director, staff, and other audiences.

[1] From Brown, R., & Braskamp, L. Summary: Common themes and a checklist. In L. Braskamp & R. Brown (Eds.), Utilization of evaluative information. San Francisco: Jossey-Bass, 1980.

B. Understanding the Organizational Context

1. Obtain and study the organizational chart.

2. Identify the names of key people within and outside the organization.

3. Identify the decision makers and potential users of evaluation information within and outside the organization.

4. Understand the policy-making process of the organization.

5. Determine which decisions and policies are made as a result of the evaluation.

6. Know when decisions are made.

7. Determine which staff and other users should be consulted as the evaluation is planned and conducted.

8. Determine whether the sponsor of the evaluation is committed to the evaluation activity and uses evaluative information.

9. Determine the information sources and channels within the organization.

10. Trace the path and impact of previous evaluations in the same setting and determine how this affects this evaluation.

C. Planning the Evaluation

1. Make sure there is clear understanding of the evaluation role (that is, formative or summative).

2. Set up specific sessions in which the evaluation plan and its implementations are discussed with key persons.

3. Assess the implications of decisions based on the evaluation that affect personnel.

4. Assess the political implications of various evaluation findings.

5. Determine the likely sources of resistance to positive evaluation results.

6. Determine the likely sources of resistance to negative evaluation results.

7. Determine the freedom to provide evaluative information to various audiences.

8. Determine strategies for dealing with potential conflict and tension between program director/staff and evaluator.

9. Design an evaluation plan that will have technical credibility and provide needed information.

10. Establish a mutual problem-solving approach with the program personnel and decision makers.

D. Conducting the Evaluation

1. Make sure that everyone understands the purpose of the evaluation.

2. Involve key personnel in determining the purposes, issues, and general evaluation strategies.

3. Involve representatives of potentially affected groups in making decisions about instrumentation and data sources.

4. Be accessible to program staff during the evaluation to learn of and share perspectives from which each is interpreting the information.

5. Collect data from multiple sources.

6. Make sure the data collection instruments and procedures are understandable and relevant.

7. Have informal as well as formal meetings with key persons.

8. Maintain a mutual problem-solving relationship with staff and administrators throughout the evaluation.

9. Collect information needed, but only that.

10. Adapt the evaluation plan to meet changing information needs.

E. Communicating the Evaluative Information

1. Make periodic informal reports or presentations.

2. Ask program staff, especially those most affected, to assist in interpreting the findings.

3. Communicate major findings when available and considered appropriate; do not wait for the formal report deadlines.

4. Share rough drafts or preliminary thoughts with key persons before making a final presentation.

5. Write different reports for different audiences.

6. Make presentations understandable and easy to follow.

7. Link presentation to key issues and decisions.

8. Make sure that all audiences receive the evaluative information in sufficient time prior to key decision-making events.

9. Keep written reports brief.

10. Use several media (slides, charts) when making formal presentations.

Score Interpretation. Here are some rough guidelines for interpreting the results of your analysis. Allow two points for each question answered positively.

25 or less	Don't expect much to happen as a result of your efforts. Most likely your information will be ignored or gather dust on a shelf somewhere.
26 -50	You may be called back later to do another evaluation, but don't count on it. Perhaps you might get a publication from your efforts, but the world won't change.
51-75	Somebody may actually do something different as a result of the evaluation, especially if it reinforces what they were already thinking.
76-100	Be careful! You may be so effective that someone may have you earmarked to be an administrator, even though you have no desire to be one.