Political and Cultural Factors in Achieving Continuity with a Primary Health Care Provider at an Indian Health Service Hospital

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PRIMARY CARE IS A MAJOR FOCUS of health policy discussions in the United States today. In this paper we describe the primary care system established at a small rural Indian Health Service (IHS) hospital, the Zuni-Ramah Comprehensive Health Care Center, in Zuni, N. Mex. We offer this report as a feasibility study to encourage further evaluation and implementation of primary care in the IHS.

The IHS is charged with the health care of American Indians. "The IHS goal is to elevate the health status of Indians and Alaska Natives to the highest level possible. The mission is to ensure . . . [the] availability and accessibility of a comprehensive high quality health care delivery system providing maximum involvement of American Indians and Alaska Natives . . ." (*1*). The care can be given in a rural clinic or a major city hospital, in an IHS facility or in a private facility paid for by the IHS.

We worked with primary care services at a rural hospital and clinic. Before we describe the Zuni primary care system, we offer a definition of primary care and put it in the perspective of the whole IHS.

The Millis report (*2*) defined primary care as the rendering of comprehensive, continuing health services. The Institute of Medicine (*3*) listed these five specific attributes of a primary care system:

1. accessibility to patients;
2. provision of comprehensive care, not just illness-oriented care;
3. accountability to patients and community;
4. coordination among the various parts of the care system; and
5. provision of continuity of care with a personal provider.

When we speak of primary care in this paper, we refer to this general definition and these specific attributes of the system.

Three special features of the IHS that bear on these attributes should be kept in mind—the range and depth of care provided, the economics of care, and the characteristics of IHS physicians. The IHS—staffed by sanitarians, pharmacists, social workers, health educators, dentists, and dieticians along with physicians and mid-level practitioners—offers many health care services. Public health nurses, tribal community health representatives, and maternal-child health workers can bring services to patients at home. Staff is available to provide comprehensive care.

Care at IHS facilities is free for eligible patients, except for some nonessential items. Also covered is care from private sources to which an IHS physician

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has referred the patient. An eligible patient can go to any IHS facility and receive free care as often as the patient thinks it is necessary. Cost does not interfere with access, and free transportation is often provided. Self-referral and doctor-shopping are not limited by the patient's economic restraints. The multiple sources of free care available in some localities can discourage continuity, but access is assured.

A third special characteristic is the background of IHS physicians and their integration into the Service's health care system. Some physicians enter the IHS directly after internship or residency to fulfill scholarship obligations, for practical experience before making permanent career choices, or for adventure. They often have had no clinical experience except in their training hospital. Some physicians only remain in the IHS for 2 years. Inexperience and a short term of service are common.

In the IHS, different providers often give inpatient and outpatient services. Frequent staff turnover means that physicians have little time to learn about the organization of health care and to set up health systems that fit local needs. Patients see the physicians as temporary, too. The Indian Health Service hospital or clinic is regarded as the long-term health care provider rather than an individual physician. Not all Service sites operate on this model. An exception is the White River Apache Service Unit Hospital in Arizona, which began its continuity system in 1972; there, patients consistently see and identify with one physician. Fort Defiance (*4*) and San Carlos IHS Hospitals have similar systems, but overall, physician turnover and inexperience work against continuity.

Three of the seven physicians at Zuni-Ramah health center believed that the organization of health care could be improved. Two of us had had previous experience in private practice, and the third had worked with the continuity system at White River. We observed that individual patients often saw a different physician for each outpatient visit or hospitalization. Although a few patients saw one physician regularly, the great majority saw whichever provider was available, often a different one each time. There was no functional appointment system to allow patients reliable access to a specific provider. Patients had minimal phone access to physicians. Public health nurses and tribal workers saw their patients regularly, but there was no consistent physician backup and little coordination among different aspects of care. The hospital staff showed commitment and responsibility for patients, but little of this attitude could be attributed to personal physician-patient relationships. The health center was accountable to the tribe and the IHS, access and comprehensive care were provided, but continuity and coordination were weak.

Zuni and Continuity of Care

Primary care services must fit the community and the people being served. Zuni-Ramah Comprehensive Health Care Center is in west central New Mexico, 3 miles from the village of Zuni. The center provides health care to about 7,000 Zunis, all but a few of whom live in the central village on their 400,000-acre reservation. Most speak both Zuni and English and the economy is based on silverwork and farming. The health center also provides backup for outpatient care and most inpatient care for 1,500 Navajo people from Ramah, N. Mex., and sporadic care for 1,000 to 2,000 patients from Gallup, N. Mex. When the center is fully staffed, seven physicians and three physician's assistants provide outpatient services for 30,000 to 35,000 visits a year and admit patients to 45 beds. In this paper, we discuss the primary care effort directed at the Zuni village residents.

We identified a continuing relationship with a personal physician, our definition of continuity, as a key element in providing and improving health care. We believed that coordination of staff and services would follow if physicians worked in the context of a health team. The literature on continuity is ambiguous about the effects continuity has on the quality of health care (*5–8*). However, personal continuity between physician and patient is the standard form of health care for most people in the United States. It seemed to us that there are also compelling theoretical advantages to continuity for the Zuni people. Regular contact between individual patient and physician should increase cross-cultural sensitivity, trust, and consistency in explanations. It should allow phone contact between patient and physician and encourage home visits. Seeing one's own physician on each visit should increase patients' use of appointments and decrease waiting time. Farsighted long-term care might decrease costs and increase efficiency. A stable physician-patient relationship could focus on the patient's health care needs and simplify coordination of required health services. For all these reasons, we believed that continuity of care would improve our patients' health care.

Methods

Preliminary steps—the political process. We wanted to evolve a system that strengthened continuity and coordination and also took into account Zuni culture and the realities of the IHS. Therefore, we decided that change must be approached carefully and only after extensive planning. We expected a cautious response from staff and community; change instituted by people

who may be gone in 1 or 2 years deserves the suspicion of those who must continue to live with the changes.

Our first step was to discuss the ideas informally with Zuni friends, patients, staff, and community leaders. Since they supported the idea of continuity, we sought and received endorsement from the tribal health board and tribal council. The local radio station broadcast descriptions of the idea of continuity of care.

Community input taught us two unanticipated principles that we found necessary to incorporate into the system. First, participation in the continuity system must be voluntary. Patients could still see physicians at random if they chose. Second, the patient must be allowed to switch from the assigned physician without confrontation if he or she chose. We did not fully understand these reservations at first, but we adopted them on faith out of respect for the community.

We added two principles that stemmed from physician and staff input. First, one physician would supply both inpatient and outpatient care during regular hours unless the patient requested otherwise. The physician on call would give care after hours. Second, the physician would be part of a multidisciplinary team that included a public health nurse and tribal staff who could participate in patient care if needed.

Some measure of the work done by each physician seemed necessary to insure approximate equality of workload and to identify problems. We wanted to see if the system worked, that is, if providers gave continuous care. With the help of the IHS' Albuquerque Area Office of Program Research, we developed a monthly computer printout that showed workload as it related to a provider's regular patients, patients of other providers, and unassigned patients. The printout included all visits whether by appointment, walk-in, or after hours.

The primary care system. Assignment to an individual provider was determined by the location of the patient's home in the village or the patient's strong personal preference. We divided the village into three geographic areas according to boundaries that had been drawn up for a previous study. Each was designed to have equal utilization rates. Patients in each area would be cared for by one of two or three physicians or a physician's assistant who were assigned to that area. Each team included a public health nurse, a maternal and child health worker, and two community health representatives.

As patients who did not have an assigned provider came to the hospital outpatient department, their charts were coded according to their location in the village. They were given a written description of the continuity system and had access to Zuni-speaking staff who could explain it. A physician or physician's assistant from the assigned team then saw them. At the end of the encounter, the physician or physician's assistant offered to serve as the patient's primary health care provider. Most patients gladly accepted this commitment. The provider then wrote his or her name on the chart and gave a personal business card to the patient.

All of the patient's subsequent appointments were set up for times when that provider was available. If an assigned patient walked in during clinic hours without an appointment and his or her provider was not available, another provider from that team saw him. The assigned physician also gave that patient all inpatient care during regular hours. After hours, the patient was seen by the physician on call.

Physicians and physician's assistants are only part of the continuity system. The tribal health workers provide cross-cultural insights to patients and providers alike. They also assist in home care, with transportation, and with communication. They and the public health nurse can consult a specific primary provider about a particular patient's care. All members of the team meet periodically to discuss such things as hospital discharge planning, long-term management of ambulatory patients with difficult problems, and the need for home visits.

Since the provider-patient relationship was a new concept at Zuni, various devices were used to reinforce it. In the waiting room was a bulletin board with the photographs of all primary providers, public health nurses, and visiting physicians. Primary care providers distributed personal business cards, as previously mentioned. Further, some providers encouraged phone consultations from their regular patients and made house calls.

Results

Evaluation of the system consists of two parts—objective data regarding the effort to improve continuity and subjective observations about the changes in coordination and in other attributes of primary care.

Objective evaluation. We evaluated continuity with a personal provider in several ways. During a month-long evaluation in February 1979, which was the eighth month of the Zuni primary care system's existence, 64 percent of all outpatients who visited the center already had an assigned provider. (A provider had written his or her name on the chart cover during a patient's previous visit within the 8 months.) The percentages of patients from Zuni's three areas with an assigned provider follow:

Area	*3rd month*	*8th month*
Total	28	64
Team X	31	60
Team Y	46	70
Team Z	26	65

In 59 percent of the visits, patients saw their assigned provider and in 82 percent, patients saw their provider or a member of the provider's team (see chart). This proportion included all visits—by appointment, walk-in, and after hours. Patients with appointments were virtually assured of seeing their regular provider.

Patients' continuity with their providers was determined by dividing their total visits to any provider by their visits to the assigned provider. The continuity of both patients and providers is expressed in percentages in the following table.

Provider	*Patients' visits with assigned provider*	*Provider's total visits with assigned patients*
A	67	57
B	53	29
C	47	31
D	61	51
E	59	44
F (PA)	NA	NA
G	65	61
H	35	63
I (PA)	77	15

NA = not applicable.

Provider H was on leave much of the eighth month and provider F had no assigned patients. The variability in continuity for patients seemed related to providers' absences for vacations or other assignments and to variable use of the appointment system.

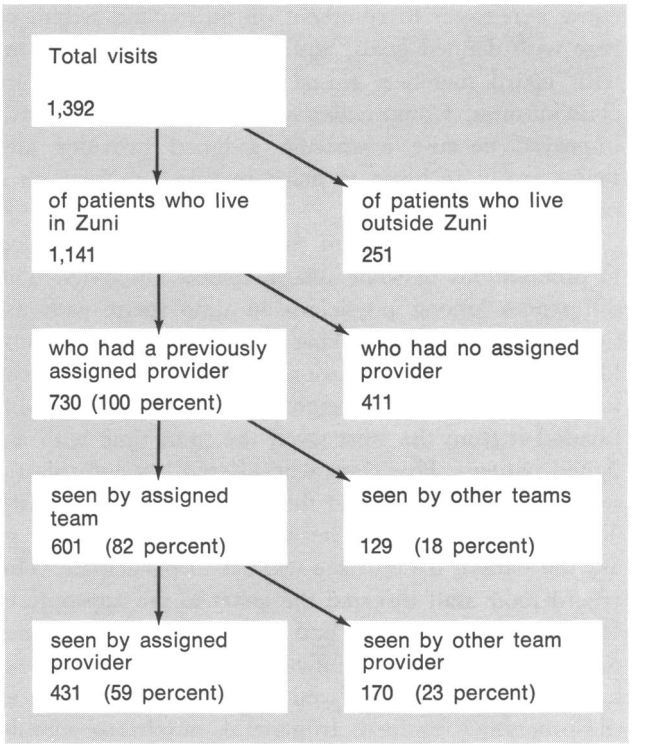
Continuity for providers was determined by dividing a provider's total number of visits with his or her assigned patients by the provider's total number of visits during the evaluation period.

These data demonstrate, first, the feasibility of assigning a specific provider to individual patients and, second, the level of continuity of care that can be achieved in 8 months. Other objective data consist of studies of patients' waiting time before and after the primary care system was started (*9*). The studies were done by the IHS Office of Research and Development. Waiting time for appointment patients was reduced by 13 percent, partly because of a more workable appointment system that resulted from the continuity effort.

Subjective evaluation. Effects on coordination and other aspects of primary care were evaluated subjectively. We also offer observations about acceptance of the primary care system.

Team meetings have become the means of coordinating hospital discharge planning, home care, and out-

Distribution of patients' visits after 8 months of the Zuni primary care system



patient management. Sanitarians, social workers, and other staff know the appropriate provider to consult about any patient. The team public health nurse, tribal health workers, and health care providers do indeed work together. Our general observations of patient care and staff discussions during daily rounds indicate that patients with chronic health problems benefit most from having a regular provider. A typical example of those benefiting is a patient with organic brain syndrome who is able to manage better and with fewer hospitalizations because there is one physician to coordinate care.

Patients' access to provider's advice by telephone was improved because they knew whom to call. Access to home visits was also improved, because a provider is more willing to see someone who is familiar. The tribal health board questioned whether there was decreased access because of longer waiting times, but the time study (*9*) showed that the wait was actually shorter. They were also concerned that patients had less access to their provider of choice. We began an ongoing education program about the continuity system that was directed at these misconceptions. The program included announcements on the local radio station and explanations to individuals by the tribal health and record room staffs.

Accountability seems to have improved, as indicated

by the tribal health board's taking a more active role than formerly. This change may have come about because it is easier to comment on an explicit system of care with defined goals, and our numerous discussions with board members raised the level of community consciousness. Comprehensiveness also seems to have improved because a specific assigned provider and teams are more likely to bring resources to bear on a patient's care.

Subjective evaluation of the system's acceptance led to observations of some unanticipated outcomes. The differences among physicians in time spent with assigned patients were striking. This variation was most likely attributable to variation in physician commitment to the program. In the eighth month physicians who favored it from the start spent the most time with assigned patients. Physicians who offered less enthusiastic support in discussions had the fewest assigned patients. This result came about because the physician had to ask the patient if he or she wanted to participate. The record room staff directed the chart to the appropriate team, but the physician had to write his or her name on the chart cover. Significantly, the physicians who saw few assigned patients initially were seeing more as the program continued. In general, physicians' morale seems better. Physicians look forward to seeing patients whom they know, and some seem to have increased sensitivity to Zuni culture. Of special interest is the powerful potential of the Zuni primary care program for recruiting new physicians. Frequently, prospective recruits have called because they had heard of this primary care system.

Physician's assistants were not initially receptive to the primary care system. Their objections were based on feeling ill-prepared for long-term responsibility for patient care, even with backup from a specific physician and on fear of violating the patient's privacy. They were concerned that, in seeing a patient consistently, they might learn more about him or her than the patient would like. Both physician's assistants are American Indians, and both were trained in programs that did not emphasize continuity. The lack of a model during training may help to explain their reluctance. Concern for privacy was also expressed by patients during planning discussions in their insistence that participation be voluntary. In the context of Zuni, a village with high population density and close kinship ties, it is understandable that privacy would indeed be precious. This issue deserves careful attention, especially since American Indian physician's assistants offer the best possibility for long-term primary care in many remote communities. We respected their reluctance and made their participation voluntary.

Patients have accepted the program well. The record room staff and tribal health workers confirm that there has been little physician switching. To our knowledge, a provider's offer of continuity has never been rejected and patients usually returned to their provider, as shown by our data. Community acceptance has also been good if one judges from discussions with the tribal health board.

Discussion

This feasibility study demonstrates that continuity of primary care can be achieved by a limited staff in a small IHS hospital. The 64 percent of patients who had their own primary care physician compares favorably with the report by Aiken and co-workers that 62 to 78 percent of all U.S. patients have such physicians (*10*). During a month-long evaluation, from 47 to 77 percent of the patients from three areas of the village saw their own providers when they came to the health center and, in 82 percent of the visits, patients saw their provider or the provider's team colleague. These values are well within the 46 to 86 percent range that has been reported in the literature on provider continuity (*11–14*). The range varies, of course, depending on the definition of continuity and the study site. It should be remembered that we included after-hours visits in our statistics.

It is significant that this system was put into effect with no extra funding or staff. The small cost of the computer program for evaluation and the monthly printout, both provided by the Albuquerque Area Office, were free to our service unit.

Improving continuity and coordination at Zuni-Ramah seems to have also strengthened access, comprehensiveness, and accountability. Waiting time was shortened, home visits and phone contacts increased, care may have improved for chronic patients, and physicians' morale seems higher. It is too soon to determine the effect on the rate of physician retention, and we have no data on costs of care.

Changes in local systems of health care must be approached cautiously. Our preparations paid off. Because of feelings expressed in planning discussions, we made the program voluntary and allowed patients to switch physicians. These choices were seldom exercised, but the option was reassuring to people who might believe that the system was imposed on them or that it threatened their privacy or free choice. Having data on workload was also reassuring to physicians. In retrospect, we probably could have predicted which physicians would be nonsupportive. More discussions with them might have led to a smoother start for the system.

Conclusion

A primary care system can be instituted in a small IHS hospital using existing staff and with no increase in funds. Some evidence suggests that theoretical advantages become actual ones with such a system. Careful planning is worth the effort. The system should be voluntary for patients and must allow them to switch physicians easily. Such a change requires utmost respect for the local culture and a deliberate political planning process to insure that all people are heard.

The same advantages of primary care in the IHS apply in theory to the Veterans Administration, the Armed Forces, county hospitals, and prepaid group settings. However, primary care varies in these settings. Now that we have shown that such a system is possible in the IHS, rigorous testing should be done to see if the theoretical advantages materialize in other settings. If they do, a major change of emphasis from fragmented care to continuity of care in the IHS and in these other settings would have significant benefits.

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SYNOPSIS

DIETRICH, ALLEN J. (Veterans Administration Hospital, Palo Alto, Calif.) and OLSON, ARDIS L.: *Political and cultural factors in achieving continuity with a primary health care provider at an Indian Health Service hospital. Public Health Reports, Vol. 96, September–October 1981, pp. 398–403.*

A primary care system was established at Zuni-Ramah Indian Health Service Hospital and clinic in New Mexico. Continuity and coordination of care were added to a health care system that was already accountable, accessible, and comprehensive. The new system offered each patient a personal health care provider who worked as a member of a multidisciplinary team.

In changing the health care system, special attention was given to its cultural and political setting, the village of Zuni. After thorough discussion with community and staff, community members' concerns about patients' privacy and free choice were better understood, and special efforts were made to safeguard them.

Ongoing evaluation is essential to maintain continuity. Eight months after the primary care system was begun, 64 percent of patients who came for care had established a personal relationship with a health care provider. For 59 percent of the visits during the 1-month evaluation period, patients saw their regular provider and, for 82 percent, patients saw their provider or one of his or her team colleagues. These percentages include night and walk-in visits. The system required no extra funding or staff.

The political process of planning and consultation helped anticipate and alleviate the community's concerns, but resistance from physician's assistants and some physicians was unexpected. A flexible approach has led to a gradual acceptance of this voluntary system.

This experience with the people of Zuni village shows that a primary care system can be started in a rural Indian Health Service facility with minimal outside help. Apparent improvements in quality of care make the continuity of primary care worthy of further consideration in the IHS and similar health services systems.