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Disease Management Guidelines: Promoting Quality Care and Cost Effective Prescribing Behaviors

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Background

Health care organizations are continuously striving to improve the quality of health care delivery while seeking ways to maximize the use of cost effective therapy. The Indian Health Service (IHS) is no exception. During the past year, groups of senior IHS and tribal health care professionals have worked to develop two Disease Management Guidelines: (1) Diabetes Mellitus, type 2, based upon the Staged Diabetes Management™ Program from the International Diabetes Center, and (2) Hypertension. These protocols are intended to be the foundation of a series of disease management guidelines that eventually will be made available as therapeutic references for all health care professionals working for IHS, tribal, or urban programs.

Why Disease Management?

Disease management makes sense. The goal is to address a patient's illness or condition with maximum effectiveness and cost efficiency by developing a systematic approach to the problem. In simple terms it is attacking the disease with a plan that has some basic consistencies across a service entity or health care organization. The foundation of disease management is a set of guidelines that offers a consensus approach to a particular illness, based on the best available medical evidence. Clinical practice guidelines serve to decrease physician practice variation, assist health professionals in staying abreast of new clinical information, help control health care costs, and promote better health care outcomes. The current medical literature cites many examples of

successful strategies for a number of disease processes.¹⁻⁸

Disease management should not be a rigid or mandatory one-way-fits-all approach. It must be flexible enough to offer a series of choices that practicing health care professionals can adapt to fit individual patient needs. Within the core of the process, however, is the concept of providing a unified message and restricting ineffective or cost inefficient care. Many activities supported by the IHS Diabetes Program, including Staged Diabetes Management™, are functional examples of disease management within our own health care organization.⁹⁻¹⁰

Protocol Development

To initiate the process, an advisory panel of physicians was brought together at the request of the IHS Managed Care Committee. It was elected to establish a Guidelines Development Panel (GDP), consisting primarily of clinical

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pharmacists as well as two physicians to develop draft disease management protocols with recommendations for specific drug therapy. Information and data from the Department of Veterans Affairs, the Pharmaco-economics Center, the International Diabetes Center, the medical literature, and the IHS was used to develop draft documents.

The draft documents were then provided to the Disease Management Panel (DMP), which consisted primarily of senior-level “front-line” Indian health physicians, but also included a physician assistant and a pharmacist (who also served on the GDP). The DMP reviewed and revised the two documents. The guidelines were next distributed to field providers for further input. A number of helpful comments and suggestions were received, and the documents were further revised accordingly. This process was used to allow for maximum input from field personnel.

Diabetes and Hypertension

Diabetes mellitus type 2 (DM) and hypertension (HTN) were chosen as the first two management protocols because of the high prevalence of these diseases in the population we serve. Although other disease entities might involve medications and treatments with larger budgetary consequences, the effective management of DM and HTN can impact greatly on patient care outcomes. For the most part, Indian health professionals are experienced in caring for patients with DM and HTN. However, variations in recommendations for the treatment of DM and the great array of available HTN medications make these two disease processes ideal targets for disease management guidelines. These guidelines are intended to serve as a valuable reference point for all levels of health professionals.

It is fully understood and appreciated that the IHS Diabetes Program and the International Diabetes Center have been collaborating for some time to establish the “Staged Diabetes Management Decision Paths” approach to DM care at local sites throughout the IHS. It is not the intention of the DMP to supersede or replace these efforts if they are already in place at a particular facility. However, since effective DM management is so important, it was the Committee’s belief that complementary DM guidelines from the DMP would provide an additional source of guidance for service units, particularly those not currently involved in Staged Diabetes Management.™

Disease Management — Key Success Factors

Disease management is total patient care, not just the regular referencing of guidelines. The health care professional must have an appreciation for the course of the disease, and target patients who will likely benefit from intervention (in the case of DM and HTN, this would include pretty much everyone). There must be a continued focus on primary and secondary prevention, as well as resolution of complications as they arise. Finally, one must strive for increased patient adherence through education and the provision of continuity of care. Disease management guidelines alone do not address all these issues, but

they do provide the foundation for a unified, step-wise approach to the treatment of a particular disease entity.

Barriers to Acceptance

Clearly there are several barriers to initiating a program like this across such a diverse setting as Indian health (IHS, tribal and urban programs). There must be a buy-in process for the health care professionals involved. The guidelines must be user friendly so they don’t just end up on a shelf collecting dust. They must be flexible enough to conform to the local setting. There must be an opportunity for feedback, and the guidelines must remain up-to-date, providing the most current evidence-based therapeutic options.

With these issues in mind, practicing health care professionals were tapped at each stage of the development. Every attempt was made to keep the guidelines clear and concise. We heard very clearly from the field that the guidelines would not be endorsed unless they could be adapted to local needs. The guideline summary and several algorithms point out areas where local norms can be adapted or local guidelines for specific medications can be added. The guidelines also provide a contact for feedback and comment. Finally, every attempt will be made to review the guidelines on an annual basis and update those sections that require changes based on new medical evidence.

Evaluation

A monitoring and evaluation process will be necessary to determine what impact the use of guidelines has on management choices and patient outcomes. A series of service units will be participating in a structured evaluation process. Individuals from these service units are being asked to help determine monitoring elements that will most likely reflect how the guidelines have or have not affected prescribing habits and patient outcomes. The primary principle of the exercise will be to utilize readily accessible data, preferably that which is currently available on the RPMS system. Once tested and refined, these elements can be made available to any interested service unit.

Availability

The guidelines are intended for use at all IHS service units, tribal programs, and urban clinics. Copies may be obtained through your respective Area Office Chief Medical Officer. Copies of the guidelines may also be found on the IHS Intranet at <http://home.hqw.ihs.gov/pharmacy/clinical/draft.htm>.

When your service unit decides to begin using the guidelines, it is recommended that the medical staff go over the protocols in an organized fashion to ensure that the algorithms are understood and everyone has an opportunity to become familiar with them. This would also be the best time to make any necessary local adaptations, as well as determine the specific mechanics of implementation. It is realized that mid-level providers may refer to the guidelines to a different degree

than physicians, but their use should be encouraged for all health care staff managing diabetic and hypertensive patients.

In reality, we cannot hide from the economics of medical practice. At the same time, we want to furnish our patients with care management that will afford the best possible outcomes. Disease management guidelines are not something to be feared, rather they are meant to serve as one more tool to help the health professional achieve these goals. □

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Editor's Note:

In the September 1997 issue of *The IHS Primary Care Provider* (Volume 22, Number 9, pages 137-139), we published an article by Boyce et al entitled "The Accreditation Association for Ambulatory Care: An Option for Ambulatory Health Centers." That article described an alternative to Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation for ambulatory health care facilities. The article that follows here, submitted by the Executive Director of the JCAHO's Ambulatory Care Program, describes the JCAHO's perspective on the accreditation process.

The Joint Commission on Accreditation of Healthcare Organizations: A Comprehensive Review Process

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Since 1982, the Joint Commission on Accreditation of Healthcare Organizations has been surveying Indian Health Service (IHS) facilities. During this time, the growth and modernization of these hospitals and clinics has been tremendous. The Joint Commission and the IHS facilities have enjoyed a good and mutually respectful relationship over the years working as a team to improve health care services.

The Joint Commission was instrumental early in the relationship in making recommendations to the IHS to improve the quality of care they offered. Using those recommendations, the IHS was able to turn to their funding sources with solid sug-

gestions for improvements that are now evident throughout IHS facilities. Clinics and hospitals of the IHS have been modernized, and populations served by those facilities now have better access to quality patient care due, in part, to the teamwork between the IHS and the Joint Commission.

The Accreditation Process

As IHS facilities have changed over the years, so has the Joint Commission. The Joint Commission survey process has evolved into one that is more consultative and educationally oriented. As a thorough and independent evaluation, the current focus of the accreditation survey is to assist organizations in improving their processes with the objective of improving patient care.

Health care organizations voluntarily seek Joint Commission accreditation. Created in 1951, the Joint

Commission is a not-for-profit organization that accredits more than 18,000 health care organizations nationwide. In addition to ambulatory care organizations and hospitals, such as those found in the IHS, the Joint Commission also accredits home health care organizations, long term care facilities, behavioral health care entities, and laboratories. The Joint Commission also accredits health plans, integrated delivery networks, and other managed care organizations.

In a manner of speaking, preparing for a survey and going through the accreditation process can be compared to working with a physical trainer. A good trainer knows how to draw the best results from his or her client. He is educated about techniques that will facilitate improvement. The one who hires the trainer knows that the process of training is difficult, tough, and demanding. But he also knows that the trainer will assist him in working up to his potential and bringing out the best in him. Organizations often choose to work with the Joint Commission for precisely these reasons: the Joint Commission accreditation process is rigorous, and the implementation of state-of-the-art standards assists organizations in improving the quality of care they provide to their patients.

Joint Commission accreditation recognizes an organization's performance in complying with national standards. The standards are intended to help organizations achieve the highest level of performance possible, reduce patient risk for undesirable outcomes, and create an environment for continuous improvement. By going through the Joint Commission's accreditation process, the IHS has demonstrated its commitment to implementing these objectives.

In addition to assisting organizations in improving the quality of care they offer, health care organizations seek Joint Commission accreditation for a variety of other reasons, including the fact that it enhances community confidence, enhances medical staff recruitment, expedites third-party payment, often fulfills state licensure requirements, may favorably influence liability insurance premiums, and may be used to meet certain Medicare certification requirements.

The Joint Commission's accreditation process is about responsibility and accountability, focusing on performance, not paperwork. Paperwork is simply a tool of accountability. The process for becoming accredited encompasses standards setting, evaluation, and education activities. A unique characteristic of Joint Commission accreditation is the breadth and diversity of services provided under an umbrella that is national in scope and recognition. Joint Commission standards represent a national consensus on quality patient care that reflects changing health care practices and health care delivery trends. Accreditation engages an organization's governing board, professional staff, and administration in a cooperative effort to continuously improve patient care quality.

The Standards

Joint Commission standards are patient-centered and performance-focused, concentrating on the functions and aspects

of patient care that are essential to quality care and a safe environment. In terms of performance, the standards state explicit objectives and then offer principles on how to achieve them. They set forth performance expectations for activities that affect the quality of patient care. Standards concentrate on what the organization is doing and the integration of their functions, not on documentation. If an organization does the right things and does them well, there is a strong likelihood that patients will experience good outcomes.

Standards, which are designed to be reasonable, achievable, and surveyable, are organized around functions common to all health care organizations. State-of-the-art ambulatory care standards are regularly updated and refined with input from the ambulatory health care field and with guidance from the Ambulatory Care Professional and Technical Advisory Committee, a group of experts representing a wide range of relevant professional organizations, including the IHS, the American College of Surgeons, the American Medical Group Association, the American Nurses Association, and the Society for Ambulatory Anesthesiology.

In addition to state-of-the-art timeliness, Joint Commission standards also represent good business practices. The activities addressed in Joint Commission standards are precisely the kind of activities that a health care organization would want to do on its own as a matter of sound business practice and future survival in today's rapidly evolving health care marketplace.

The Next Evolution in Accreditation

As part of the development of its standards, the Joint Commission has introduced "ORYX: The Next Evolution in Accreditation." The purpose of the ORYX initiative is to ensure a more thorough and comprehensive accreditation process, one which not only evaluates a health care organization's methods of doing the right things but the outcomes of these methods as well. The ORYX initiative will serve as the critical link between standards and the outcomes of patient care. It will allow the Joint Commission to review data trends and work with health care organizations to use the data to improve patient care. Currently, ORYX requirements apply to hospitals and organizations providing long term care, home care, and behavioral health care services. Ambulatory care organizations will be folded into the ORYX initiative in the future. A parallel, but different, group of requirements is in place for integrated delivery networks, health plans, and provider-sponsored organizations.

The Manual

In order to help health care facilities come into compliance with standards, the Joint Commission works hard with organizations. *The Comprehensive Accreditation Manual for Ambulatory Care (CAMAC)* is the tool that ambulatory care organizations use to put Joint Commission standards into practice. The manual is filled with examples of implementation; organizations use the manual as a self-assessment guide.

If an ambulatory care professional doesn't understand how to put the standards into practice, he or she can consult the manual for the intent of the standards, and also find examples for implementation.

If organizations still need further assistance, the Joint Commission's Department of Standards is only a phone call away. The Department of Standards is staffed with a team of experts such as physicians, nurses, architects, and engineers — who stand ready to answer questions about standards and implementation. In addition, the Joint Commission offers education programs, for a fee, to help health care professionals learn more about Joint Commission standards. Classes throughout the United States are taught by surveyors and other experts.

The Surveyors

Organizations focus a good deal of time, talent, and energy on implementing standards in preparation for undergoing a Joint Commission survey. The survey team may spend several days at the health care organization observing activities, interviewing patients and staff, and reviewing documents. To perform surveys, the Joint Commission employs more than 500 highly qualified surveyors who are physicians, nurses, health care administrators, medical technologists, psychologists, respiratory therapists, pharmacists, durable medical equipment providers, and social workers. They are practicing professionals who are familiar with the survey process, having experienced it themselves. To ensure current knowledge of the marketplace, every Joint Commission surveyor is required to work a minimum of 36 survey and education days annually. Surveyors bring with them knowledge accumulated over time from many health care organizations, and that knowledge in turn is imparted to surveyed organizations.

When the American College of Surgeons (ACS), one of the founders of the Joint Commission, performed surveys during the first half of this century, it used volunteer surveyors. However, the ACS determined that using volunteers was impractical. Use of a volunteer staff made it hard to develop uniformity within the survey process. It also made it difficult to create a sense of accountability beyond the spirit of volunteerism. In addition, the use of volunteers created obstacles to educating the surveyors. It was determined that a paid staff would be more effective. So, in the early 1950s, the ACS joined forces with the American Hospital Association, the American Medical Association, and the Canadian Medical Association, and created the Joint Commission.

Since then, the Joint Commission has demonstrated significant commitment and investment in the recruitment, training, coaching, and management of its team of surveyors. This commitment and investment enables the Joint Commission to create a strong, flexible team and maximize resources based on customer demand. Surveyors are continuously profiled in Joint Commission databases in order to monitor and improve consistency of performance and appro-

priately align surveyors to the surveyed organizations. In addition to performing the survey, the surveyors offer health care organizations counsel on how to enhance performance. The surveyors routinely provide consultation and education to staff members as an integral part of the survey.

After going through the accreditation process and a successful survey, an organization is awarded accreditation by the Joint Commission. It is important to note that — with the exception of laboratories — accreditation for organizations surveyed under all Joint Commission accreditation programs is effective for three years from the date of the survey. Laboratory accreditation is effective for two years.

The Performance Reports

After an organization is accredited, the Joint Commission makes detailed information about the performance of individual health care organizations available to the public through organization-specific performance reports. The Joint Commission is committed to public accountability, which is displayed in every aspect of the Joint Commission's operations. This accountability is fundamental to the priority accorded to protecting and improving health care quality. The performance reports are designed to assist individuals in making decisions about their health care provider. These reports have also had the desired ancillary benefit of spurring quality improvement initiatives throughout the industry. Performance reports are available by calling the Joint Commission at (630) 792-5800 or by visiting the Joint Commission's Website at www.jcaho.org.

Conclusion

The Joint Commission accreditation process will continue to evolve and to grow. New standards will be developed in order to keep pace with the rapid changes in health care; new initiatives will be developed to enhance the delivery of health care services. These developments will be in keeping with the Joint Commission's mission: to improve the quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations.

The Joint Commission is proud of its work with the IHS and is pleased to have been a partner in the development of the quality health care services offered at IHS facilities. Accreditation by the Joint Commission is recognized nationwide as a symbol of quality, and by going through the Joint Commission accreditation process, the IHS has demonstrated its commitment to providing quality health care to the patients it serves.

For additional information about the Joint Commission's Ambulatory Care Program, please call (630) 792-5000. □

Factors Influencing Physician Selection of Rural or Nonrural Practice Sites in the Indian Health Service

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Introduction

Recruitment and retention of physicians is a critical issue for the Indian Health Service (IHS). According to IHS Headquarters, there is a perennial shortage and excessive turnover of IHS doctors. In the last three years, there has been a 16% vacancy rate for physicians in the Agency. As one measure to address these issues, the IHS has established the Health Professions Support Team (HPST) that seeks to coordinate and support the recruitment activities of the Areas, service units, and tribal and urban Indian health programs. It may be useful to examine the relationships in physician recruitment and retention in the rural and nonrural practice sites within the IHS.

The IHS clinical staff consists of approximately 800 physicians, 390 dentists, 100 physician assistants, 590 pharmacists, and 2,500 nurses, among others. The Agency also employs allied health professionals such as nutritionists, health administrators, engineers, and medical records administrators. There is approximately a 10% vacancy rate overall for health professionals positions in the IHS. The 16% vacancy rate for physicians includes the primary care disciplines, such as family practitioners, obstetrician/gynecologists, internists, and pediatricians, as well as other specialists.

A project was implemented to examine the influence of personal, demographic, economic, professional, and hospital/clinic factors on physicians' decisions to select nonrural or rural sites within IHS. The IHS provides health care services to about 1.4 million American Indians and Alaska Natives through a comprehensive health delivery system. The IHS system maintains 37 hospitals, 64 health centers, 50 health stations, and five school health centers throughout the country. Services are provided directly and also through contracted and managed care plans. Health services also include those purchased from more than two thousand private providers.

Approximately 200 physicians are recruited every year into full-time positions in the IHS. About 40% (80) of these are in the IHS Loan Repayment Program (LRP). Another 5-10 of the physicians recruited come through the National Health Services

Corps (NHSC) Scholarship Program. There are also approximately 15 physicians recruited annually as IHS scholarship recipients. These programs pay an individual's medical school bills in return for a pledge to spend time in medically underserved areas. As one can see, approximately half of the physicians recruited each year are volunteers with no obligation. The American Medical Association's Project USA, a source of some 300 temporary or locum tenens physician placements annually, is supported by the IHS through a contract.

There is a need to determine factors related to, or predictive of, physician turnover in the IHS. The study described herein was designed to find out what factors determine whether physicians stay or leave practice sites within IHS. The information collected from this study could then be used to design recruitment programs and focus on resolving the problem of excessive physician vacancies in the IHS.

Five categories of factors were identified for analysis in this study. These categories were as follows: personal, demographic, economic, professional, and hospital/clinic. The factors were derived from a review of the literature and from conventionally held wisdom in the Agency.

Methods

A self-administered questionnaire was sent to 50% of the 800 federally employed physicians in the IHS. A random sampling strategy was used to try to avoid bias and to obtain a representative sample. The sampling was judged to be a valid representation of the twelve IHS Areas. The survey instrument contained 55 questions relating to the five categories mentioned above. The last three questions were open-ended, inviting written responses; these questions dealt with the intention to stay or leave the IHS within the next twelve months.

Descriptive analysis, Chi-square analysis, and stepwise discriminant analysis were used to test the relationships between the five categories of factors (the independent variables) and selection of rural or nonrural practice (the dependent variable).

Results

The initial and only mailing of 433 questionnaires was sent on February 6, 1997. By April 4 (the cutoff date for responses), 283 completed surveys had been received (a 65% response rate). There was no follow-up mailing conducted.

Descriptive data collected from the survey revealed that

the majority of respondents were male physicians (70%), and the majority of the respondents were married (86%). Most physicians (67%) were practicing in a rural location, which was defined as a community population of 24,999 or less. Approximately 58% of physicians had at least one child at home (no difference for rural versus nonrural practice locations). Spouses' employment opportunities were considered very important for 54% of those in all practice sites; while a larger percentage considered spouses' acceptance in the community as very important (61%).

Demographic factors indicated that a vast majority of physicians consider geographic area as important (97%). The quality of schools in an area was judged to be important to over half of all physicians responding to this survey (56%) for both rural (52%), and nonrural (59%) physicians. A great majority of IHS physicians considered access to cultural and recreational activities very important (93%), with no differences between rural and nonrural physicians.

Results from the survey revealed that 83% of all physicians consider income guarantee and income increases important. Retirement plans and benefits were important to 81% of physicians. These economic factors suggest the importance of offering competitive salaries and benefits to recruit physicians to any IHS site.

Approximately 96% of the respondents indicated that professional growth was important. Access to other specialties and consultation was considered an important factor by 91% of the respondents; this included 97% of rural physicians and 89% of nonrural physicians.

Hospital/Clinic factors that physicians identified as important were also revealing. Approximately 90% of physicians in this study considered facility equipment and current technology as important factors. The medical facility reputation and image were also considered important among 87% of respondents.

A statistically significant plurality of physicians who were married were found to be in rural practice locations. The majority of physicians selecting rural practice locations did not have prior rural practice experience. Geographic area was a significant factor for physicians choosing nonrural locations. The data did not reveal any statistical significance of a physician's community background, that is, the size of the community that the physician calls home. This may be due to a long period of time that may have elapsed between a physician's home community experience/background and the community in which the physician now resides and works.

Analysis of responses received to a question about the intent of physicians to stay or leave IHS within the next twelve months was conducted. The majority of the respondents planned on staying in the IHS for the next twelve months: 79% indicated that they intended to stay and 21% stated they planned to leave.

Discussion

It was interesting to note that the data suggest that educational loan payback (or state "forgiveness" programs, where

they exist) were not major factors influencing physicians' selection of rural or nonrural practice locations. The Loan Repayment Program is one tool in an array of incentives used in recruitment efforts by IHS. Factors that do seem to influence physicians to select rural settings include being married and the quality of schools and cultural/recreational opportunities. The availability of consultations was considered more important for rural than nonrural physicians. Staff qualifications were also considered more important for rural physicians.

Factors that influence physicians to select nonrural settings include spouse employment/acceptance and prior experience/origins in nonrural settings. The study showed that geographic area is more important to the nonrural than the rural physician. Professional growth/education was also considered more important for the nonrural physicians.

Conclusions

Physicians in the Indian Health Service come from a broad variety of backgrounds and are recruited through many different mechanisms. Recruitment and retention are increasingly becoming the total responsibility of the service units. By examining their own needs, each facility can tailor their recruitment efforts to the service unit and the population it serves.

It should be acknowledged that IHS rural practice locations offer mainly positions that attract primary care specialties. Since staff qualifications were found to be significant in recruiting and retaining physicians, consideration should be given to continuing to focus on staff qualifications. Additional efforts may be warranted to examine successful recruitment strategies to find out the most efficient sources and processes to attract and keep physicians and other health care professionals.

The health care industry is changing in all environments, including in the IHS. More tribes are opting to manage health care for their communities, resulting in the transfer of approximately one-third of the Agency's resources directly to tribes thus far as they assume this responsibility for their own health programs. This includes the recruitment and retention of physicians by the tribes instead of the IHS. Future studies need to examine the changes brought on by tribal assumption of health care and its impact in recruitment and retention of physicians.

Results from this study should be used as a tool to structure policy to recruit and retain IHS physicians who are committed to provide health care to American Indians and Alaska Natives. In determining qualifications of physicians, the credentialing process will remain very important. Staff qualifications and physicians' satisfaction are critical factors to consider in implementing programs and incentives to recruit and retain the rural and nonrural IHS physician.

Acknowledgments

Special thanks to the IHS physicians who completed and returned the questionnaire for this project. Without their participation, this study would not have been possible. □

Focus on Elders: A New Regular Section Devoted to Elder Care

Robin Miller, RN, CS, Clinical Nurse Specialist and Staff Educator; and Bruce Finke, MD, Staff Physician, both at the Zuni-Ramah Service Unit, Zuni, New Mexico

In the May 1998 issue of *The Provider*, we introduced the new coordinators and location of the Indian Health Service Elder Care Initiative. We described the goals and approach of the program, and outlined the current priorities. This issue of *The Provider* introduces a regular section on Elder Care that we will call "Focus on Elders."

As currently envisioned, the Focus on Elders section will have two components. One element will be a concise discussion of an issue of importance in Elder Care. This might

be a clinical topic or the description of an interesting and innovative program. We will be asking you, the readers, for your help in providing useful and informative articles for this section. The second element will be a listing of information about resources. This will include websites of interest, grant/funding opportunities, meetings and training opportunities of interest, and programs and contact persons.

Our hope is that these pages will further focus our attention on our Elders and help us in our efforts to provide them with the best possible care.

Also below is an invitation to you to join in this effort. We need to know who you are, what your interests are, what you are doing at your site, and how to reach you. With this information we can begin to tailor our services to your needs. Please take a moment to fax or mail this back to us at the Elder Care Initiative, P.O. Box 467, Zuni, NM 87327; fax: (505) 782-5723. □

What Are You Up To? Elder Care Initiative Questionnaire

Name: _____

Address: _____

Site: _____ IHS Tribal Urban

Telephone: _____ Fax: _____ E-mail address: _____

Specific interest area or topic: _____

Interesting program(s) I know about: _____

Meetings of interest that I know about: _____

Websites I have found helpful: _____

I would be interested in connecting with others in a special interest group on the following topics: _____

I don't have any answers, I'm just interested in elder care issues:

Fax or mail to:

**Elder Care Initiative
P.O. Box 467
Zuni, NM 87327
Fax: (505) 782-5723**

Change of Address or Request for New Subscription Form

Name _____ Job Title _____

Address _____

City/State/Zip _____

Worksite: IHS Tribal Urban Indian Other

Service Unit (if applicable) _____ Social Security Number _____

Check one: New Subscription Change of address

If change of address, please include old address, below, or attach address label.

Old Address _____

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