PROMOTING PRIMARY CARE: A CLIENT INFORMATION BROCHURE

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By

Josephine Lister Hendrix

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ABSTRACT

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Patients often seek healthcare for non-emergent problems in emergency departments and urgent care walk-in centers instead of seeking care with a primary care provider. This practice may prevent patients from receiving optimum quality care and may predispose patients to episodic care and unnecessary work-ups and treatment. This form of care also increases healthcare costs. This practice, according to Kasper (1987), is especially problematic in the lower socioeconomic populations in the United States. This project outlines some of the barriers to primary care and discusses the attributes of primary care.

The purpose of this scholarly project was to develop a tool to increase an awareness of primary care through patient education. A brochure is designed for the general public, but targets the lower socioeconomic population of the Grand Traverse region, and therefore is written in an easy to comprehend format. The brochure provides a definition of primary care, benefits of primary care, examples of care that can be appropriately treated by a PCP (primary care provider), and examples of a true health care emergency. There is a section with information on accessing

the PCP during and after office hours and it is formatted for customizing that information.

The information in the brochure is designed to encourage patients to seek primary care for non-emergent health concerns instead of choosing episodic care in emergency departments and walk-in clinics. The PCP will review the brochure with patients in an interactive educational process.

The Innovation-Decision Process Model by Rogers (1995) was used as a conceptual framework for this scholarly project. This model represents the diffusion of a new concept or idea and the path to adoption of that idea, which in this case, is primary care.

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CHAPTER I

ISSUES AND PROBLEM STATEMENT

Introduction

The Institute of Medicine (IOM) (1993) noted that historically, lower socioeconomic populations have a significantly higher morbidity and mortality from chronic and acute disease processes because of lack of primary care. The (IOM) was charged with developing a set of indicators to monitor access to healthcare by the U.S. public. The first matter the IOM Committee attended to was the establishment of the specific indicators to monitor access to personal healthcare, and they found that little progress had been made over the past decade. Low socioeconomic populations were still at risk for disease and death due to a real or perceived lack of access to proper healthcare. This risk existed whether there was an actual lack of healthcare providers, or the patients received inappropriate and inconsistent episodic healthcare in the emergency departments.

Educating the public about the primary care benefits of longitudinal care, continuity of care, and access to care is a priority of healthcare providers. Without access to care, certain populations will suffer the effects of poor health outcomes related to episodic care. Education that focuses

on the definition and description of primary care can improve patient's understanding of the healthcare system and promote effective utilization of primary care providers.

The primary care brochure that was developed for this project provides education material relevant to these issues.

Background and History of the Problem

Issues and Trends: Patients seeking care for non-emergent problems/health-concerns often look to the emergency departments of hospitals to provide that care. Greene (1996) reported on a recent effort by University of California-based medical center to curtail inappropriate use of emergency rooms by non-emergent patients. "Nationwide, emergency room visits have increased about 5% annually over the past 10 years" (p. 38). Greene (1995) stated that a 1993 study by the General Accounting Office found that 43% of all emergency room visits are nonemergency cases and could be treated by primary providers, thus saving insurance providers and patients about $7 billion per year in unnecessary costs.

In the Medicaid population, as well as others, it has been a common practice to seek any and all care in the emergency department (ED), and some families have grown up with this care as the norm. According to Kasper (1987), this is especially true with lower socioeconomic level of women and the uninsured or those receiving Medicare. Kasper

stated that this patient population has sought care for themselves and their children in the ED for decades.

With the new healthcare reform, Medicaid recipients are finding that a PSP (professional service provider) now appears on their monthly card. PSP is a primary care provider that the recipient chooses, or one is chosen for them from a list of providers. These providers are physicians and nurse practitioners who are approved by Medicaid, Medicare, and others to provide primary care. They are the gatekeepers who must authorized treatment in the ED or other specialty practice. Many healthcare institutions, Health Maintenance Organizations (HMOs) and other insurance plans are also involved in the same practice to help keep non-emergent care with the primary care providers.

In reviewing the history of primary care, Davis (1991) noted that from the economic studies of the 1960s through the early 1980s, it became apparent that one of the successes in healthcare accessibility was centered around community health centers; this was especially true with the ones that served the very young, the very old, those with chronic illness and African Americans. Davis also stated that literature published on research in the 1980s showed that access to proper healthcare was necessary for overall positive health outcomes of the patient population.

According to Baraski (1993) et al., a study done at Munson Medical Center (MMC) in Traverse City demonstrated

that in the 1993 fiscal year, visits to Munson Medical Ceter Emergency Department (ED) for minor emergencies (Levels I & II care) accounted for an estimated $899,000 in costs. Minor emergencies at Munson ED accounted for 64% of the ED's total visit volume in the 1993 fiscal year (p.1). Minor emergencies cited in a retrospective study on fast track triage by Baranski et al. (1993) were: headaches, conjunctivitis, simple bronchitis, sore throats, fevers gastroenteritis, skin rash, dermatitis, minor burns, insect bites, or minor lacerations (non-facial or extensive), suture removal, wound checks, and minor fractures (p.2). The number of patients who were seen for minor emergencies was 16,778, a 17.6% decline from the peak volumes in 1988. Competition of Urgent Care, a walk-in clinic, which opened in 1988 contributed to the decline of minor emergency volumes at MMC. According to Baranski et al. (1993) most consumers (88%) have a family or personal physician but less than half choose this option for minor medical emergencies occurring during the daytime (p.1).

A customer survey done by The T.C. Community Survey (1993) demonstrated that patients preferred Urgent Care for ease in parking, cost of visit ($40.00 at Urgent Care compared to $45.00 at Munson ED) and location. Charges for primary care providers were not included in this listing. Urgent Care is more visible for patients, especially tourists, because it is located on US 31, the main thoroughfare in Traverse City. Munson is more difficult to

locate as it is four blocks from the main street. Primary care offices frequently are not as accessible due to location. In summary of this survey, primary care offices should be more accessible to the public to be competitive to urgent care centers and the emergency department.

The purpose of this project was to develop a brochure that has an educational focus on primary care, with definitions of primary care and attributes of having a primary care provider. The overall goal of this brochure is to increase awareness of primary care through patient education, and focus on the benefits of access to longitudinal care vs. episodic care. This brochure was developed for the general public to read, but targets the underserved populations of the Grand Traverse area. Munson Healthcare System, the area's regional referral center, provides healthcare service to this largely rural area that encompasses Benzie, Grand Traverse, Kalkaska, Leelanau, and Wexford counties primarily, but also includes surrounding counties.

According to the Northwest Michigan Council of Governments (1994), the Grand Traverse Area population consists of Caucasians (98.05%), Native Americans (0.86%), Mexican Americans (0.78%), African Americans (0.40%), and Asians (0.49%). In 1970 that population consisted of 98.88% Caucasian, 0.56% Native America, 0.33% African American,

0.0% Asian, and Mexican Americans was listed as "NA" (p.88).*

Leelanau County had a growth of Native Americans between 1970-1990 of 1.99% and the surrounding Counties showed similar figures in the 1990 Census Report. The example above is a trend toward a less homogenous society, ad with this change comes socioeconomic change and more difficulties accessing primary care.

Although the minority population is small, they are growing in number. The Northwest Michigan Council of Governments noted that there also remains a number of socioeconomically disadvantaged Caucasians. In 1990 the mean personal income per capita in the five county area was $17,000 per year. The high school dropout rate in the 1990 census was 14.1% in Leelenau County, 30.4% in Kalkaska County, and 51.1% in Grand Traverse County.

Problem Statement

When patients choose emergency departments and urgent care centers for non-emergent healthcare, they do not access longitudinal, cost effective, and optimum quality healthcare.

Although many individuals routinely seek non-emergent healthcare in emergency departments and urgent care centers, insurance companies are beginning to limit payments for this costly delivery of healthcare. Presently, there is a paucity of literature available to the general public

*These are published percentages.

regarding primary care settings as preferred sites for non-emergent healthcare. This is particularly an issue for some socio-economically disadvantaged populations.

Goals and Objectives of this Brochure

The purpose of this scholarly project was to develop an informational brochure on primary care that will facilitate knowledge on access to primary care. The intended audience for the brochure is the general public, with special focus and format designed for the socioeconomically disadvantaged. The content of this brochure will include the following:

1. Definition of primary care.
2. Description of primary care providers.
3. Instructions regarding access to a PCP.
4. Description of attributes of accessible, longitudinal, cost-effective, coordinated healthcare.
5. Definitions of a true healthcare emergency.
6. Description of episodic healthcare issues can be treated by a primary care provider.

CHAPTER II

CONCEPTUAL FRAMEWORK

Rogers' Innovation-Decision Process Model

The **Innovation-Decision Process Model** (Figure 1) is the conceptual model created by Rogers (1995) to demonstrate decision-making as a process rather than a random instantaneous act. The following concepts are the series of actions that occur during diffusion of an innovation. In the case of this project, these are the series of occurrences involved in diffusion of the innovation of primary care to the lower socioeconomic populations of the Grand Traverse and surrounding areas.

Changing an individual's concepts, traditions, or beliefs regarding choices in acquisition of non-emergent healthcare is an educational process. The model of the Innovation-Decision Process is a depiction of the process that occurs over time, during a decision to accept and adopt a new idea/innovation. This process is begun by educating the individual or group about the innovation. This model has an anthropological basis and is especially applicable in the Traverse City and the Grand Traverse region where the heterogeneous population exists with a moderate number of lower income persons who may not have access to primary care

ROGERS' MODEL OF STAGES IN THE INNOVATION-DECISION PROCESS

PRIOR CONDITIONS

1. Previous practice
2. Felt needs/problems
3. Innovativeness
4. Norms of the social systems

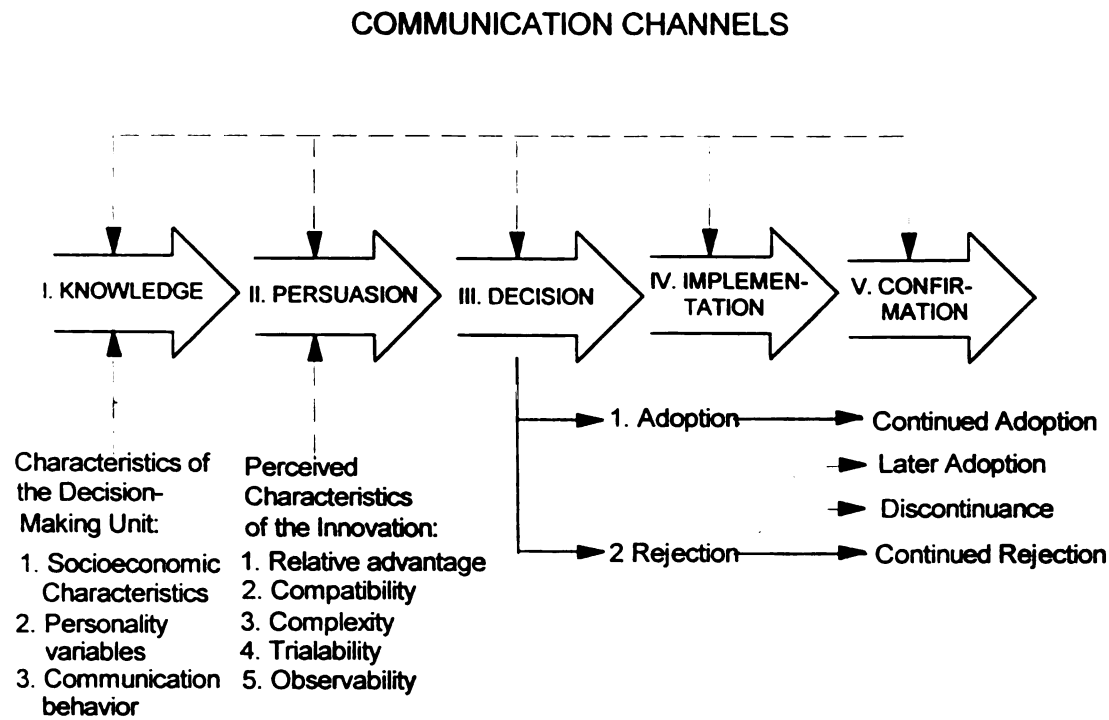


Figure 1: Model of Stages in the Innovation-Decision Process. Rogers (1995) Diffusion of Innovations (p.162)

because of traditional, cultural or economic reasons. Some are in need of education about primary care in order to modify their beliefs about episodic health care that is neither an optimum choice for healthcare, nor cost effective healthcare. Education about primary care, utilizing the primary care brochure as a tool, may enable the population to seek primary care for non-emergent healthcare problems.

Rogers' Conceptual Definitions

Innovation: As defined by Rogers (1995), the concept of innovation is "an idea, practice, or object that is perceived as new by an individual or another unit of adoption" (p.xvii). A unit of adoption, according to Rogers, is an individual, an organization, a family, or a social system. The structure of a social system can either facilitate or impede the diffusion of an idea, or change in a particular social system, depending upon the communication that occurs in the system. Patterns of communication predict, to a large degree, the behaviors of the individuals in the social system, including if and when they adopt an innovation. Rogers also stated that an innovation may take years to be accepted depending on the type of diffusion, rate of diffusion, or involvement of a change agent, in this case, the primary care provider.

Characteristics of Innovation: 1) Relative advantage of the innovation is the degree to which an innovation is perceived as better than the idea it supersedes; 2) Compatibility is the degree to which an innovation is

perceived as being consistent with the existing values, past experiences, and needs of potential adopters; 3) Complexity is the degree to which an innovation is perceived as difficult to understand and use; 4) Trialability is the degree to which an innovation may be experienced, tried, and sampled on a limited basis; 5) Observability is the degree to which the results of an innovation are visible to the others in the group.

Diffusion: The concept of diffusion, as defined by Rogers (1995), is "the process by which an innovation is communicated through certain channels over time among the members of a social system" (p.5). An innovation causes social change when the process of an intention or idea occurs and is diffused, then is accepted or rejected. In some instances, a change agent must be utilized in order to bring about change through education hence the primary care provider can be utilized as the change agent to communicate and educate patients about primary care. A primary care brochure can be the educational tool used by primary care providers (change agent) in an attempt to persuade the lower socioeconomic groups to adopt primary care over episodic care.

There are many means of educating the public and each method appeals to different populations. Lifestyle, culture, and values play a very important role in how individuals obtain information about healthcare. Rogers (1995) stated that diffusion of information is necessary for

change to occur. The diffusion process is made up of four steps: 1) The Innovation is introduced to the person or social group; 2) Communication over time is necessary for diffusion to occur and is related to the dimension of diffusion from the time the innovation was introduced, through the acceptance and adoption of the innovation; 3) Communication of the innovation occurs through interpersonal communication channels; 4) Communication occurs among the members of a social system or culture who are a problem solving entity, congregated to accomplish a common goal. The NP, as educator and change agent, can understand and somewhat predict the success and time frame required for diffusion of the idea of primary care.

The Innovation-Decision Process Model (Rogers, 1995) has a linear configuration, but the model demonstrates an overall continuum of communication that interacts along the phases of the diffusion of a concept or idea (innovation). The decision to accept or reject the innovation is also a characteristic of the model which allows the individual to change a decision about the innovation, i.e., to later accept or reject once an initial decision is made.

The Innovation-Decision Process Model consists of five stages: 1) *Knowledge* that occurs when an individual or group involved in a decision making process is exposed to the existence of an idea or innovation; 2) *Persuasion* of an individual or decision-making group occurs after knowledge and thus a favorable or unfavorable attitude toward the

innovation is formed; 3) *Decision* is reached when the individual group is involved in activities that lead to a choice to accept or reject the innovation; 4) *Implementation* occurs after the decision is reached to put the innovation into use; 5) *Confirmation* of the decision to implement the innovation occurs when the individual or decision-making group, according to Rogers (1995) "seeks reinforcement of an innovation-decision- already made" (p.162).

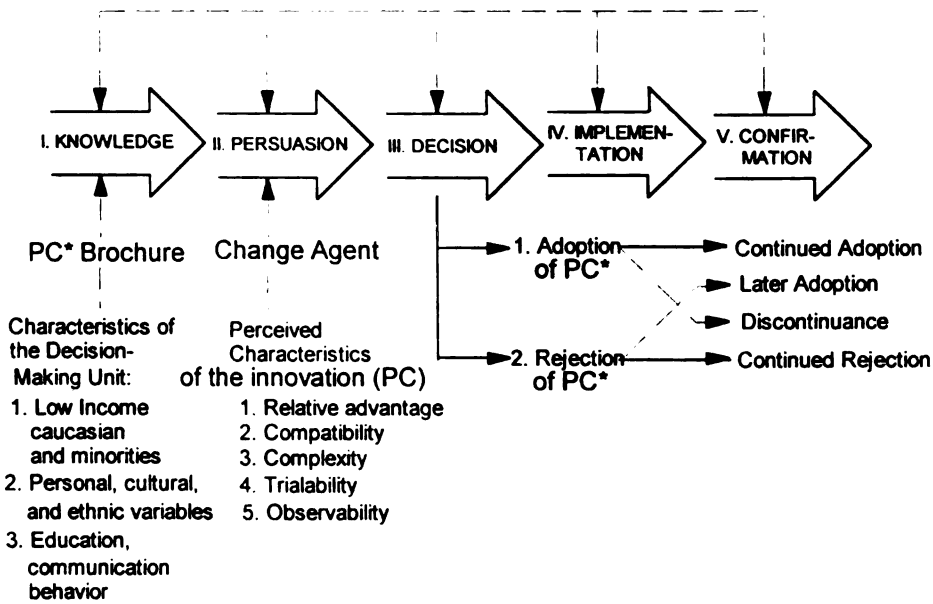
In examination of the Innovation-Decision Process Model, it is apparent that the activities from the time the decision was made, through the implementation, and to the confirmation stage, involves multidirectional movement possibilities. It is possible to reject an innovation initially and adopt it at a later date, or to adopt an innovation early on, then discontinue it later. Therefore, the model is not a closed or one-way system, but an open, multidirectional system. It is with this premise that the primary care provider can educate and increase the knowledge base of the individual patient or of a family to help them reach a decision to adopt primary care for their non-emergent health care needs.

The adapted Innovation-Decision Process Model (Figure 2) depicts the premises of the original diffusion model (Figure 1). These premises were utilized to develop an educational tool, the primary care brochure.

ADAPTATION OF ROGERS' MODEL OF STAGES
IN THE INNOVATION-DECISION PROCESS

PRIOR CONDITIONS
1. Previous practice of seeking health care
2. Felt needs/problems of episodic health care
3. Innovativeness to change behavior
4. Norms of the social systems: visits to non-primary care providers (emergency departments, walk-in clinics)

COMMUNICATION CHANNELS



*Primary Care

Figure 2: Adaptation of Model of Stages in the Innovation-Decision Process. Rogers (1995) Diffusion of Innovations (p.162).

The section in the upper left corner is labeled *Prior Conditions*. Before education can begin, these prior conditions must be addressed:

1. Previous practice of seeking healthcare.
2. Felt needs/problems of episodic healthcare.
3. Innovativeness to change behavior.
4. Norms of the social systems: visits to non-primary care providers (emergency departments, walk-in clinics).

Steps of the Innovation-Decision Process are shown as a continuum linked by communication channels. The steps in the process are depicted by five arrow-shaped boxes. The first box is titled *knowledge*. This portion of the model is the foundation for a decision process, i.e., one must have knowledge of primary care in order to make a decision. Knowledge is conveyed by education. The area directly under the knowledge box has *PC brochure* blended with the arrow that is pointed toward *knowledge*. The primary care brochure describes primary care, benefits of primary care, etc. This is connected to the area entitled, *Characteristics of Decision-Making Unit*. These characteristics are 1) low income Caucasians and Minorities; 2) personal, cultural, and ethnic variables; and 3) education and communication behaviors of the individuals who would obtain knowledge of PC.

The second box is titled ***Persuasion***. An individual may require education in order to be persuaded to accept the innovation of primary care. Persuasion may occur through a

change agent, who can be the NP or a member of a social group. The NP can review the brochure with an individual and elaborate on the perceived characteristics of PC which are located in the area below the words *Change Agent*. An arrow connects the characteristics and points toward *persuasion*. The perceived characteristics are: a) *relative* advantage; b) *compatibility with values*; c) *complexity*; d) *trialability of PC provider and system*; and e) *observability of others who have PCP*.

The third box is titled *Decision*, and interfaces with an area depicted as *Adoption of PC* and *Rejection of PC*. These two variables interface with variables of continued adoption, later adoption, discontinuance, and continued rejection. This process is a representation of the dynamics and multidirectional characteristics of decision making. For example, a person may initially reject the innovation of primary care, but may later adopt the behavior of seeking primary care if a change agent persuades the person to adopt that behavior.

The *implementation* box represents the action of putting the innovation to use. For example, a woman makes a decision to seek primary care and reserved an appointment with a primary care provider, thus implementing her decision to trial primary care.

The *confirmation* box represents the individual seeking reinforcement for the decision he/she made to visit a PCP. If the visit was a positive experience that behavior will

continue and the innovation of primary care will not be rejected. If the experience does not meet the person's expectations, or if there are negative or conflicting messages about PC by family or social system, the person may reject primary care.

Conceptual Definitions

The concept of *primary care* is defined by the Michigan Primary Care Association (1989) as:

> A basic level of healthcare usually rendered by general practitioners, family practitioners, internists, obstetricians and gynecologists, and pediatricians, as well as non-physician health practitioners with specialized training and skills. Primary care includes those services people receive on first contact with the healthcare system, i.e., prevention, maintenance, diagnosis, limited treatment, management of chronic problems and referral. Primary care services are provided in ambulatory settings, i.e., outpatient clinics and physician's offices (p. 149).

The definition of *provider*, according to Starfield (1992), is a healthcare professional with licensure to practice medicine as a physician (DO or MD), or licensure to practice as an advanced practice nurse, known as a nurse practitioner (NP). Calking (1984) defined advanced nursing practice as the "deliberative diagnosis and treatment of a

full range of human responses to actual or potential health problems" (p.27). Other healthcare providers are physician assistants (PAs), who are board certified and function as providers under the supervision of a physician. Although PAs are not licensed providers, they can provide care and bill under the physician's personal identification number for Medicare and Medicaid, the insurance most often provided for the lower socioeconomic population.

In summary, this adapted model of stages in the Innovation-Decision Process may assist providers to evaluate reasons why primary care is adopted or rejected by the lower socioeconomic populations in the Grand Traverse area or in other areas with similar demographics. The adapted model also assists the provider to understand his/her role as change agent in educating the patient about the benefits of primary care. The primary care brochure is a tool to promote this innovation.

CHAPTER III

A REVIEW OF THE LITERATURE

The review of literature is organized to: *overview the attributes of primary care, identify some cultural/socioeconomics drive barriers to accessing primary care*, and *provide an overview of methods to promote education about primary care.*

Attributes to Primary Care

Starfield (1992) stated that the four key attributes of primary care are: *first contact care, longitudinality, coordination, and comprehensiveness.*

First contact care implies accessibility to and the use of services for each new problem or episode of an old problem for which people seek healthcare. A facility does not provide first contact care unless the potential users believe this care will be accessible to them for further care.

Longitudinality implies the existence of a regular source of care, and the patient uses this source of care over time. Thus longitudinality is possible when the patient remains with the primary care provider who will care for the patient in all forms of health and illness care. Starfield (1992) also stated that having longitudinal care

means that persons will identify with a provider as their provider, and that the provider or groups of providers do identify the existence of a relationship or contract as that person's regular source of care. While longitudinality implies continuity of care, there exists a difference in actual definitions. Starfield (1992) explained that longitudinality refers to successive events of care, is time-bound and across the full spectrum of potential problems or reasons for visits to the provider. *Continuity* is then defined as the succession of events between provider visits, without regard to "where or why they occur" (p.79). Starfield also noted that people who have longitudinal care have fewer emergency hospitalizations and shorter hospitalizations, as demonstrated by a study by Wasson et al. (1984), in which men over the age of fifty-five were randomly assigned to two different groups for care, one longitudinal and the other not. Those persons who chose primary care over visits to an emergency department for treatment lessened any time spent in the hospital if they were later admitted for serious problems.

Comprehensiveness refers to primary care that provides initial and follow up care by that primary care provider, or referral to specialists if the condition warrants, and follow up thereafter. The endpoint is a return to the primary care provider for assessment and continued care.

Coordination of care is an integration of care that requires some form of continuity, either by practitioners,

medical records, or both, as well as problem recognition. Coordination of care is essential for good outcomes of healthcare.

Barriers to Primary Care

Barriers to accessing primary care exist within the lower socioeconomic population, and are barriers to the diffusion of primary care. Melnyk (1990) defined barriers to care as *intrinsic* or *extrinsic*. That author stated that barriers perceived by the client/patient are intrinsic barriers. Examples of these are the inconvenience of seeking healthcare, previous adverse healthcare experiences, or social, cultural, or religious issues. These are the most difficult to modify since they are usually rooted in the patient's beliefs or values. Extrinsic barriers are negative relationships with healthcare providers, lack of providers, lack of transportation to health care facilities or other site related barriers, and financial concerns.

Financial problems prevent access to primary care for a significant percentage of the population. Hastings (1995) reported that "A 1987 survey of the uninsured revealed the poor, or near poor, constituted approximately 37.3% of the population. Low income Americans made up 21.4%, middle income persons comprised 27.8%, and high income earner comprised 13.5%" (p. 53).

Patients with lower socioeconomic status tend to visit emergency departments instead of choosing a primary care provider. Many of these patients have gone from one

provider to another because they owe money that they cannot pay from previous visits. Hulen (1995) states that many of those patients have tried to do the right thing and have exhausted all resources in seeking healthcare. Hulen also observed that these patients feel that they have no other option but to come to the emergency department for acute, nonurgent problems.

Patients who seek care in emergency departments do not receive longitudinality and continuity of care. Kelly (1994) stated that "one of the most disturbing problems we observed as the "shotgun therapy" received by so many patients who returned to the emergency department over and over with varied complaints such as abdominal pain, headache, or back pain" (p.455). The author also found that patients repeatedly received extensive workups because of their poor history and a lack of access to complete medical records. Kelly also noted that definitive care and follow-up in a primary care setting would have been better care and would not have exposed these patients to endless workups, poor compliance on the patients' part and ongoing medical problems. Kelly was instrumental in organizing Peach Tree Clinic in 1992. The clinic was built to care for persons seeking non-emergent care and was staffed with primary care physicians, physician assistants and nurse practitioners. Inner city clinics are more accessible for urban poor.

According to Mezy and McGivern (1993) national surveys have demonstrated that 15% of the U.S. population does not

have a regular care provider. Nursing surveys found that 17% of Americans had inadequate access to physicians. Children from low income families are especially vulnerable to lack of adequate healthcare. Kleinman et al. (1981) found that children from low income families were twice as likely to have not seen a physician in the past five years and that children from low income families had 47% fewer physician visits overall. These authors also noted that such families need education on how they can access primary care and what financial arrangements can be individualized for them.

Stevensen et al. (1994) stated that America's healthcare system is failing to meet the needs of children and the health status of children is declining. Medically indigent children are lacking adequate healthcare because there is a lack of providers and insurance. Stevenson noted that persons with public insurance (Medicaid) were more likely to use hospital emergency departments and government clinics for health care. While Medicaid assists low income parents to obtain healthcare for their children, it may not be cost-effective care. Medicaid insurance (public insurance) and medical care use were correlated by Butler et al. (1985) in a stratified, four stage, area probability sampling design. In a study of children ages 0-18 in the Northeast section of the United States (U.S.), a sample of 5,662 children was correlated with an estimate of 69.7 million children in the U.S. in 1980. Researchers found

that 13.6% (SE 1.3) did not have health care insurance and 37.5% (SE 2.9) had no regular provider. While the researchers found no causal relationship to regular care and reported insurance coverage, they did find that those children with a regular source of care have lower average charges per visit; $31.68 for those with a regular provider compared to $40.68 for those with episodic care (had no regular source of care) (p.502). The increased cost of those with non-primary care providers was in part due to disproportionate use of expensive ER visits and other hospital based services. Large differences in care were found according to race or ethnicity as well. During a one year period approximately one third of African Americans and Hispanic children did not see any type of provider, compared to 21% of Caucasian children who did see a provider.

Virji (1990) found that patients from lower socioeconomic environments, particularly single mothers, had negative attitudes toward making appointments. The recommendation from the study was to have a mixed open access and appointment system to better serve that patient need. This would allow for spontaneity in visiting the clinic, a behavior that group continued to value. The clinic's innovation allowed for a change in type of health care obtained, but change in the behavior of seeking immediate care was not accomplished. Primary care clinics are more desirable than government clinics and emergency departments because in the government clinics and EDs,

patients usually face long waiting lines and discontinuity of care. According to Aday and Anderson (1984), these patients are less likely to seek preventative care and will seek episodic care for illness. Along with these barriers associated with emergency departments and government agencies, personal or cultural feelings and attitudes about healthcare may cause barriers that influence behaviors in seeking healthcare.

Barriers to healthcare are often related to misunderstanding cultural beliefs of Native American patients. Kutenai (1996) believed that primary care NPs and physicians can make a difference in whether or not Native Americans take the antibiotic that they are prescribed, or refuse to take medicine due to the provider's poor understanding of the patient's cultural beliefs. Kutenai stated that Native Americans have traditional ways of healing using herbs, sweat lodges, and prayer. Primary care physicians and NPs can learn Native ways by communicating with patients over time, learning their beliefs and values regarding treatments that are prescribed. In contrast, a poorly conducted discharge by the ED or fast-track staff may lead to "non-compliance", a term used too frequently by persons who do not understand cultural needs.

Care and consideration of outcomes is an important part of primary care. Jackson (1993) reported the case of a Vietnamese toddler who was treated with moxibustion, a form of Asian treatment for illness, which involves burning

mugwort leaves over skin acupuncture points. The burns were noted by ED staff when the child was admitted for pneumonia. The child's mother was educated on American treatment of pneumonia, primary care follow-up was established, and maintained by the child's parents. Western medicine was applied by providing knowledge of new treatments for pneumonia, while validating previous beliefs, and the persuasion to make the change was put forth by the nurses, physicians, and social services. The parents made the decision to change and adopted the new form of treatment. New treatment was implemented, and confirmation of the change for the good was established when the child recovered from the pneumonia.

The primary care provider can view cultures holistically in order to discover methods to interact in health and illness care. Leininger (1991) addressed cultural values such as kinship, social factors, socioeconomic status, educational background, religious and philosophical factors. These factors are important in explaining the role primary care has in providing optimum care over episodic care. Leininger also stated that "Culture care was conceptualized and transformed into a nursing perspective to develop a body of new or distinct knowledge in nursing" (p.24).

Many patients may not find in an urgent care walk-in clinic or fast track ED, a culturally sensitive environment. Abdullah (1995) found that too often the health needs of

patients with diverse cultural backgrounds are not always completely met due to partially recognized problems. For example, Mexican American migrants may prefer to come to the emergency department for acute care needs that are not an emergency. The IOM (1993) reported that a study of migrants' health care needs and found that knowing about the existence of the migrant health center as well as of the area in which it was located was a factor in increasing that population's ability to access care. Of those migrants who were recent immigrants, 45% had no knowledge of the migrant health center, compared to only 10.4% of the long-term migrants. Fifty-one percent of the recent-immigrants had not seen a physician in the past year (p.208). Those who were not aware of the migrant clinics tended to seek episodic care or no care at all.

Methods Used to Promote Education About Primary Care

There are various methods of educating the public about primary care and each method appeals to different populations. Some cultural norms do not value primary care, especially in some lower socioeconomic groups, or in others where there are barriers to accessing primary care. Rogers (1995) states, "Norms are the established behavior patterns for the members of a social system" (p.26). With norms and behavior patterns it is often difficult to persuade individuals to change beliefs and to reach them with education.

Television and radio are effective methods to educate the public. Television spots may attract the attention of viewers, but these are costly and usually require funding from a lucrative group. Persons who live in poverty may not have access to a television. According to Lorig (1992), many media approaches such as interactive TV or VCR programs are not reaching rural and semi-rural environments. These are difficult to engineer and are very costly. Thus, large segments of the population may be denied educational programs. Lorig stated that "the simplest and most often used solution to this problem is the use of printed materials" (p.40).

Radio is another medium that reaches many persons during their day in the car, work, home, or leisure time. Radio is also expensive and not a means to reach some of the population who are seeking healthcare. Socially disadvantaged individuals may find newspapers difficult to read. Therefore, public education on the advantages of primary care, descriptions of what primary care is, who provides it, and how to access those caregivers can be difficult to bring to certain cultures and individuals. With this in mind, the educational brochure, as a method to provide education, has an advantage over other forms of communication.

Brochures and other printed teaching materials can be beneficial for review of educational sessions with the PCP and patients can enjoy reviewing the material at their

leisure. Redman (1993) stated that "Printed teaching materials can be described as a frozen language that is selective in its description of reality" (p.140). Redman added that printed material encourages limited feedback, but the material is always available and readers can control the speed at which they read and comprehend. Redman also noted that certain types of education seems to demand written expression, i.e., a complex sequence of thoughts, definitions, or qualifications.

Redman offered comparisons of various readers' abilities to absorb written text, in particular, the novice reader. "Novices take advantage of the text's stability to slow the rate of information processing; as a result they are able to review the material" (p.141).

Price and Everett (1996) described a process for developing a pamphlet specifically designed for low socioeconomic and less well educated persons. When developing materials for populations with limited education, the writer must frequently evaluate the pamphlet to reduce the number of barriers to comprehension and make the material more interesting to read. A person's reading ability is a combination of motivation and skill, and if the content is too difficult to read, the motivation to read the material will be lost. Price and Everett provide the following guidelines for less well educated readers (p.163): 1) Use one or two syllable words whenever possible; 2) Keep sentences concise; 3) Present one idea (innovation) at a

time; 4) Define and use phonetic pronunciation for difficult words; 5) Use simple fonts: avoid all capitals, but use bold print and italics; 6) Use illustrations and cartoons, photos, and diagrams for ease of reading and appeal.

PCPs utilize pamphlets and brochures to educate on various healthcare topics. Shires et al. (1987) stated that educational brochures have two roles in primary care practice. First, books and pamphlets provide "food for thought" and often motivate patients to seek more information. The authors also stated that there is some limited potential for health education during the "downtime" when the patient, family and/or escorts are waiting for service. Placing pamphlets or brochures in the waiting rooms provides reading material to meet this education potential. This may also indicate to the patients and significant others that the provider extends a primary care relationship to them.

Television, home videos and other methods of education are available today but many educators overlook the brochure as an easy method to educate patients and families. Haggard (1989) noted that with today's technology and education of the media, some people tend to ignore the simple handout. But in education as an art, simpler is often the better way to reach out to patients. The author relates a study of one hospital that believed that a newer, sleeker video approach would be the best presentation of their material. They conducted a market survey to determine whether the written

patient education materials could be supplemented by the addition of a similar videotape. The survey indicated that 90% of the respondents preferred a brochure alone. Respondents also said it was helpful with home care to have the brochure to read and re-read at their convenience. Only 1% said they wanted the videotape either instead of, or in addition to, the brochure (p.84).

Haggard (1989) also related the advantages health care providers may realize in writing their own educational material. Those advantages are that the provider will have the ability to: 1) Target questions frequently asked by patients; 2) Highlight special interests or attributes of primary care; ad 3) Clarify difficult concepts using approaches that have worked for that provider in the past.

Studies conducted to evaluate patient knowledge on self care have demonstrated that educational booklets have an advantage over oral instructions alone. Maggs et al. (1996) conducted a single-blind randomized controlled trial on the effect on knowledge base of arthritis self-care utilizing an educational booklet for patients with chronic arthritis. The authors learned that a booklet was found to be more useful in gaining knowledge about arthritis when used alone, or in addition to individualized instruction, compared to group education only. All of the three groups involved in the study had a similar knowledge base about arthritis self-care prior to the study. The researchers learned that in the three groups of 50 person studied over a six week

period, knowledge base increased significantly ($p<0.0001$) in those given the booklet, and those with the booklet and oral instruction ($p<o.001$). But for the oral instruction alone group the increase in knowledge was not significant (ns). The mean knowledge increase score was slightly higher in the booklet and individual instruction group. A Mann-Whitney U-test was used to test the statistical differences between ratio values, using SPSS PC equipment (p.776).

Limitations of the Review of the Literature

Most of the literature regarding the access of primary care is focused on barrier issues, especially financial barriers. There is minimal primary care literature regarding education programs for patients that focuses on the benefits of primary care. There is a paucity of brochures or handbooks for the public other than the materials sent by government or private insurance companies.

CHAPTER IV

METHODS

Overview

The brochure focusing on primary care (Addendum A) was developed to aid the health care provider to educate the lower socioeconomic populations of the Grand Traverse region about primary care. The brochure is a tool that will promote and enhance discussion about primary care with patients. It was designed for the lower socioeconomic patient population to provide an overview of the benefits of seeking non-emergent and health maintenance care by a primary care provider. The verbiage and format was designed to facilitate ease in reading and comprehension of the material. The brochure will be evaluated by primary care providers for content, clarity and ease of comprehension before it is distributed to patients.

The cover of the triple-fold brochure is colorful to attract the reader's attention and will be titled, "Primary Care: We care best for you". The title was chosen in an attempt to reinforce the attributes of primary care (as stated in the review of literature) over episodic care. There is an illustrated representation of a provider and family on the cover. This illustration was selected because the provider depicted in the illustration is a person of

color, thus providing ethnic-sensitive validation to the culturally diverse population. The provider is surrounded by a family thus implying family centered care.

The left section of the inner portion of the brochure is titled, "What is Primary Care?" This section defines primary care succinctly, according to the Michigan Primary Care Association (refer to p.12 in the concept section). The inner section is titled, "Why is Primary Care the best care?" This section addresses, in simple terminology, the attributes of primary care, *accessibility, continuity, longitudinality,* and *cost effectiveness*. The inner right section is titled, "Who are Primary Care Providers?" The providers, are noted by Starfield (1992), to be physicians (MD/DO), nurse practitioners (NP), and physician assistants (PA) (p.146). These providers are listed and there is a brief explanation of the functions of NPs and PAs. A stethoscope illustration is located on the bottom of this section to signify a professional diagnostic tool associated with healthcare. It was also selected to add color and interest for the reader. The left side on the back of the brochure is titled: "When do I see my Primary Care Provider? A list of minor injuries, medical problems, according to Parker (1984), and health maintenance services are listed as: Flu, coughs, and colds, rashes, abdominal discomfort, small cuts and burns, mental problems, infections, minor injuries, routine examinations, immunizations, health maintenance, and chronic health problems.

An illustration of an ambulance will precede the section titled: "When do I go to the Emergency Room?" Problems that require emergent care, according to Parker (1984), are listed as: severe breathing problems, fainting, unconsciousness, or confusion, chest pain, severe bleeding, burns, or broken bones, and rashes that cause swollen lips and tongue.

The back side of the brochure has a section for address and phone numbers of the PCP, the emergency department and ambulance. The illustration of a cheerful appearing family is centered on this section and it depicts primary care as family centered care. The simple illustration is the type suggested by Price and Everett (1996) as noted in the review of literature. A space is provided above the illustration for the business card or stamp of the PCP. Below the illustration is a section stating, "for appointments call". The PCP telephone number can be printed there. "We are available 24 hours a day by calling" is next and is for the PCPs phone number, which is provided for patient access to a provider (or on-call PCP). Following that section is a section titled, "If you have to go to the Emergency Room, call:" This is to assist the patient to phone for triage advice if he/she perceives the problem to be severe (see list). The last section is "If you need an ambulance, call:" 911.

This brochure will be available as a pilot educational tool in four selected areas: Two primary care clinics,

Partners in Family Practice in Traverse City, and The Medicine Lodge at Peshawbestown, the Native American clinic at the reservation; Munson Medcare Community Health Care (walk-in); and the Emergency department at Munson Medical Center. The facilities involved with the pilot educational brochure will evaluate the tool and provide feedback prior to utilizing the brochure for their socioeconomically underserved patient population. These facilities were selected for reasons of convenience and this author's familiarity with the clinic staff. The Medicine Lodge was also chosen for reasons of concentrated ethnic (Native American) population base.

The evaluation (Addendum B) will consist of 8 questions that are designed on a Likert Scale as follows: 1=strongly disagree; 2=disagree; 3=no opinion; 4=agree; and 5=strongly agree. The questions are: 1) The brochure has sufficient content to describe primary care; 2) The definition of primary care provider: DO/MD; NP and PA is clear; 3) The definition of primary care is clear and concise; 4) The definition of conditions requiring emergent care is clear and concise; 5) Examples of illness and injury that can be treated by a primary care provider are clear; 6) The brochure is written for ease of comprehension by lower socioeconomic or persons with a limited education; 7) The brochure is colorful, attractive and neat; and 8) I would use the brochure in my practice. Room for comment is provided at the bottom of each question.

A week before the brochures are distributed a letter will be sent to the providers participating in the survey. The letter will describe the questionnaire, brochure, and purpose for the study. Questionnaires will be hand-delivered to providers in the facilities stated and will be collected three weeks later. After the questionnaires are collected they will be evaluated and the brochure may be modified in accordance with feedback from the participating providers.

The primary care education brochure, designed for this project, can be reviewed with applicable patients before they leave their provider's office. This is a time for the provider to answer questions and clarify points of the brochure. The health care provider, through education, can influence patients and families by helping them accept the innovation of primary care and thus assist them in accessing primary care.

In summary, the brochure is an educational tool utilized to educate the lower socioeconomic population about the attributes of primary care, identify the providers of primary care, and to assist them to make decisions about emergent and non-emergent care needs.

CHAPTER V

IMPLICATIONS FOR ADVANCED PRACTICE NURSING

Overview

The primary care brochure has a focus on APN by briefly defining the role of the nurse practitioner (NP). It is important for individuals to be acquainted with the role that NPs play in primary care. Pearson (1995) cited a draft of the Clinton healthcare reform plan that included NPs as one of the important primary care providers. Pearson also noted that primary care physicians have come to recognize the need for the addition of NPs to their practices. This need is related to overwhelming volumes of lower socioeconomic patients requiring primary care and the concurrent, significant reduction in reimbursement for care of these patients. Patients from lower socioeconomic groups, often require more education and follow-up than do other patients. Bernard (1994) stated that NPs serve the healthcare needs of rural populations and those in less desirable locations, such as inner cities. As stated in Nursing's Agenda for Healthcare Reform (1994), nurses have improved access to care in a wide variety of non-geographic settings that are underserved by physicians. These areas include nursing homes, adult foster care homes, homeless shelters, the prison system, as well as many other sites.

Nurse Practitioners continue to help fill the need for primary care to those patients that do not have access to physicians or patients who prefer NPs for primary care.

According to Giger and Davidhizar (1991), nurses today have different cultural insights into humanity and have a deeper appreciation for human life and values than do other providers. Nurses are developing a sensitivity for different clinical approaches with respect to their patient's cultural and emotional needs and multivariate lifestyles. Nurse Practitioners have the ability to meet educational needs of various patient populations.

Nurse Practitioners in primary care practice have many opportunities to assist patients to choose primary care over episodic care. Nurse Practitioners function as *educators*. Nurse practitioners (NPs) in particular, are educators who can be the change agents who introduce the innovation of primary care to the public. One of the domains of the NP, according to Benner (1984), is the Teaching-Coaching Function. Nurse Practitioners are educated to assess and interpret a patient's readiness to learn, preferred methods of learning, and make culturally avoided aspects of an illness approachable and understandable. Nurse Practitioners explain benefits of having longitudinal, comprehensive, coordinated, cost effective, and accessible healthcare. This can be accomplished by teaching patients and families, utilizing the brochure, addressing the community, church groups, or by using the media. Nurse

Practitioners can educate individuals about the importance of healthcare maintenance, screening and continuity of care. Focus can be made on education of patients and families in regard to when they need to seek immediate treatment for emergent problems and which problems can wait for an appointment with the primary care provider. Patients are more likely to adopt this behavior if NPs make their practice more accessible. One way this is accomplished by leaving openings in the schedule for drop-ins.

Nurse Practitioners serve as *consultants* for patients and families who have medical or emotional concerns. An individual may need a brief phone conversation with the NP to alleviate fears and concerns or the problem may require an office visit. In either case, NPs can set aside a block of unscheduled time to address these patients or they may be scheduled for an appointment. As stated in the review of literature, it is often the lower socioeconomic populations or minority patients who seek immediate care for their problems. This response by the NP may again reinforce their decision to adopt primary care instead of episodic care. NPs role of *advocate* enables patients to make healthcare decisions by transferring responsibility for these decisions to the patients. This role is accomplished by keeping patients informed and directing the healthcare back to them for self-care, when possible. Nurse Practitioners can assist patients to obtain Medicaid or other general assistance for health care reimbursement, and obtain cost-

free medication samples and supplies from pharmaceutical companies. This will enable patients to continue self care regimens.

Nurse Practitioners are excellent *clinicians*, who address healthcare concerns and can formulate a plan of care for acute and chronic illness in a timely manner to promote a feeling of care and concern that patients expect. Patients will hold the belief that they are a partner in their health and illness care, and this may deter their visits for episodic care.

Nurse Practitioners are *assessors* who identify and diagnose health problems and outline a plan for their patient population. This is an especially integral role when caring for minorities and others who are socioeconomically challenged. Native Americans, according to Kutenai (1996), are often reluctant to admit they are taking Native remedies along with conventional medicine, or may not admit they do not understand what the provider is treating. Careful assessment of cultural views and relationships is essential to reinforcing continuity of care by the primary care provider. Nurse Practitioners must frequently assess the compatibility and social characteristics of a patient before implementing an innovation.

Nurse Practitioners serve as a *change agent* when demonstrating the primary care brochure, thus using Rogers' (1995) model to introduce and persuade the individual and/or

family to adopt primary health care instead of episodic care. The NP, as change agent, will provide optimum health and illness care, and assist the patient to change poor health behaviors. This is especially needed in the lower socioeconomic culture when morbidity and mortality are higher than in the middle and upper classes, as shown by the literature review.

Nurse Practitioners can provide more culturally sensitive care if they research cultural behaviors and beliefs of Native American, Mexican American, and Asian patients and families. If a Native American grandmother is burning sweetgrass and sage to cure her hypertension, the NP attempts to understand these ways and address a healthcare plan for hypertension that is compatible with the patient's beliefs. She/he can provide data to the patient which demonstrates the relative advantage of the plan.

Nurse Practitioners serve as *collaborators* who work with other members of the healthcare team to plan a patient's care, including the available resources for the patients after regular primary care hours. This is to give a sense of direction and security to patients so they don't feel abandoned when the NPs office is closed. The NP can use the primary care brochure to outline what is a true emergency to assist the patient to make a good decision. If they are in doubt they can phone the emergency department for assistance in making a decision.

Finally, NPs serve as a *role model* whose behavior is worthy of emulation by patients and other healthcare members. Nurse Practitioners use the combined roles of advance practice nursing to enable the patient, family, or social system to adopt the innovation of primary care and implement that behavior for long term optimum healthcare delivery. The primary care brochure may serve to reinforce the role of NPs in primary care and to confirm the innovation for those who adopt primary care for a lifetime.

A Website is an excellent and expedient method of distributing the primary care brochure for downloading and utilization by other health care providers. Information printed in the brochure can be individualized for primary care clinics across the United States and possibly other countries. Horton (1994) stated that web sites are beneficial for retrieving documents because less time is spent searching for information, and that information such as the brochure, can be easily accessed by providers.

A research question that may be generated from this scholarly project is: "Does this primary care brochure promote a change in behavior of the lower socioeconomic population of the Grand Traverse Area, who presently seek non-emergent care in emergency departments and urgent care centers, to instead seek primary care?" Nursing research can demonstrate whether or not a behavioral change occurs in this population toward maintaining a primary care relationship with their providers.

Summary and Implications of This Study: Potential Contributions

The purpose of this scholarly project was to develop an educational tool to assist the primary care provider to educate the lower socioeconomic population of the Grand Traverse area and surrounding counties about primary care. The decision to educate this population about primary care was founded on reviewing literature on the patterns they have of seeking episodic care in emergency departments and walk-in clinics. Barriers to access of primary care were addressed, according to Melnyk (1990), as *intrinsic* and *extrinsic*. Intrinsic barriers were noted as: the inconvenience of seeking healthcare, previous adverse healthcare experiences, or cultural, religious, or social issues. Extrinsic barrier Melnyk stated are, for example: lack of providers, transportation, or financial concerns.

The conceptual model for this project was based on Rogers' Innovation-Decision Process Model (1995) in order to apply this concept in the decision-making process of the lower socioeconomic population after education about primary care. The outcome after education about primary care can be a change toward adopting primary care instead of episodic care. The Innovation-Decision Process Model was adapted to: review previous practices of seeking healthcare, review needs or problems of episodic care, assess innovativeness to change the behavior of seeking episodic care, and assess

norms of the social/cultural systems that apply to beliefs about seeking healthcare.

The communication channels for this process are: knowledge, persuasion, decision to change, implementation of the change, and confirmation of the change to adopt primary care (p.14).

Implementation of the project. An educational brochure was developed for this project that is to be utilized by the primary care provider to educate the described population about the attributes of primary care compared to episodic care. The brochure was selected after researching literature on various educational methodologies. Brochures were found to be a valid and useful method for educating the lower socioeconomic populations and the general population as well. The primary care brochure is a tri-fold brochure that provides a definition of primary care, describes the attributes of primary care, identifies the providers of primary care (DO/MD, NP, and PA). The brochure lists non-emergent health concerns that may be treated by a primary care provider. The brochure also explains which concerns require emergency department intervention. Sections are provided by a listing of phone numbers and addresses for accessing a primary care provider. Guidelines for developing brochure information to lower socioeconomic patient populations are outlined by Haggard (1989). An evaluation tool and methodology was developed to evaluate the brochure for use in the primary care setting. The

brochures may be duplicated for educational use by any healthcare provider and can be reproduced in Spanish for the migrant population. A Website can be utilized to download the brochure for use by healthcare providers across the United States and in other countries.

Recommendation for Nurse Practitioners

The primary care brochure can be a tool for NPs to educate lower socioeconomic populations about primary care. Nurse Practitioners, as stated by Barnard (1994), serve the healthcare needs of rural populations. Nurse Practitioners also provide culturally sensitive care as described by Kutenai (1996). The multifaceted roles of the NP as educator, consultant, advocate, assessor, role model, collaborator, change agent and clinician, provide patients with an optimum quality primary care provider. Nurse Practitioners use the roles of the advanced practice nurse to enable the patient, family, or social system to adopt primary care for accessible, longitudinal, and cost-effective healthcare.

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APPENDIX A

Primary Care Brochure

When do I see my Primary Care Provider?

- Flu, cough, and colds
- Rashes
- Abdominal discomfort
- Small cuts and burns
- Mental problems
- Infections
- Minor injuries
- Routine examinations
- Immunizations
- Health maintenance
- Chronic health problems

When do I go to the Emergency Room?

- Severe breathing problems
- Fainting, unconsciousness, or confusion
- Chest pain
- Severe bleeding, burns, or broken bones
- Rashes that cause swollen lips and tongue

- For appointments, call:
- We are available 24 hours a day by calling:
- If you have to go to the Emergency Room, call:
- If you need an ambulance, call: 911

Primary Care

We care *best* for you

What is Primary Care?

Primary care is the first contact with your health care provider for each new and old (chronic) problem that occurs over time. Primary care is also:

- Health and wellness care
- Physical examinations and counseling
- Preventive, follow-up, and rehabilitative care
- Referrals to specialists, if required

Why is Primary Care the *best* care?

- We are available 24 hours a day to provide care for you and your family
- We offer personal, ongoing care for all your health and illness needs
- We will care for you from infancy to old age
- Primary care is usually less costly care

Who are Primary Care Providers?

- **Physicians** (M.D. or D.O.)
- **Physician Assistants** (P.A.)
  A physician assistant has special training to treat illness and prescribe medicine under the supervision of a physician.
- **Nurse Practitioners** (N.P.)
  A nurse practitioner is a nurse with advanced education and clinical training to perform physical examinations, health and wellness care, family planning, diet, exercise, and other health teaching. Nurse practitioners diagnose and treat most common illnesses.

APPENDIX B

Evaluation of the Primary Care Brochure

Primary Care Brochure

Jo Hendrix
5942 Marilyn Ct.
Traverse City, Mi. 49684
April 30, 1998

Dear Healthcare Provider,

Thank you for agreeing to participate in the evaluation of a pilot brochure that will be used as an educational tool to teach our lower socioeconomic population of patients about primary care. The brochure is designed to facillitate conversation between you and your patient regarding the benefits of seeking their primary care provider for health and illness concerns. This educational process is intended to persuade patients to change the behavior of seeking episodic care at the emergency department and urgent care centers.

On May 8, I will be providing you with a copy of the primary care brochure pilot tool along with an attached evaluation form. I will collect the evaluation forms 3 weeks after that date (May 29). If you have any questions I can be reached at 616-943-3005.

Sincerely,

Jo Hendrix, RN, MSN
*

EVALUATION OF THE PRIMARY CARE BROCHURE:
A pilot educational tool

Please answer the following questions by assigning each one number from 1 to 5. The value for the numbers are as follows:
1=strongly disagree; 2=disagree; 3=no opinion; 4=agree; and 5=strongly agree

1. The brochure has sufficient content to describe primary care. 1 2 3 4 5
Comments:

2. The definition of primary care provider: DO MD; NP and PA is clear 1 2 3 4 5
Comments:

3. The definition of primary care is clear and concise. 1 2 3 4 5
Comments:

4. The definition of conditions requiring emergent care is clear and concise. 1 2 3 4 5
Comments:

5. Examples of illness and injury that can be treated by a primary care provider are clear. 1 2 3 4 5
Comments:

6. The brochure is written for ease of comprehension by lower socioeconomic or persons with limited education. 1 2 3 4 5
Comments:

7. The brochure is colorful, attractive and neat. 1 2 3 4 5
Comments:

8. I would use the brochure in my practice. 1 2 3 4 5
Comments:

Name _____ (optional)
Thank you for participating in this evaluation and agreeing to trial this educational tool. I will collect them on May 16, 1998. If you have questions, phone 943-3005.

Jo Hendrix, RN, MSN