

I

A Framework for Health Education



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Overview of the Miller–Stoeckel Client Education Model

OBJECTIVES

Upon completion of this chapter, you will be able to do the following:

- Introduce the Miller–Stoeckel Client Education Model.
- Describe the purposes and goals of health education.
- Define the concepts, propositions, and assumptions of the Miller–Stoeckel Client Education Model.
- Elaborate on the major concepts and embedded concepts of the model.
- Explain the Wellness Illness Functional Continuum.

CHAPTER OUTLINE

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INTRODUCTION

This chapter introduces the Miller–Stoeckel Client Education Model as the conceptual framework around which this text is written. The use of the model is a unique contribution to understanding the delivery of health education and nursing science. The chapter begins by giving the purposes and goals of health education and then defines the concepts, propositions, and assumptions of the Miller–Stoeckel Client Education Model. Concepts are elaborated on, and the Stoeckel Wellness–Illness Functional Continuum is explained. There is a review of health belief and health promotion models, and then the chapter concludes by reviewing the context for health education.

PURPOSES AND GOALS OF HEALTH EDUCATION

We view *purpose* and *goal* as having essentially the same meaning (Webster's, 2013) and believe the overall purpose and goal of health education is to promote, retain, and restore health, which is a phrase you will see throughout this text. It involves the prevention, treatment, and management of illness and the preservation of clients' mental and physical well-being. Comprehensive client education includes maintenance and promotion of health, illness prevention, restoration of health, and coping with impaired function. This view of health care can be achieved only by shifting the emphasis away from illness and cure and integrating client education into a comprehensive approach to health maintenance, prevention, and promotion (Davidhizar & Cramer, 2002).

Health education promotes positive, informed changes in lifestyle and involves encouraging behaviors that prevent acute and chronic disease, decrease disability, and enhance wellness. Nurses as educators empower clients to strive for optimal health and well-being. Individuals learn to make informed decisions about personal and family health practices and use health services in the community. From a public health perspective, health education is intended not only to enhance individuals' abilities to make positive lifestyle changes but also to support social and political actions that promote health and quality of life in communities. Hall (2001) notes that effective community education is essential as individuals, communities, and the nation shift focus to wellness and illness prevention. The concept of community empowerment is designed to help individuals and organizations use their abilities and resources in collective efforts to address their health priorities and needs. The ultimate goal of health education is for nurses as educators to help clients make changes in behavior that support healthy living.

THE MILLER–STOECKEL CLIENT EDUCATION MODEL

The Miller–Stoeckel Client Education Model provides the conceptual framework for understanding the essential, interrelated concepts of health education. The terms *conceptual framework* and *conceptual model* are used interchangeably. Fawcett (2005) defined a conceptual model as:

A set of relatively abstract and general concepts that address the phenomena of central interest to a discipline, the propositions that broadly describe these concepts, and the propositions that state relatively abstract and general relations between two or more of the concepts. (p. 16)

Conceptual models assist us in identifying concept links that we believe exist and then communicating those concepts to others. Models include concepts, propositions, and assumptions. Concepts are words or phrases that summarize the essential characteristics or properties of a phenomenon. Propositions are statements about a concept or a statement of the relationship between two or more concepts. Assumptions are “I believe” statements believed to be true. Models have practical value because they guide practice and research. Conceptual models give direction to the search for relevant questions about the phenomena of interest to nursing as a discipline and also suggest solutions to practical problems.

The theoretical basis for the Miller–Stoeckel Client Education Model is drawn from theories of nursing and education: Hildegard Peplau’s interpersonal relations theory (1952); Ida Jean Orlando’s nursing process discipline theory (1972); Nola Pender’s health promotion model (2011); Josepha Campinha-Bacote’s model of cultural competence in the delivery of healthcare services model (1998); Christine Tanner’s model of clinical judgment in nursing (2006); Bernadette Melnyk and Ellen Fineout-Overholt’s process of evidence-based practices (2011); and Malcolm Knowles’s adult learning theory—*andragogy* (1990). These theories provide the theoretical support for the model and are applied throughout the text.

The four major concepts of the Miller–Stoeckel Client Education Model follow:

- **Nurse as Educator:** Nurses are professionals who plan, organize, teach, and direct health education to promote, retain, and restore health in a variety of settings.
- **Client as Learner:** Clients are consumers of health education and include individuals, families, groups and communities, and health team members.
- **Nurse–Client Relationship:** the Nurse–Client Relationship creates the environment for the interaction that focuses on the achievement of health education goals.
- **Client Education Outcomes:** Client Education Outcomes are the results of health education efforts.

The four embedded concepts of the Miller–Stoeckel Client Education Model follow:

- **Cultural Caring:** Behaviors and attitudes exhibited by the nurse that respects and values diversity.
- **Communication:** The exchange of information in spoken, written, and nonverbal forms that is the foundation for clients to understand and act on health information.
- **Negotiation:** The give and take within the relationship that acknowledges the client as a partner with the nurse in achieving mutually acceptable goals.
- **Collaboration:** Sharing, planning, setting goals, solving problems, and working cooperatively together to achieve the goals of health education.

The propositions for the model are as follows:

- The Nurse as Educator and Client as Learner come together in the Nurse–Client Relationship to achieve Client Education Outcomes of promoting, retaining, and restoring health.
- The environment created by the Nurse–Client Relationship is influenced by the embedded concepts of Cultural Caring, Communication, Negotiation, and Collaboration.

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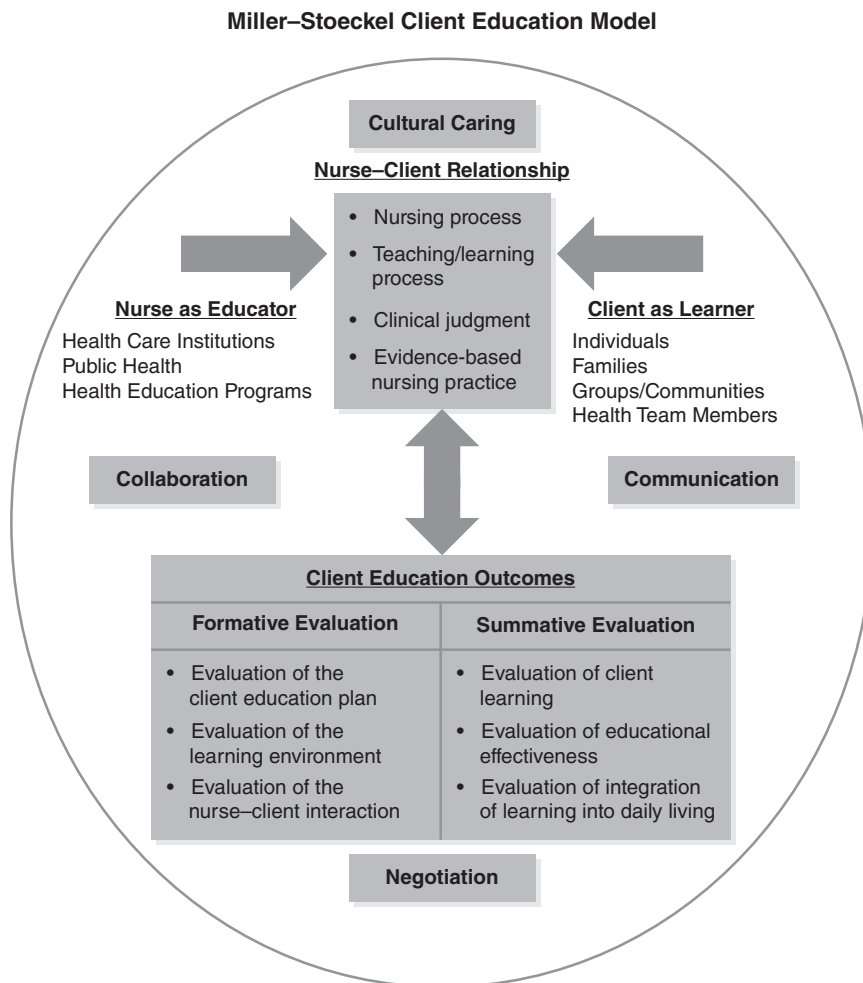
The major assumptions of the model are as follows:

- Health status can be improved for most clients through health education.
- Health status is affected by a variety of factors, including lifestyle, heredity, environment, culture, and availability of health care.
- Clients can learn positive health behaviors.
- Clients are responsible for choices under their control that affect their health.
- Nurses are primary providers of health education in a variety of settings (**Figure 1-1**).

The remainder of the chapter will now further elaborate on the concepts of the model.

FIGURE 1-1

Overview of the Miller–Stoeckel Client Education Model



NURSE AS EDUCATOR

Nurses are professionals who plan, organize, teach, and direct health education to promote, retain, and restore health in a variety of settings. The Nurse as Educator implements health education through the client education plan or teaching plan. The model shows that nurses work in public health, healthcare institutions, and health education programs. The model is not meant to limit nurses to those settings but to identify the most common places in which nurses are employed. Nurses as Educators are employed in many areas beyond what we have identified; we list these only as examples.

Nurses work with other healthcare professionals, civic groups, and community officials to identify health needs, develop desirable health education goals, and evaluate the availability of healthcare services. Nurses as Educators focus on promoting optimal health and preventing illness, but they also deal with social, cultural, behavioral, legal, and economic issues as they affect health.

Nurses' Role in Health Education

The teaching role of nurses has long been recognized as a function of nursing practice. It has been within the scope of nursing practice since the days of Florence Nightingale. In 1918 the National League of Nursing Education (NLNE), precursor to the present-day National League for Nursing (NLN), defined nursing as the prevention of illness and the promotion of health especially in public health, child welfare, schools, home visiting, industries, hospitals, and social services. Nurses were expected to be responsible for health teaching. Two decades later, in 1937, the NLNE stated that a nurse was essentially a teacher and an agent of health in whatever field nursing practice occurred. In 1998 the American Nurses Association (ANA) stated in the Standards of Clinical Nursing Practice that educating clients is a primary responsibility of nurses. The ANA continues its long-standing support for patient teaching as a primary component of nursing care. Today all state nurse practice acts in the United States include client teaching within the scope of nursing practice. Further support for the role of Nurse as Educator is found in the Patient's Bill of Rights, which was first adopted by the American Hospital Association (AHA) in 1973. The current bill was approved by the AHA board of trustees in 1992 and states that patients have the right to "relevant, current, and understandable information concerning diagnosis, treatment, and prognosis" (AHA, 1992, Right #2). The Joint Commission, the organization that accredits hospitals, revised its patient education standards to include follow-up treatment and services in 2009 (The Joint Commission, 2009). Many practicing nurses and nurse educators support client education as an essential role for nurses (Bastable & Alt, 2014; Pender, 2011; Redman, 2006).

Just as important as educating clients, nurses also have a professional responsibility to educate colleagues and health team members. The health care environment changes rapidly and requires colleagues and team members to stay current in their knowledge and skills. Nursing team members have differing levels of education and training and may require additional education. The Nurse as Educator is often the primary educator and resource for the team (Donner, Levonian, & Slutsky, 2005). Lifelong learning is essential for those in the healthcare professions and requires all providers to stay current with their knowledge and skills.

Nurses coordinate client health education because they are the healthcare providers who have the most continuous contact with clients. Nurses are with clients at teachable moments and do much of the health education. As a nurse, your educational background in anatomy, physiology, nutrition, psychology, sociology, anthropology, and other social and physical sciences enhances your role as

an educator. Your education has taught you how the body can and should function and about the interplay among mind, body, and spirit. Your understanding of the importance of using current research helps you assist clients in choosing and maintaining healthy behaviors.

Nurses have earned the public's trust, and by modeling healthy habits, they are more believable when they teach. Clients are entering the healthcare system better informed about health issues. This means they will be demanding more knowledgeable caregivers, and they expect to be provided with current, sound information. Many clients have done considerable reading about their particular health problem and consequently ask informed, sophisticated questions. Your credibility will be established by your answers and ability to access information.

CLIENT AS LEARNER

We chose the word *client* to describe the learner in this text because the client is the consumer of health education and is the focus of our teaching efforts. We define clients as individuals, families, groups and communities, and health team members, which covers the scope of humanity. Clients are everywhere and include everyone in need of health information. The word *client* connotes someone who is free to come and go from your presence; someone who is free to accept or refuse the services, counsel, and teaching that nurses offer. We view clients as responsible, thinking individuals who have the right to make choices about their health.

Contrast the view of the client with the view of the individual as a patient. When examined from this perspective, we think of individuals who must depend on nurses for their care and sometimes for their very survival. The term *patient* conjures up an image of someone who is dependent and in need of physical or psychological assistance related to health. A patient is in your presence—on your nursing unit or in your service area—and needs the health education that nurses can deliver.

Clients bring their individual and collective perceptions of what optimal health is to the Nurse–Client Relationship. Perceptions are influenced by their expectations, emotions, and needs. Perceptions about health are determined individually, culturally, environmentally, and socially. Clients' perceptions may not always be the same as nurses' perceptions. In the client education context, we perceive clients as active participants in health education to the extent of their ability and choice.

NURSE–CLIENT RELATIONSHIP

Between the Nurse as Educator and Client as Learner is the Nurse–Client Relationship. This is the participants' point of contact where the environment between them is created. The Nurse–Client Relationship is built upon the embedded concepts of Cultural Caring, Communication, Negotiation, and Collaboration. These concepts more fully describe the context in which interactions occur within the model. We call them embedded because they permeate the environment in which health education occurs. The concepts are readily understandable and essential to the process of teaching clients.

The Nurse as Educator uses skills in Cultural Caring to be sensitive to clients' needs in all aspects of the model. Cultural Caring is manifest in all verbal and nonverbal Communication in teaching clients. Through Communication we get an understanding of what clients need to learn and how best to structure the teaching, which in itself is a process of Negotiation. To achieve successful

outcomes, it is often necessary to Collaborate with others, including the client’s family and other health professionals. The embedded concepts are part of the process of creating an environment that supports successful client outcomes.

The Nurse–Client Relationship is therapeutic, promoting a psychological environment that facilitates positive change and growth. This aspect of the model is drawn from Hildegard Peplau’s interpersonal nursing theory (1952) that stressed the importance of the therapeutic interpersonal process. Therapeutic communication between the Nurse as Educator and the Client as Learner is collaborative and focuses on the achievement of health education goals. It focuses on the client achieving optimal personal growth and the highest level of wellness possible given the client’s situation. An explicit time frame, a goal-directed approach, and the expectation of confidentiality are important to the relationship. The nurse establishes, directs, and takes responsibility for the interaction where the clients’ needs take priority over nurses’ needs.

Four goal-directed phases characterize the Nurse–Client Relationship. The preinteraction phase occurs before meeting the client and involves gathering all available client information. This gives the nurse time to anticipate health concerns and plan for the initial interaction. The orientation phase occurs when the Nurse as Educator meets the Client as Learner and they get to know one another. The working phase occurs when the Nurse as Educator engages in health teaching and works with the client to solve problems and accomplish goals. Last is the termination phase, which is the process of ending the relationship (Potter & Perry, 2009).

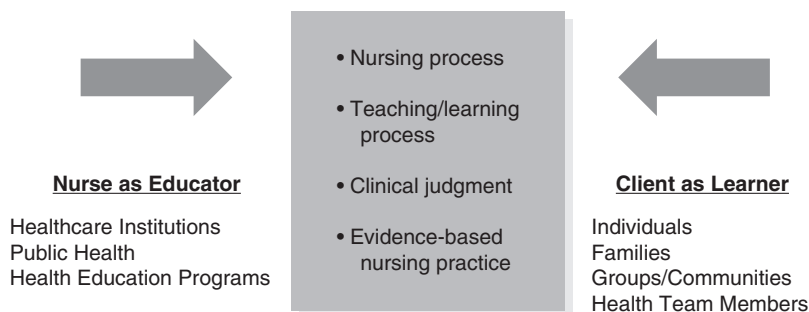
The components that shape the environment of the Nurse–Client Relationship are the Nursing Process, the Teaching and Learning Process, Clinical Judgment, and Evidence-Based Nursing Practice (EBNP). We describe each in order (**Figure 1-2**).

Nursing Process

The Nursing Process is a variation of the scientific reasoning process that allows you to organize your thoughts and systematize nursing practice. Its focus is to address client problems in professional practice in a variety of clinical settings. Steps in the nursing process include assessment, analysis, planning, implementation, and evaluation. Applied to health education, the steps of the nursing

FIGURE 1-2

Nurse–Client Relationship in the Miller–Stoeckel Client Education Model



process relate directly to the learning needs of clients that are designed to improve clients' health knowledge and promote, retain, and restore health.

The steps of the Nursing Process are iterative because they may overlap or occur simultaneously. Reassessment, reordering of priorities, new goal setting, and revising the client education plan continue as part of the process toward attainment of the health education goals. A discussion of the steps of the nursing process as they apply to health education follows.

Assessment

Assessment is gathering the essential information about the client to identify health education needs. As you assess the physiologic, psychological, sociocultural, developmental, and spiritual influences on each client, it helps to determine each individual's learning style and learning capacity. Assessment includes collecting subjective and objective client data, recording the data, and noting the data that affect learning. Subjective data include clients' perceptions of their condition and health status. How does the client view his or her situation? How does the client view his or her health? Is the client's situation conducive or obstructive to learning? Does the client show a readiness to learn? Do you have the requisite knowledge, skills, and attitudes to facilitate each client's learning in the situation at hand?

Analysis

The second step, analysis, is a careful examination and validation of the facts to identify the client's specific health education needs. When possible, you will collaborate with clients to diagnose their learning needs. A clear understanding of these needs becomes the basis for planning, implementing, and evaluating the client education plan. This step includes analyzing both your perceptions and your clients' perceptions of the learning needs to validate them. Assessing and analyzing needs also includes determining the kind of learning clients want. For instance, in which domain are your clients deficient? Do they lack information? What do they want to know? Do they lack necessary skills? Is their developmental level a barrier to learning? Do they display attitudes that impair their optimum functioning?

When your client is a specific population, your assessment becomes complex. You may need to conduct a survey as part of the assessment. Another option is to form a focus group composed of individuals who are representative of the large group you are teaching. For smaller groups, interviewing selected members of the group may serve your purpose just as well. In all instances, it is important to avoid making assumptions about what clients need to learn. Ask them and be as thorough in your assessment and analysis as possible.

Another way to approach clients is from the perspective of potential growth. What information do they desire? What new skills do they wish to learn? What opportunities for growth are inherent in their developmental stages? What attitudes are they ready to exhibit? What attitudes do they already possess that could motivate further growth? What strengths of mind, body, and spirit do they manifest that can help them in the inevitable transitions of life?

A nursing diagnosis identifies the human response to the disease process. Standard classifications of nursing diagnosis used to identify dysfunctional patterns include North American Nursing Diagnosis Association (NANDA), Nursing Interventions Classification (NIC), and Nursing Outcomes Classification (NOC) (McFarland & McFarland, 1997). These diagnoses are applicable to health education.

Planning

Planning, the third step of the Nursing Process, is the development of the client education plan. In this step you will outline the learning objectives based on the assessment and analysis of the findings. It involves identifying specific learning objectives and educational outcomes, establishing priorities, and selecting teaching strategies to achieve the outcomes. Planning is deciding what needs to be learned and what strategies and materials will most likely facilitate achievement of the learning objectives. Once these are selected, a written client education plan is devised.

The planning step should involve clients and their families when appropriate. For example, if your client has Alzheimer’s disease, then significant others, such as caregivers, a spouse, or family members, must be included in the formation of plans. It is important to get feedback during the planning process about what is to be learned and how this is to be accomplished to discover if you and the client are in accord.

Implementation

Implementing the plan involves acting to accomplish the learning objectives and educational outcomes. You and your clients will carry out the actions that are most likely to facilitate the desired learning. During this step you will need to elicit periodic feedback and stay attuned to behavioral clues that indicate clients’ feelings of success or failure. You will use a variety of teaching strategies and instructional materials to facilitate client learning. Ongoing reassessment and continued analysis are part of implementation and involve adapting to feedback as you enact the plan. Note the client’s responses to your teaching and modify your approach as needed. Last, it is important to document the health education that you provide.

Evaluation

The evaluation phase is the final step of the Nursing Process. This is where you and your clients evaluate teaching effectiveness. Did the clients learn what was expected? Is their behavior more conducive to good health? Has the client’s level of wellness improved? Are the problems with which clients needed help diminished, or are they coping with their problems more effectively? Two-way communication with clients helps you to summarize and interpret results.

Although evaluation is presented as the final step of the Nursing Process, evaluation takes place throughout the Teaching and Learning Process. During the assessment phase, for instance, while identifying how clients perceive their problems, you will evaluate how well you communicated. Did you understand what the clients conveyed? To find out, repeat back your interpretation of what they said. Did clients indicate that they were understood correctly? Did clients indicate that your words and actions made sense to them? Such transactions are ongoing throughout each step of the Nursing Process. Evaluation involves determining the overall quality of health education.

Some suggest that the Nursing Process contributes to linear thinking. Chitty and Black state that “the nursing process can be taught, learned, and used in a rigid, mechanistic and linear manner” (2007, p. 194). However, we believe it can be used as a creative approach to health education by attending to feedback throughout the process. The Nursing Process used in health education is ongoing, with constant evaluation and reassessment to meet the ongoing learning needs of clients.

Teaching and Learning Process

The Teaching and Learning Process is the next component of the Nurse–Client Relationship. The process of teaching and learning means to engage with others to acquire new knowledge, behaviors, and skills. Nurses as Educators use “planned learning experiences based on sound theories that provide individuals, groups and communities the opportunity to acquire the information they need to make quality health decisions” (Wurzbach, 2004, p. 6). Learning is a process by which behavior changes as a result of experiences (Ormrod, 2012). In teaching, the Nurse as Educator chooses teaching strategies and selects instructional materials to assist the Client as Learner to make behavioral changes that promote, retain, and restore health.

Learning theories guide teaching practices. They are the foundation of the Teaching and Learning Process. Some learning theories are more applicable than others, depending on the teacher, the client, and the learning context. You will be introduced to behavioral, cognitive, and social theories of learning as they apply to learners at all ages. Learning theories are important and provide the foundation that guides you as educator. Together the Teaching and Learning Process and the Nursing Process provide a holistic approach to address clients’ health education needs.

Clinical Judgment

The third component in the Nurse–Client Relationship is the exercise of sound Clinical Judgment during teaching and learning. Clinical Judgment in nursing is the outcome of clinical reasoning, often referred to as clinical decision making. It is a characteristic way of thinking in the nursing discipline. You exercise Clinical Judgment as you assess clients, develop client education plans, select teaching strategies and instructional materials, and evaluate the success of your efforts. Your judgments and decisions impact the outcome of health education.

Some nursing educators believe that critical thinking is “the brain’s tool for developing the expert nursing judgment needed to improve patient outcomes” (Scheffer & Rubenfeld, 2006, p. 195). Others believe that forming clinical judgments in the delivery of nursing care is distinct from general critical thinking skills (Tanner, 2005). Regardless, it is essential for nurses to exercise sound Clinical Judgment in the Teaching and Learning Process.

The Teaching and Learning and Nursing Processes provide the structural framework through which Clinical Judgment and clinical reasoning occur. Nurses engage in a variety of thinking patterns because no single pattern characterizes all situations. Tanner (2006) proposed a model with four aspects describing how nurses reason in the clinical area that is applicable to health education situations. The first aspect is noticing, whereby the nurse grasps the situation at hand. The second is interpreting, whereby the nurse develops an understanding of the situation. The third is responding, whereby the nurse decides on an appropriate course of action. The fourth is reflecting, whereby the nurse evaluates the effectiveness of the outcomes. These thinking and reasoning patterns occur within each step of the Teaching and Learning Process and Nursing Process to guide the nurse in the formation of Clinical Judgments related to health education.

Clinical Judgment in nursing develops as nurses gain experience and expertise in a practice area and expand their knowledge, moving from being a novice to being an expert. To become an expert in nursing, a beginning nurse passes through five levels of proficiency: novice, advanced beginner, competent, proficient, and expert (Benner, 1984). The novice has no experience in a situation, relies on rules, and is inflexible. The advanced beginner has more experience and has marginally acceptable performance. The competent nurse has 2 to 3 years of experience in similar

situations and brings perspective, abstract, and analytic thinking to problem solving. The proficient nurse sees situations as wholes rather than specific aspects and has learned from past experience what to expect in situations and what to do when things do not go as expected. The expert nurse has a deep understanding and intuitive grasp of situations and no longer needs rules or guidelines. This nurse sees the totality of situations and quickly identifies the nature of the problem and how to solve it. These skill levels apply not only to the delivery of nursing care but also to the delivery of health education.

Evidence-Based Nursing Practice

The last component of the Nurse–Client Relationship is EBNP as it relates to health education. EBNP is the use of current best practices in making decisions about patient care by using a problem-solving approach. This approach incorporates a systematic search for evidence, clinical expertise, and patient preferences and values (Melnik & Fineout-Overholt, 2004). It is the act of applying current research findings to clinical practice. Applying research to health education is an integral part of the Miller–Stoeckel Client Education Model. It means using the best available and most pertinent research to make health education decisions.

The history of evidence-based research goes back to Dr. Archie Cochrane, an English physician who, in 1972, confronted healthcare professionals about the lack of randomized control studies to support medical practice decisions. Because of his influence, the first electronic database of clinical trials was established in 1988. First called the Oxford Database of Prenatal Trials, it later became The Cochrane Collaboration (Bliss-Holtz, 2007). The Cochrane Collaboration is now an international database that disseminates research worldwide.

The concept of evidence-based practice was embraced by nursing and other healthcare professions in the 1990s. The motivation behind this decision was the realization that many healthcare practices were based on intuition, experience, clinical skills, and guesswork rather than science. EBNP uses a research-based decision-making process to guide the delivery of holistic client-centered nursing care and health education. The specific steps involved in carrying out EBNP include defining the problem and searching for evidence, critically appraising the evidence, applying the findings to practice, taking into account the client–learner’s values and preferences, and then evaluating outcomes.

Although EBNP is accepted as a means of promoting best practices, differences of opinion exist among nurses regarding what types of studies constitute the strongest evidence and what weight to give them. The terms *levels of evidence* and *strength of evidence* refer to systems for classifying the evidence in a body of literature through a hierarchy of scientific rigor and quality. Several dozen of these hierarchies exist (Agency for Healthcare Research and Quality, 2002). The reviewers must select the most relevant levels of evidence to meet their needs. The following concise definitions of terms are used in describing the levels of evidence.

- Meta-analysis is a statistical analysis of a collection of quantitative studies.
- Systematic review is a research summary that searches the literature and critically appraises individual quantitative studies to identify valid, applicable evidence.
- Randomized controlled trial is a study in which subjects are randomly assigned to groups; one receives the intervention, and the other is a control group.
- Quasi-experimental design is a modification of an experimental design in which there may not be manipulation of the independent variable, random assignment, or control group.

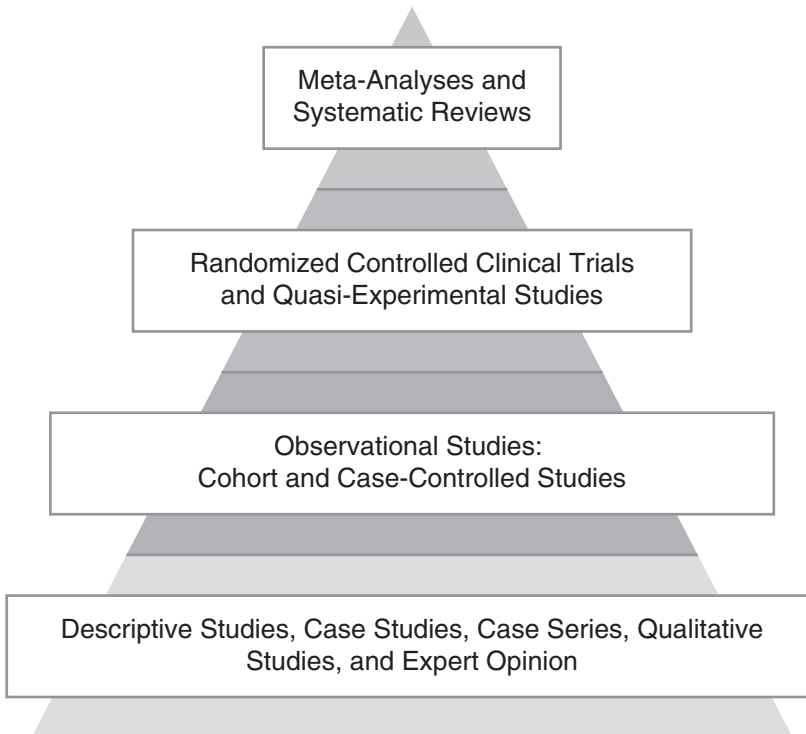
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- Observational study is a study in which researchers have no control; instead, they observe what happens to groups of people.
- Case study (case report, single case report) is an uncontrolled observational study involving an intervention and outcome in a single situation.
- Descriptive study is a statistical study to identify patterns or trends in a situation, but not cause and effect.
- Cohort study is a study that involves the selection of a large population of people who have the same condition, who receive a specific intervention, and who are followed over time and compared with a group that is not affected by the condition.
- Case-controlled study is a study that compares two groups of people: those with the condition, and a similar group without the condition. It is also called a retrospective study.
- Expert opinion is a judgment by people who have experience with a particular subject.
- Qualitative study is a study focused on subjective experiences in naturalistic settings rather than under experimental conditions. There are different types of qualitative studies.

A diagram of the hierarchy of research evidence is included in **Figure 1-3**. It illustrates a research hierarchy in which the lowest tier includes the descriptive studies, case studies, case series,

FIGURE 1-3

Levels of Evidence in Research



qualitative studies, and expert opinion. The highest tier includes meta-analyses and systematic reviews. Research at this tier has a greater chance of being generalized to a group of clients.

Nurses as Educators should rely on substantiated, critically critiqued research to ensure that the most current health education practices and teaching strategies are provided to clients. Nurses as Educators need a core foundation of health information that reflects quality care and best teaching practices supported by current research. More research is needed on the effectiveness of various teaching strategies and instructional materials for different populations. In addition to using the best available evidence, nurses are called on to exercise their best judgment in clinical and health education situations.

Interrelatedness of the Components in the Nurse–Client Relationship

The components in the Nurse–Client Relationship (Nursing Process, Teaching and Learning Process, Clinical Judgment, and EBNP) are interacting and interdependent. The components complement one another. During assessment and analysis, the client’s learning needs are assessed and analyzed to determine the extent of the client’s need for health education. In this step, the nurse grasps the client’s situation. It may involve looking for applicable literature specific to the client’s situation or a group’s health education needs.

Planning involves developing individualized care plans drawn from EBNP and setting priorities and learning objectives based on client health education needs. The nurse develops sufficient understanding of the situation and responds by involving the client in designing the client education plan.

Implementation is carrying out the client education plan. The nurse takes action and responds based on EBNP where it exists but also reflects on client responses. Using judgment, the nurse is prepared to alter the client education plan if necessary. The nurse uses judgment in selecting teaching strategies and instructional materials to meet the client’s health education needs and preferences.

Evaluation reviews the successes and failures in meeting the learning objectives of the client education plan. Teaching strategies may need to be modified to achieve the objectives. The nurse continually reviews the literature to update the client education plan using current EBNP where available. The client’s achievement of the learning objectives is measured and reinforced to help ensure continued success.

The Nurse–Client Relationship is at the heart of the Miller–Stoeckel Client Education Model. To initiate the process, the Nurse as Educator should ask specific questions that guide the process. For example, how am I using the nursing process to initiate and follow through with teaching clients? What are the teaching and learning principles I am using? How am I using clinical judgment in assessing clients and designing and implementing client education? And what research that is evidence-based supports my decisions?

The interrelatedness of the Nursing Process, Teaching and Learning Process, Clinical Judgment, and EBNP components is illustrated in **Table 1-1**.

CLIENT EDUCATION OUTCOMES

Client Education Outcomes are achieved when health-promoting changes in knowledge, attitudes, and skills occur in clients. The last portion of the Miller–Stoeckel Client Education Model focuses on evaluation. To determine if health education efforts are successful, nurses must evaluate the

TABLE 1-1**Interrelatedness of the Nurse–Client Relationship Components**

<i>Nursing Process</i>	<i>Teaching–Learning Process</i>	<i>Clinical Judgment</i>	<i>EBNP Process</i>
Assessment and analysis	Determine learning needs	Noticing	Define problem and search literature
Planning	Develop client education plan	Interpreting	Appraise research findings
Implementation	Use teaching strategies	Responding	Apply to clinical situation
Evaluation	Determine behavior change	Reflecting	Assess the outcomes

TABLE 1-2**Client Education Outcomes**

<i>Formative Evaluation</i>	<i>Summative Evaluation</i>
Evaluation of the client education plan	Evaluation of client learning
Evaluation of the learning environment	Evaluation of educational effectiveness
Evaluation of the nurse–client interaction	Evaluation of learning into daily living

results. Evaluation of client education outcomes is measuring the degree to which the learning objectives are met.

Evaluation is important to clients and educators because it informs them about their progress and the effectiveness of the Teaching and Learning Process. The Miller–Stoeckel Client Education Model addresses both Formative Evaluation and Summative Evaluation. Both are essential aspects of evaluation that provide a holistic picture of what was achieved (**Table 1-2**).

Formative Evaluation is ongoing during teaching and learning activities. It is important to know if the learning activities are meeting the learning objectives as teaching is progressing. If weaknesses are identified, they can be changed right away. Formative Evaluation addresses three areas: evaluation of the client education plan, evaluation of the learning environment, and evaluation of the nurse–client interaction. The involvement of the Client as Learner and Nurse as Educator is essential to the process.

In Formative Evaluation, evaluation of the client education plan is done by considering concept comprehension and client motivation. The learning environment is evaluated by assessing the effectiveness of the delivery format and the use of technology. The nurse–client interaction is evaluated by determining the level of client engagement and communication. These components of Formative Evaluation seek to answer the question, how are we doing?

Summative Evaluation occurs at the conclusion of the Teaching and Learning Process. It is directed toward measuring the degree to which the learning objectives and overall outcomes are

met at the conclusion of the learning activity or program. It addresses three areas: evaluation of client learning, evaluation of educational effectiveness, and evaluation of integration of learning into daily living.

Measurement of learning occurs not only at the conclusion of individual learning activities and programs, but it also involves long-term follow-up of client learning. Results of systematically conducted long-term evaluations are important from an EBNP perspective. Findings from EBNP can serve to guide future health education practices. Summative Evaluation is directed toward outcomes that determine whether clients have learned and if the activities and programs are feasible to continue in the future. Determining feasibility includes examining the effectiveness of learning materials, the costs, the time requirements, the degree of client satisfaction, and the long-term benefits of programs. Basically, Summative Evaluation asks the question, how did we do?

DEFINITIONS

The following definitions support the Miller–Stoeckel Client Education Model and will broaden your understanding of health education. The most important terms to understand are health education, health, illness, Stoeckel Wellness–Illness Functional Continuum, and Health Belief and Health Promotion Models.

Health Education

Health education enhances the quality of life for people worldwide. It is defined broadly by Green and Kreuter (1991) as any combination of learning experiences designed to encourage voluntary actions that are beneficial to health. Health education is achieved through the use of learning theories combined with teaching strategies to help individuals, families, groups and communities, and health team members to promote, retain, and restore health. It not only involves providing relevant health information, but it also helps clients make appropriate health-related behavioral changes. The term *health education* also refers to the process of educating health team members to become more effective in their roles and responsibilities.

Health

Health, as defined by the World Health Organization in 1948, is “a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity” (2004). Health is a dynamic state in which individuals adapt to changes in the internal and external environments to maintain a state of well-being in all life dimensions. This is the most popular and comprehensive definition of health worldwide, and it is applicable to individuals, families, groups, and communities. Clients bring their own definitions and perceptions of health to clinical situations. Their perceptions of what is and is not normal health influence their willingness to accept health education teaching.

Illness

Illness is a subjective perception of not being well. It is a mismatch between an individual’s needs and his or her ability to meet those needs. It signals that the present balance to maintain health is not working. During illness, changes may occur in the structure and function of a person’s body and

mind. Illness has a classifiable set of signs and symptoms resulting from disturbed body functioning. These are associated with characteristic preclinical findings, course, and etiology.

Stoeckel Wellness–Illness Functional Continuum

An individual's level of health is a constantly changing state that moves along a continuum from optimal functioning to a state of total disability. The basic premise of the Stoeckel Wellness–Illness Functional Continuum is that wellness and illness involve a variety of factors: social, physiologic, environmental, emotional, activities of daily living, and health access. The factors in the model can either enhance or distract from the client's health. Disease and illness are a failure of an individual's adaptive mechanisms to adequately counteract changes in functional and structural disturbances. Factors are displayed along a continuum showing incremental increases or decreases in health functioning. Each factor is plotted on the continuum moving from the center (score of 5 is neutral) toward the right (highest score of 10 indicates highest level of wellness) or left (lowest score of 0 indicates lowest level of wellness) and shows changes in the state of health. High-level functioning or wellness involves increased ability to perform the activities of daily living. Low-level functioning is brought on by illness or disability, resulting in the decreased ability to perform activities of daily living.

This continuum is useful when working with clients to get a holistic picture of their functioning. Clients can place themselves on each factor's continuum to identify their strengths and weaknesses. Each person is unique, with different degrees of wellness and illness. Plotting the continuum for each factor helps the Nurse as Educator determine clients' health perceptions and needs. By using the Stoeckel Wellness–Illness Functional Continuum as an assessment tool when working with clients, you gain a more accurate picture of how the client perceives his or her state of health. The continuum can also be used to compare a client's previous level of health with the present level, but because of its subjective nature, it cannot be used to compare one client with another. The continuum illustrates the dynamic, ever changing state of health (**Figure 1-4**).

Health Belief and Health Promotion Models

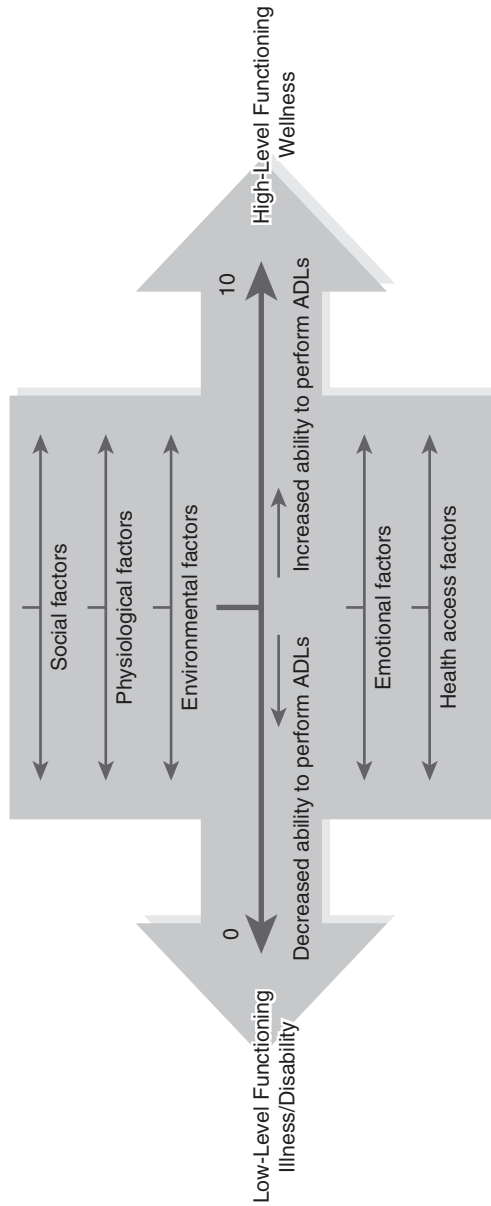
The Health Belief Model (Rosenstock, 1974) was developed in the 1950s to explain why people did not use preventive health services such as immunizations. The model examines the relationship between a client's beliefs and behaviors, and it helps nurses understand these factors to plan teaching that effectively assists clients in promoting, retaining, and restoring health. An important assumption of this model is that the nurse collaborates with the client to reach mutually agreed-upon goals by understanding the factors that influence health beliefs. The Health Belief Model identifies the following factors that influence health beliefs:

- Personal expectations regarding health and illness
- Perception of the seriousness of the illness
- Likelihood of following prescribed healthcare measures
- Perceived barriers related to such factors as cost, inconvenience, or pain

A criticism of the Health Belief Model is that it is based on the Western cultural health belief system and does not allow for other influences or for the fact that clients do not always act on their belief system. Our approach, shown in **Table 1-3**, uses the basic format of the model, but it includes questions that address the cultural aspects of client teaching. Our approach is a starting point for examining client decision making concerning health education and can be used to develop client

FIGURE 1-4

Stoeckel Wellness-Illness Functional Continuum



Factors That Affect Health Status: (plot status on each continuum)

- *Social factors* include support system, family, friends, work associates
- *Physiological factors* include genetic issues, disease, developmental issues
- *Environmental factors* include lifestyle, community, housing, pollution, safety
- *Emotional factors* include spiritual, adaption to changes, mental status, attitude
- *Health access factors* include insurance availability, financial, physical access

TABLE 1-3**Health Belief Model: Perceptions**

<i>Client Perceptions</i>	<i>Nursing Application</i>
Need for care	<ul style="list-style-type: none"> • Clarifies client concerns and reasons for seeking treatment • Explores client experiences with health issues, past and present • Asks about family and cultural factors affecting client perceptions
Seriousness and consequences of condition	<ul style="list-style-type: none"> • Clarifies client perceptions of harm that the condition can cause • Clarifies client perceptions of consequences without treatment • Answers questions and clarifies prognosis; describes experiences with similar problems • Explores common and different beliefs and values
Value of health intervention	<ul style="list-style-type: none"> • Discusses treatment client is seeking • Describes treatment: medical treatment, behavior change (lifestyle), medication (side effects), costs, answers questions, and so forth • Clarifies client perceptions of treatment
Effectiveness, cost, and barriers of treatment	<ul style="list-style-type: none"> • Prepares goals and timeline for client and nurse responsibilities • Sets ground rules and boundaries for nurse–client relationship • Outlines knowledge and skills for client and nurse • Suggests and provides resources for knowledge and skill development • Clarifies client understanding of proposed plan

Data from Rankin, S. H., Stallings, K. D., & London, F. (2005). *Patient education in health and illness* (5th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

education plans. It is important for the nurse to understand client perceptions about health and the likelihood of adhering to health recommendations. This involves examining beliefs through a cultural lens. Communication is targeted at clarifying the nurse's and the client's perceptions and beliefs. Based on this information, nurses use those strategies that are most effective to meet client health education needs.

Nola Pender's health promotion model (2011) assists nurses in understanding the major determinants of health behaviors as a basis for behavioral counseling to promote healthy lifestyles. Her theory encourages health educators to look at variables that have been shown to impact health behavior. The model uses research findings from nursing, psychology, and public health to understand client health behaviors. This model can be used as a foundation to structure nursing protocols and interventions. This will be further discussed later in the text.

CONTEXT FOR HEALTH EDUCATION

Nurses play a vital role in improving health on a local, national, and global scale. Nurses, in partnership with other healthcare professionals, facilitate delivery of health education in different venues to achieve positive client education outcomes. In this section we address the importance of the wider scope of health education. Nurses should be aware that individual health affects the larger community and eventually affects global health.

National Importance of Health Education

The 1979 surgeon general's report, *Healthy People*, laid the foundation for a national prevention agenda. Every 10 years since that time, the U.S. Department of Health and Human Services has provided science-based, 10-year national objectives for promoting health and preventing disease. *Healthy People 2000* and *2010* established national health objectives that serve as the basis for the development of state and community health initiatives. Currently, *Healthy People 2020* (U.S. Department of Health and Human Services, 2012) continues the tradition of improving the health of Americans by establishing benchmarks and monitoring progress over time to encourage collaboration across communities and sectors, empowering individuals toward making informed health decisions, and measuring the impact of prevention activities. *Healthy People 2020* contains about 1,200 objectives in 42 topic areas designed to serve as this decade's framework for improving the health of all people in the United States (**Box 1-1**). This information is available at <http://www.healthypeople.gov/2020/about/default.aspx> on a U.S. government website. Core objectives will remain centered on the prevention of illness and disease as the foundation of health.

Living in an Interactive and Interdependent Global Community

Maintaining health is a global concern. Health issues have global consequences that not only affect the people of developing nations but also the world community. Healthy, productive citizens are essential for global economic growth and security. Stable populations reduce pressures on global economies and the environment. Stable populations also reduce the number and risk of humanitarian crises. Programs to control the spread of infectious diseases reduce the threat of epidemics. With healthcare services placing ever-greater pressures on state and federal health budgets, the economic burden of disease, and the burden to individuals and families, is a cause of great concern for governments and healthcare systems. Health education not only affects the immediate recipients but also future generations that will benefit from improved health habits and efforts to prevent illness. Eventually improved health behavior will be ingrained when health education is widely available and an accepted part of health care. The prevention of illness and the promotion of health through the delivery of efficient and effective health education lie at the core of society's ability to affect health worldwide.

Future Challenges and Trends Facing Nurses as Educators

Future challenges in health care are difficult to predict, but current demographic and societal trends point to the increased need for Nurses as Educators. Demographic trends point to an increasing older population and a greater percentage of minority groups living in the United States that have

BOX 1-1

Healthy People 2020 Overarching Goals

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equality, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development, and healthy behaviors across all life stages.

unique health challenges. Societal trends show changes in social practices, such as cohabitation, acceptance of gay relationships, and more single-parent families. Other trends point to greater access to reliable information using technology, more reliance on alternative medicine, and more questioning of medical advice. Nurses as Educators must be aware of demographic and societal trends. They must adjust to these trends and incorporate the challenges they present into their health education practices.

It is important for nurses to expand their knowledge of health education, their leadership abilities, and their involvement in health policy development. More collaborative networks with other healthcare providers are needed that foster accountability. This collaboration should occur not only on the local level but also within the global community. Basing health education practices on research, demanding adherence to ethical standards, and promoting social justice are escalating challenges and trends. Doing it more, doing it better, and doing it with less are the future challenges (Breckon, Harvey, & Lancaster, 1998).

SUMMARY

This chapter introduces the Miller–Stoeckel Client Education Model. The model serves as the conceptual framework around which this text is organized and written. The four major concepts of Nurse as Educator, Client as Learner, Nurse–Client Relationship, and Client Education Outcomes were defined and explained, as were the four embedded concepts of Cultural Caring, Communication, Negotiation, and Collaboration.

The nature of the Nurse–Client Relationship involves the Nursing Process, the Teaching and Learning Process, Clinical Judgment, and EBNP. The model concludes with an examination of Client Education Outcomes that encompass Formative and Summative Evaluation. Finally, the future challenges and trends facing Nurses as Educators were discussed. In this section we examined how health education can impact health, illness, and wellness in the local, national, and global health arenas. In the subsequent chapters of this book, we delve into greater depth about all aspects of providing health education.

EXERCISES

Exercise I: Philosophy of Health Education

Purpose: Develop a philosophy of health education.

Directions: Working with a small group of colleagues, write your philosophy of health education. This will take time, thought, and discussion. Your philosophy statement should be about two to three pages in length. Include your beliefs about the following:

1. The value of health education as an aspect of comprehensive health care
2. Teaching and what it means
3. Learning and its place in the human experience
4. The role of the Nurse as Educator
5. The role of the Client as Learner
6. The relationship that should exist between the educator and the learner
7. The value of Client Education Outcomes

Exercise II: Apply the Miller–Stoeckel Client Education Model

Purpose: Gain experience using the model.

Directions: Select a client with whom you have worked who needs health education. Visualize how you could use the model to build a positive Nurse–Client Relationship and achieve the educational outcomes.

- How do you see your role as a nurse educator?
- How do you see your client as a learner?
- How can you use the nursing process to initiate and follow up with teaching your client?
- What teaching and learning principles can you use?
- How can you use clinical judgment to assess clients and design and implement client education?
- What research that is evidence-based supports your decisions?

Exercise III: Using the Stoeckel Wellness–Illness Continuum

Purpose: Self-analysis of wellness–illness state.

Directions: Chart and analyze your progress on the Stoeckel Wellness–Illness Continuum. Print a copy from the book to plot your score on, or write out your answers.

- Score each factor from 1–10: social, physiological, environmental, emotional, and health access.
- Make a summative statement about your overall health.
- Discuss in paragraph form how your personal beliefs, culture, and background affect your views of health, illness, and wellness.

Exercise IV: Ways to Promote Client Education

Purposes:

- Promote creative thinking.
- Raise consciousness regarding client education.

Directions: Form small groups and discuss the following situation. Take notes and prepare a report to be shared with the rest of your peers.

While carrying heavy patient care assignments and responsibilities, some nurses are managing to teach their clients in mutually satisfactory ways. What client teaching have you observed by your clinical instructors, supervisors, primary nurses, or other nursing personnel? What are you doing to promote client teaching? If you are not yet in the clinical area, seek out nurses in your school, hospital, or neighborhood and ask them what they are doing to promote health teaching. Draw on your experiences as a patient, client, relative, or observer. Upon reflection, summarize the nurses' role in client education.

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