PART ONE

Perspectives on Teaching and Learning

CHAPTER 1

Overview of Education in Health Care

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CHAPTER HIGHLIGHTS

- Historical Foundations for Patient Education in Health Care
- The Evolution of the Teaching Role of Nurses
- Social, Economic, and Political Trends Affecting Health Care
- Purposes, Goals, and Benefits of Patient and Nursing Staff/Student Education
- The Education Process Defined
- The Contemporary Role of the Nurse as Educator
  - *Interprofessional Education and Practice*
  - *Patient-Centered Care*
  - *Quality and Safety Education in Nursing*
  - *The Institute of Medicine Report: The Future of Nursing*
- Barriers to Teaching and Obstacles to Learning
  - *Factors Affecting the Ability to Teach*
  - *Factors Affecting the Ability to Learn*
- Questions to Be Asked About Teaching and Learning
- State of the Evidence

KEY TERMS

barriers to teaching
education process
interprofessional education (IPE)
interprofessional practice
learning
obstacles to learning
patient education
patient-centered care (PCC)
staff education
teaching and instruction

OBJECTIVES

After completing this chapter, the reader will be able to:

1. Discuss the evolution of patient education in health care and the teaching role of nurses.
2. Recognize trends affecting the healthcare system in general and nursing practice in particular.
3. Identify the purposes, goals, and benefits of patient and nursing staff/student education.
4. Compare the education process to the nursing process.
5. Define the terms *education process*, *teaching*, and *learning*.
6. Identify why patient and staff/student education is an important duty for nurses.
7. Analyze the significance of interprofessional education (IPE) and interprofessional practice to the delivery of patient care.
8. Explain why the patient-centered care (PCC) movement is an important trend in health care.
9. Discuss the barriers to teaching and the obstacles to learning.
10. Formulate questions that nurses in the role of educator should ask about the teaching–learning process.

Education in health care today—both patient education and nursing staff/student education—is a topic of utmost interest to nurses in every setting in which they practice. Teaching is an important aspect of the nurse's professional role (Andersson et al., 2015; McKenna et al., 2018; Steketee & Bate, 2013), whether it involves educating patients and their family members, colleagues, or nursing students. The current trends in health care are making it essential that patients be prepared to assume responsibility for self-care management and that nurses in the workplace be accountable for the delivery of safe, high-quality care (Dineen-Griffin et al., 2019; Lockhart, 2016; Shi & Singh, 2015; U.S. Department of Health and Human Services [USDHHS], 2015). The focus of modern health care is on outcomes that demonstrate the extent to which patients and their significant others have learned essential knowledge and skills for independent care or to which staff nurses and nursing students have acquired the up-to-date knowledge and skills needed to competently and confidently render care to the consumer in a variety of settings (Committee on Quality of Health Care in America & Institute of Medicine [IOM], 2001; Doyle et al., 2013; IOM, 2001; Salmond & Echevarria, 2017).

Patient education is an issue in nursing practice and will continue to be a significant focus in the healthcare environment (Friberg et al., 2012). Because so many changes are occurring in the healthcare system, nurses are increasingly finding themselves in challenging, constantly changing, and highly complex positions and, in some cases, do not have the appropriate skills to effectively teach patients (Gillespie & McFetridge, 2006; McKenna et al., 2018; Pollack, 2017; Vennum, 2017). Nurses in the role of educators must understand the forces, both historical and present day, that have influenced and continue to influence their responsibilities in practice.

One purpose of this chapter is to shed light on the historical evolution of patient education in health care and the nurse's role as teacher. Another purpose is to offer a perspective on the current trends in health care that make the teaching of clients a highly visible and required function of nursing care delivery. Also, this chapter addresses the continuing education efforts necessary to ensure ongoing practice competencies of nursing personnel.

In addition, this chapter clarifies the broad purposes, goals, and benefits of the teaching–learning process; focuses on the philosophy of the nurse–client partnership in teaching and learning; compares the education process to

the nursing process; stresses the importance of interprofessional education (IPE), interprofessional practice, and patient-centered care (PCC); identifies barriers to teaching and obstacles to learning; and highlights the status of research in the field of patient education as well as in the education of nursing staff and students. The focus is on the overall role of the nurse in teaching and learning, regardless of who the audience of learners might be. Nurses must have a basic prerequisite understanding of the principles and processes of teaching and learning to carry out their professional practice responsibilities with efficiency and effectiveness.

Historical Foundations for Patient Education in Health Care

"Patient education has been a part of health care since the first healer gave the first patient advice about treating his (or her) ailments" (May, 1999, p. 3). Although the term *patient education* was not specifically used, considerable efforts by the earliest healers to inform, encourage, and caution patients to follow appropriate hygienic and therapeutic measures occurred even in prehistoric times (Bartlett, 1986). Because these early healers—physicians, herbalists, midwives, and shamans—did not have a lot of effective diagnostic and treatment interventions, it is likely that education was, in fact, one of the most common interventions (Bartlett, 1986).

From the mid-1800s through the turn of the 20th century, described as the formative period by Bartlett (1986) and as the first phase in the development of organized health care by Dreeben (2010), several key factors influenced the growth of patient education. The emergence of nursing and other health professions, technological developments, the emphasis on the patient–caregiver relationship, the spread of tuberculosis and other communicable diseases, and the growing interest in the welfare of mothers and children all had an impact on patient education (Bartlett, 1986; Dreeben, 2010). In nursing, Florence Nightingale emerged as a resolute advocate of the educational responsibilities of district public health nurses and authored *Health Teaching in Towns and Villages*, which advocated for school teaching of health rules and health teaching in the home (Monterio, 1985).

Dreeben (2010) describes the first four decades of the 20th century as the second phase in the development of organized health care. In support of maternal and child health in the United States, the Division of Child Hygiene was established in New York City in 1908 (Bartlett, 1986). Under the auspices of this organization, public health nurses provided instruction to mothers of newborns in the Lower East Side on how to keep their infants healthy. Diagnostic tools, scientific discoveries, new vaccines and antibiotic medications, and effective surgery and treatment practices led to education programs in sanitation, immunization, prevention and treatment of infectious diseases, and a growth in the U.S. public health system. The National League of Nursing Education (NLNE) recognized that public health nurses were essential to the well-being of communities and the teaching they provided to individuals, families, and groups was considered "a precursor to modern patient and health education" (Dreeben, 2010, p. 11).

The third phase in the development of organized health care began after World War II. It was a time of significant scientific accomplishments and a profound change in the delivery system of health care (Dreeben, 2010). The late 1940s through the 1950s is described as a time when patient education continued to occur as part of clinical encounters, but often it was overshadowed by the increasingly technological orientation of health care (Bartlett, 1986). The first references in the literature to patient education began to appear in the early 1950s (Falvo, 2004). In 1953, Veterans Administration hospitals issued a technical bulletin titled *Patient Education and the Hospital Program*. This

bulletin identified the nature and scope of patient education and provided guidance to all hospital services involved in patient education (Veterans Administration, 1953).

In the 1960s and 1970s, patient education began to be seen as a specific task in which emphasis was placed on educating individual patients rather than providing general public health education. Developments during this time, such as the civil rights movement, the women's movement, and the consumer and self-help movement, all affected patient education (Bartlett, 1986; Nyswander, 1980; Rosen, 1977). In the 1960s, voluntary agencies and the U.S. Public Health Service funded several patient and family education projects dealing with congestive heart failure, stroke, cancer, and renal dialysis, and hospitals in a variety of states became involved in various education programs and projects (Rosen, 1971). By the mid-1960s, patients were recognized as healthcare consumers and society adopted the new perspective that health care was a right and not a privilege for all Americans. In 1965, the U.S. Congress passed Titles XVIII and XIX of the Social Security Act, which created, respectively, the Medicare and Medicaid plans to provide health care to indigent persons, older adults, and people with medical disabilities (Dreeben, 2010).

Concerned that patient education was being provided only occasionally and that patients were not routinely being given information that would allow them to participate in their own health care, the American Public Health Association formed a multidisciplinary Committee on Educational Tasks in Chronic Illness in 1968 that recommended a more formal approach to patient education (Rosen, 1971). One of the committee's seven basic premises was an educational prescription that would base teaching on individual patient needs and be included as part of the patient's record. This recommendation represented one of the earliest mentions of the documentation of patient education (Falvo, 2004). The committee ultimately developed a model that defined the educational processes necessary for patient and family education that could be used with any illness by any member of the healthcare team (Health Services and Mental Health Administration, 1972).

In 1971, two significant events occurred: (1) A publication from the U.S. Department of Health, Education, and Welfare, titled *The Need for Patient Education,* emphasized a concept of patient education that provided information about disease and treatment as well as teaching patients how to stay healthy, and (2) President Richard Nixon issued a message to Congress using the term *health education* (Falvo, 2004). Nixon later appointed the President's Committee on Health Education, which recommended that hospitals offer health education to families of patients (Bartlett, 1986; Weingarten, 1974). Although the terms *health education* and *patient education* were used interchangeably, this recommendation had a great impact on the future of patient education because a health education focal point was established in what was then the U.S. Department of Health, Education, and Welfare (Falvo, 2004).

Resulting from this committee's recommendations, the American Hospital Association (AHA) appointed a special committee on health education (Falvo, 2004). The AHA committee suggested that it was a responsibility of hospitals and other healthcare institutions to provide educational programs for patients and that all health professionals were to be included in patient education AHA, 1976). Also, the healthcare system began to pay more attention to patient rights and protections involving informed consent (Roter et al., 2001).

Also in the early 1970s, patient education was a significant part of the AHA's *Statement on a Patient's Bill of Rights*, affirmed in 1972 and then formally published in 1973 (AHA, 1973). This document outlines patients' rights to receive current information about their diagnosis, treatment, and prognosis in understandable terms, and information that enables them to make informed decisions about their

health care. The *Patient's Bill of Rights* also guarantees a patient's right to respectful and considerate care. The adoption of this bill of rights promoted additional growth in the concept of patient education, which reinforced the concept as a "patient right" and it being seen as an obligation and legal responsibility of health professionals. In addition, patient education was recognized as a condition of high-quality care and as a factor that could affect the efficiency of the healthcare system (Falvo, 2004). Furthermore, during the 1970s, insurance companies began to deal with issues surrounding patient education, because they saw how patient education could positively influence the costs of health care (Bartlett, 1986).

Further support for and validation of patient education as a right and the expectation of high-quality health care came in the 1976 edition of the *Accreditation Manual for Hospitals* published by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), now known as The Joint Commission (Falvo, 2004). This manual broadened the scope of patient education to include both outpatient and inpatient services and specified that criteria for patient education should be established. Patients had to receive information about their medical problem, prognosis, and treatment, and evidence had to be provided indicating that patients understood the information they were given (JCAHO, 1976).

In the 1980s and 1990s, national health education programs once again became popular as healthcare trends focused on disease prevention and health promotion. This evolution represented a logical response to the cost-containment efforts occurring in health care at that time (Dreeben, 2010). The USDHHS's *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*, issued in 1990 and building on the U.S. Surgeon General's *Healthy People* report of 1979, established important goals for national health promotion and disease prevention, which included establishing educational and community-based programs (USDHHS, 1990).

In addition, in recognition of the importance of patient education by nurses, The Joint Commission (TJC) established nursing standards for patient education as early as 1993. These standards, known as mandates, describe the type and level of care, treatment, and services that agencies or organizations must provide to receive accreditation. Required accreditation standards have provided the impetus for nursing service managers to emphasize unit-based clinical staff education activities for the improvement of nursing care interventions to achieve expected client outcomes (JCAHO, 2001). These standards required nurses to achieve positive outcomes of patient care through teaching activities that must be patient centered and family oriented. More recently, TJC expanded its expectations to include an interdisciplinary team approach in the provision of patient education, and evidence that patients and their significant others participate in care and decision making and understand what they have been taught. This requirement means that all healthcare providers must consider the literacy level, educational background, language skills, and culture of every client during the education process (Cipriano, 2007; Davidhizar & Brownson, 1999; JCAHO, 2001).

In the mid-1990s, the Pew Health Professions Commission (1995), influenced by the dramatic changes surrounding health care, published a broad set of competencies it believed would mark the success of the health professions in the 21st century. Shortly thereafter, the commission released a fourth report as a follow-up on health professional practice in the new millennium (Pew Health Professions Commission, 1998). This report offered recommendations pertinent to the scope and training of all health professional groups, as well as a new set of competencies for the 21st century. Many of the competencies deal with the teaching role of health professionals, including nurses. These competencies for the practice of health care include the need for all health professionals to do the following:

- Embrace a personal ethic of social responsibility and service.
- Provide evidence-based, clinically competent care.
- Incorporate the multiple determinants of health in clinical care.
- Rigorously practice preventive health care.
- Improve access to health care for those with unmet health needs.
- Practice relationship-centered care with individuals and families.
- Provide culturally sensitive care to a diverse society.
- Use communication and information technology effectively and appropriately.
- Continue to learn and help others learn.

For the 21st century, the Institute for Healthcare Improvement announced the 5 Million Lives campaign in 2006. This campaign's objective was to reduce the 15 million incidents of medical harm that occur in U.S. hospitals each year. Such an ambitious campaign has major implications for teaching patients and their families as well as teaching staff and students the ways they can improve care to reduce injuries, save lives, and decrease costs of health care (Proctor, 2007).

Another initiative was the formation of the Sullivan Alliance to recruit and educate health professionals, including nurses, to deliver culturally competent care to the public they serve. Effective health care and health education of patients and their families depend on a sound scientific base and cultural awareness in an increasingly diverse society. This organization's goal is to increase the racial and cultural mix of health professional faculty, students, and staff, who are sensitive to the needs of clients of diverse backgrounds (Sullivan & Bristow, 2007).

In addition, following on the heels of *Healthy People 2000, Healthy People 2010* built on the previous two initiatives and provided an expanded framework for health prevention for the nation (USDHHS, 2000). Specific goals and objectives included the development of effective health education programs to assist individuals to recognize and change risk behaviors, to adopt or maintain healthy practices, and to make appropriate use of available services for health care (USDHHS, 2010). As the latest iteration of the *Healthy People* initiative, *Healthy People 2030* is the product of an extensive evaluation process by stakeholders. Its 63 objectives support building a healthy future for all people using five topic areas: health conditions, health behaviors, populations, settings and system, and social determinants of health (USDHHS, 2020). Patient education is a fundamental component of these far-reaching national initiatives.

Thus, since the 1980s, the role of the nurse as educator has undergone a paradigm shift, evolving from what once was a disease-oriented approach to a more prevention-oriented approach. In other words, the focus is on teaching for the promotion and maintenance of health (Roter et al., 2001). Education, which was once performed as part of discharge planning at the end of hospitalization, has expanded to become part of a comprehensive plan of care that occurs across the continuum of the healthcare delivery process (Davidhizar & Brownson, 1999).

As described by Grueninger (1995), this transition toward wellness entails a progression "from disease-oriented patient education (DOPE) to prevention-oriented patient education (POPE) to ultimately become health-oriented patient education (HOPE)" (p. 53). Instead of the traditional aim of simply imparting information, the emphasis is now on empowering patients to use their potentials, abilities, and resources to the fullest (Glanville, 2000; Kelliher, 2013). Along with supporting patient empowerment, nurses must be mindful to continue to ensure the protection of "patient voice" and the therapeutic relationship in patient education against the backdrop of ever-increasing productivity expectations and time constraints (Liu et al., 2016; Roter et al., 2001).

The Evolution of the Teaching Role of Nurses

Nursing is unique among the health professions in that patient education has long been considered a major component of standard care given by nurses. Since the mid-1800s, when nursing was first acknowledged as a unique discipline, the responsibility for teaching has been recognized as an important role of nurses as caregivers. The focus of nurses' teaching efforts is on the care of the sick and promoting the health of the well public.

Florence Nightingale, the founder of modern nursing, was the ultimate educator. Not only did she develop the first school of nursing, but she also devoted a large portion of her career to teaching nurses, physicians, and health officials about the importance of proper conditions in hospitals and homes to improve the health of people. Nightingale also emphasized the importance of teaching patients the need for adequate nutrition, fresh air, exercise, and personal hygiene to improve their well-being. By the early 1900s, public health nurses in the United States clearly understood the significance of the role of the nurse as teacher in preventing disease and in maintaining the health of society (Chachkes & Christ, 1996; Dreeben, 2010).

For decades, then, patient teaching has been recognized as an independent nursing function. Nurses have always educated others—patients, families, colleagues, and nursing students. It is from these roots that nurses have expanded their practice to include the broader concepts of health and illness (Glanville, 2000).

As early as 1918, the NLNE in the United States, now known as the National League for Nursing (NLN), observed the importance of health teaching as a function within the scope of nursing practice. Two decades later, this organization recognized nurses as agents for the promotion of health and the prevention of illness in all settings in which they practiced (NLNE, 1937). By 1950, the NLNE had identified course content in nursing school curricula to prepare nurses to assume the role. Most recently, the NLN (2006) developed the first Certified Nurse Educator (CNE) exam to raise "the visibility and status of the academic nurse educator role as an advanced professional practice discipline with a defined practice setting" (Klestzick, 2005, p. 1).

In similar fashion, the American Nurses Association (ANA, 2015) has for years issued statements on the functions, standards, and qualifications for nursing practice, of which patient teaching is a key element. In addition, the International Council of Nurses (ICN, 2015) has long endorsed the nurse's role as patient educator to be an essential component of nursing care delivery.

Today, all state nurse practice acts (NPAs) include teaching within the scope of nursing practice responsibilities. Nurses, by legal mandate of their NPAs, are expected to provide instruction to consumers to assist them in maintaining optimal levels of wellness and manage illness. Nursing career ladders often incorporate teaching effectiveness as a measure of excellence in practice (Rifas et al., 1994; Fukada, 2018). By teaching patients and families as well as fellow staff nurses, nurses can achieve the professional goal of providing cost-effective, safe, and high-quality care (Coleman & Desai, 2019; Santo et al., 2007; Shi & Singh, 2015).

A variety of other health professions also identify their commitment to patient education in their professional documents (Falvo, 2004). Standards of practice, practice frameworks, accreditation standards, guides to practice, and practice acts of many health professions delineate the educational responsibilities of their members. In addition, professional workshops and continuing education programs routinely address the skills needed for high-quality patient and staff education. Although specific roles vary according to profession, directives related to contemporary patient education

clearly echo Bartlett's (1986) assertion that it "must be viewed as a fundamentally multidisciplinary enterprise" (p. 146).

In addition to providing patient education, professional nurses are responsible for educating their colleagues. Another role of today's nurse educator is one of training the trainer—that is, preparing nursing staff through continuing education, in-service programs, and staff development to maintain and improve their clinical skills and teaching abilities. Nurses must be prepared to effectively perform teaching services that meet the needs of many individuals and groups in different circumstances across a variety of practice settings. The key to the success of our profession is for nurses to teach other nurses. We are the primary educators of our fellow colleagues and other healthcare staff personnel (Donner et al., 2005; Lockhart, 2016; McKinley, 2009). In addition, the demand for educators of nursing students is at an all-time high (American Association of Colleges of Nursing, September 2020).

Another very important role of the nurse as educator is serving as a clinical instructor for students in the practice setting. Many staff nurses function as clinical preceptors and mentors to ensure that nursing students meet their expected learning outcomes. However, evidence indicates that nurses in the clinical and academic settings feel inadequate as preceptors and mentors as a result of poor preparation for their role as teachers. This challenge of relating theory learned in the classroom setting to the practice environment requires nurses not only to keep up to date with clinical skills and innovations in practice but also to possess knowledge and skills related to the principles of teaching and learning (Levy et al., 2009; Licata, 2014). Knowing the practice field is not the same as knowing how to teach the field. The role of the clinical educator is a dynamic one that requires the teacher to actively engage students to become competent and caring professionals (Billings & Halstead, 2019; Cangelosi et al., 2009; Gillespie & McFetridge, 2006; Salminen et al., 2013).

Social, Economic, and Political Trends Affecting Health Care

In addition to the professional and legal standards put forth by various organizations and agencies representing or regulating the practice of nursing, many social, economic, and political trends nationwide that affect the public's health have focused attention on the role of the nurse as teacher and the importance of client, staff, and student education. The following are some of the significant forces influencing nursing practice, in particular, and healthcare practice in general (Berwick, 2014; Committee on Quality of Health Care in America & IOM, 2001; Gantz et al., 2012; Glanville, 2000; Health Catalyst Editors, 2020; IOM, 2001, 2011; Lea et al., 2011; Lockhart, 2016; Martin, 2021; Moses et al., 2013; Shi & Singh, 2015; USDHHS, 2010, 2020):

- The federal government, as discussed earlier, published *Healthy People 2030,* a document that set forth national health goals and objectives for the next decade. Achieving these national priorities would dramatically cut the costs of health care, prevent the premature onset of disease and disability, and help all Americans lead healthier and more productive lives. Among the major causes of morbidity and mortality are those diseases now recognized as being lifestyle related and preventable through educational intervention. Nurses, as the largest group of health professionals, play an important role in making a real difference by teaching clients to attain and maintain healthy lifestyles.
- The Institute of Medicine (2011) established recommendations designed to enhance the role of nurses in the delivery of health care. This includes nurses functioning to the full extent of their education and scope of practice. Patient and

family education is a key component of the nurse's role.

- The U.S. Congress passed into law in 2010 the Affordable Care Act (ACA), a comprehensive healthcare reform legislation. The ACA remains one of the top healthcare trends to ensure health insurance coverage for millions of Americans. The ACA is designed to provide cost-effective, accessible, equitable, high-quality health care to all Americans with the intent of improving their health outcomes. If the ACA survives the political pressures to alter or dismantle it, universal accessibility to health care has the potential to transform the healthcare system, and nurses will play a major role in meeting the demands and complexities of this increasing population of patients.
- Medicaid expansion took effect in 2019, but legislation is still pending in many places throughout the United States, with only 37 states in 2020 providing Medicaid expanded coverage under the ACA. Medicaid expansion means more people have access to health care, especially those in remote communities where access to care has been previously unavailable.
- The growth of managed care has resulted in shifts in reimbursement for healthcare services. Greater emphasis is placed on outcome measures, many of which can be achieved primarily through the health education of clients.
- Health providers are recognizing the economic and social values of reaching out to communities, schools, and workplaces—all settings where nurses practice—to provide public education for disease prevention and health promotion.
- Social issues, such as where people live, employment status, family situation, and level of education, affect an individual's health. Social determinants of health (SDOH) impact on mortality, morbidity, life expectancy, health status, and functional well-being, to name a few. SDOH is now recognized as the cause of major disparities in health and healthcare delivery.
- Politicians and healthcare administrators alike recognize the importance of health education to accomplish the economic goal of reducing the high costs of health services. Political emphasis is on productivity, competitiveness in the marketplace, and cost-containment measures to restrain health service expenses.
- Health professionals are becoming increasingly concerned about malpractice claims and disciplinary action for incompetence. Continuing education, either by legislative mandate or as a requirement of the employing institution, has come to the forefront in response to the challenge of ensuring the competency of practitioners. It is a means to transmit new knowledge and skills and to reinforce or refresh previously acquired knowledge and abilities for the continuing growth of staff.
- Nurses continue to define their professional role, body of knowledge, scope of practice, and expertise, with client education and PCC as central to the practice of nursing.
- Consumers are demanding increased knowledge and skills about how to care for themselves and how to prevent disease. As people are becoming more aware of their needs and desire a greater understanding of treatments and goals, the demand for health information is expected to intensify. The quest for consumer rights and responsibilities, which began in the 1960s, continues into the 21st century. Consumerization also includes improving the efficiency, effectiveness, and transparency of care in appointment scheduling, exam availability, and speed in receiving exam results to reduce wasted time and increase patient satisfaction with care.
- An increasing number of self-help groups exist to support clients in meeting their physical and psychosocial needs. The success of these support groups and

behavioral change programs depends on the nurse's role as teacher and advocate.

- Demographic trends, particularly the aging of the population, require nurses to emphasize self-reliance and maintenance of a healthy status over an extended life span. The percentage of the U.S. population older than age 65 years will climb dramatically in the next 20 to 30 years, and the healthcare needs of the baby-boom generation of the post–World War II era will increase as this vast cohort deals with degenerative illnesses and other effects of the aging process.
- In addition, millions of incidents of medical harm occur every year in U.S. hospitals. Clearly, it is imperative that clients, nursing staff, and nursing students be educated about preventive measures to reduce these incidents.
- The increased prevalence of chronic and incurable conditions requires that individuals and families become informed participants to manage their own illnesses. Patient teaching can facilitate an individual's adaptive responses to illness and disability.
- Advanced technology increases the complexity of care and treatment in home and community-based settings. More rapid hospital discharge and more procedures done on an outpatient basis are expecting patients to be more self-reliant in managing their own health. Patient education assists them in following through with self-management activities independently. Virtual care solutions from telehealth visits to virtual home-based care is the new mindset to support healthcare providers and patients in staying connected in a meaningful and productive way.
- Healthcare providers increasingly recognize client health literacy as an essential skill to improve health outcomes nationwide. Nurses must attend to the education needs of their patients and families to be sure that they adequately understand the information required for independence in self-care activities that promote, maintain, and restore their health.
- Many healthcare providers believe—and this belief is supported by research—that client education improves adherence and, hence, health and well-being. Better understanding by patients and their families of the recommended treatment plans can lead to increased cooperation, decision making, satisfaction, and independence with therapeutic regimens. Health education enables patients to solve problems they encounter outside the protected care environments of hospitals, thereby increasing their independence.
- Online technologies used in nursing education programs are increasing. Nurses are expected to have the critical thinking skills needed to identify problems, conduct research on problems encountered, and apply new knowledge to address these problems. In addition, nurses are expected to have familiarity with computerized charting and electronic health information records. Nursing informatics is becoming highly important in the paperless world of patient care, and nurse educators are beginning to address the gap in skills with respect to electronic data collection and analysis that nursing students and staff face in the practice settings.
- The fields of genetics and genomics, as included in the holistic approach of nursing practice, are providing patients with more options to consider for screenings, procedures, and therapies to obtain optimal health. The United States and Europe have established core competencies in genetics and genomics for nurses to support the development of skills, knowledge, and attitudes in the delivery of safe comprehensive care.

Nurses recognize the need to develop their expertise in teaching to keep pace with the demands of patient, staff, and student

education. As they continue to define their role, body of knowledge, scope of practice, and professional expertise, they are realizing, more than ever before, the significance of their role as educators. Nurses have many opportunities to carry out health education. They are the healthcare providers who have the most continuous contact with clients, are usually the most accessible source of information for the consumer, and are the most highly trusted of all health professionals. In Gallup polls conducted since 2001, nurses have continued to be ranked number 1 for 18 consecutive years in honesty and ethical standards (ANA, 2020; Olshansky, 2011; Reinhart, 2020; Riffkin, 2014; Williamson, 2016). This is pertinent because a trusting relationship between nurses and clients facilitates the exchange of health education information.

Purposes, Goals, and Benefits of Patient and Nursing Staff/Student Education

The purpose of patient education is to increase the competence and confidence of clients for self-management. The primary goal is to increase the responsibility and independence of clients for self-care. This can be achieved by supporting patients through the transition from being dependent on others to being self-sustaining in managing their own care and from being passive listeners to active learners. An interactive partnership education approach provides clients with opportunities to explore and expand their self-care abilities (Cipriano, 2007; Dineen-Griffin et al., 2019).

The single most important action of nurses as educators is to prepare patients for self-care. If patients cannot independently maintain or improve their health status when on their own, nurses have failed to help them reach their potential (Glanville, 2000). The benefits of client education are many (Adams, 2010; Dreeben, 2010; Fereidouni et al., 2019; Marcus, 2014: Sarasohn-Kahn, 2013; Timmers et al., 2020; Wingard, 2005). For example, effective teaching by the nurse can do the following:

- Increase consumer satisfaction
- Improve quality of life
- Ensure continuity of care
- Decrease patient anxiety
- Effectively reduce the complications of illness and the incidence of disease
- Promote adherence to treatment plans
- Maximize independence in the performance of activities of daily living
- Energize and empower consumers to become actively involved in the planning of their care

Because patients must handle many health needs and problems at home, people must be educated on how to care for themselves—that is, both to get well and to stay well. Illness is a natural life process, but so is humankind's ability to learn. Along with the ability to learn comes a natural curiosity that allows people to view new and difficult situations as challenges rather than as defeats. As Orr (1990) observed, "Illness can become an educational opportunity... a 'teachable moment' when ill health suddenly encourages [patients] to take a more active role in their care" (p. 47). This observation remains relevant today.

Numerous studies have documented that informed clients are more likely to comply with medical treatment plans, more likely to find innovative ways to cope with illness, and less likely to experience complications. Overall, clients are more satisfied with care when they receive adequate information about how to manage for themselves (Ferrer, 2015; Sarasohn-Kahn, 2013). One of the most frequently cited complaints by patients in litigation cases is that they were not adequately informed (Reising, 2007).

Just as there is a need for teaching patients to become participants and informed consumers to achieve independence in self-care, so

too is there a need for staff nurses to be exposed to up-to-date information with the ultimate goal of enhancing their practice. The purpose of staff and student education is to increase the competence and confidence of nurses to function independently in providing care to the consumer and to function interprofessionally with colleagues in a collaborative, team-based approach to healthcare delivery (Johnson & Johnson. 2016; Weinstein et al., 2013). The goal of education efforts is to improve the quality of care delivered by nurses. Nurses play a key role in improving the nation's health, and lifelong learning is essential to keep their knowledge and skills current (Kelliher, 2013; Witt, 2011). According to a 2016 report by the All-Party Parliamentary Group on Global Health (APPG) of the World Health Organization (WHO), nurses are the key to improving health, promoting gender equality, and supporting economic growth (WHO, 2016a).

In turn, the benefits to nurses in their role as educators include increased job satisfaction when they recognize that their teaching actions have the potential to forge therapeutic relationships with clients, enhanced patient–nurse autonomy, increased accountability in practice, and the opportunity to create change that really makes a difference in the lives of others (Witt, 2011).

The primary aims of nurse educators, then, should be to nourish clients, mentor staff, and serve as teachers, clinical instructors, and preceptors for nursing students. They must value their role in educating others and make it a priority for their patients, fellow colleagues, and the future members of the profession. As the ancient Chinese (author unknown) proverb says, "Provide a man a fish, and he may eat for a day. Teach a man to fish, and he may eat for a lifetime." In other words, teaching is a sacred and honorable act; it is imparting knowledge to others and empowering them to no end—and there can be no higher calling than that of an educator (Jackson, 2015).

The Education Process Defined

The **education process** is a systematic, sequential, logical, science-based, planned course of action consisting of two major interdependent operations: teaching and learning. This process forms a continuous cycle that also involves two interdependent players: the teacher and the learner. Together, they jointly perform teaching and learning activities, the outcome of which leads to mutually desired behavior changes. These changes foster growth in the learner and, it should be acknowledged, growth in the teacher as well. Thus, the education process is a framework for a participatory, shared approach to teaching and learning (Carpenter & Bell, 2002; Kelo, Eriksson, et al., 2013).

The education process is similar across the practice of many of the health professions. In fact, it can be compared to the nursing process because the steps of each process run parallel to the steps of the other (**Figure 1-1**). The education process, like the nursing process, consists of the basic elements of assessment, planning, implementation, and evaluation (Dreeben, 2010; Ward, 2012; Wingard, 2005). The two are different in that the nursing process focuses on the planning and implementation of care based on the assessment and diagnosis of the physical and psychosocial needs of the patient. The education process, in contrast, focuses on the planning and implementation of teaching based on an assessment and prioritization of the client's learning needs, readiness to learn, and learning styles (Carpenter & Bell, 2002).

The outcomes of the nursing process are achieved when the physical and psychosocial needs of the client are met. The outcomes of the education process are achieved when changes in knowledge, attitudes, and skills occur. Both processes are ongoing, with assessment and evaluation perpetually redirecting the planning and implementation phases. If mutually agreed-on outcomes in either

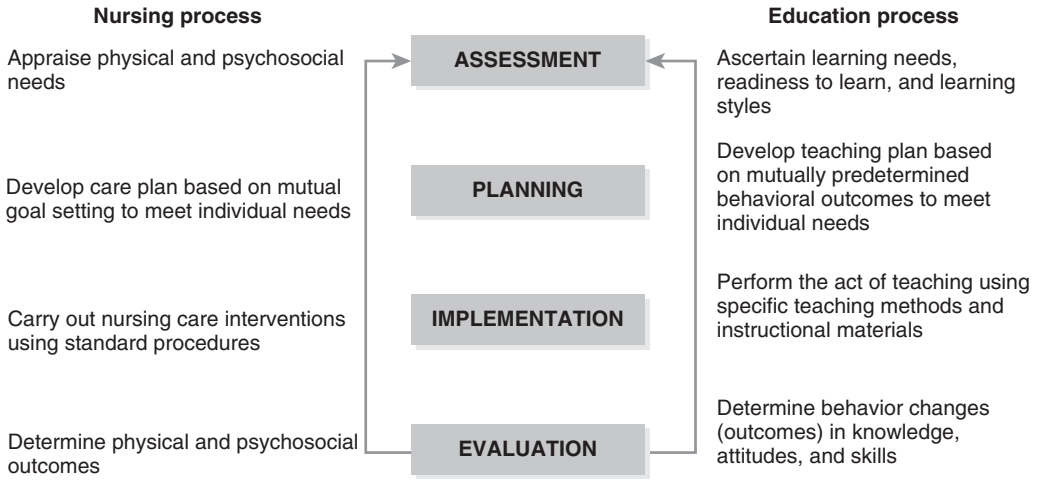

Figure 1-1 Education process parallels nursing process.

process are not achieved, as determined by evaluation, the process can and should begin again through reassessment, replanning, and reimplementation.

Note that the actual act of teaching or instruction is merely one component of the education process. **Teaching and instruction**—terms that are often used interchangeably—are deliberate interventions that involve sharing information and experiences to meet intended learner outcomes in the cognitive, affective, and psychomotor domains according to an education plan. Teaching and instruction, both one and the same, are often thought of as formal, structured, organized activities, but they also can be informal, spur-of-the-moment education sessions that occur during conversations and incidental encounters with the learner. Whether formal or informal, planned well in advance or spontaneous, teaching and instruction are nevertheless deliberate and conscious acts with the objective of producing learning (Carpenter & Bell, 2002; Gregor, 2001).

Just because teaching and instruction are intentional does not necessarily mean that they must be lengthy and complex tasks, but it does mean that they comprise conscious actions on the part of the teacher in responding to an individual's need to learn. The cues that someone has a need to learn can be communicated in the form of a verbal request, a question, a puzzled or confused look, a blank stare, or a gesture of defeat or frustration. In the broadest sense, then, teaching is a highly versatile strategy that can be applied in preventing, promoting, maintaining, or modifying a wide variety of behaviors in a learner who is receptive, motivated, and adequately informed (Gregor, 2001).

Learning is defined as a change in behavior (knowledge, attitudes, and/or skills) that can be observed or measured and that occurs at any time or in any place resulting from exposure to environmental stimuli. Learning is an action by which knowledge, skills, and attitudes are consciously or unconsciously acquired such that behavior is altered in some way. The success of the nurse educator's endeavors in teaching is measured not by how much content the nurse imparts but rather by how much the person learns (Ackoff & Greenberg, 2008; Seelig, 2016).

Patient education is a process of assisting people in learning health-related behaviors that they can incorporate into everyday life,

with the goal of achieving optimal health and independence in self-care. Friedman et al. (2011) specifically define it as "any set of planned educational activities, using a combination of methods (teaching, counseling, and behavior modification), that is designed to improve patients' knowledge and health behaviors" (p. 12). **Staff education**, by contrast, is the process of influencing the behavior of nurses by producing changes in their knowledge, attitudes, and skills to help them maintain and improve their competencies for the delivery of high-quality care to the consumer. Both patient and staff education involve forging a relationship between the learner and the educator so that the learner's information needs (cognitive, affective, and psychomotor) can be met through the process of education.

The ASSURE model is a useful paradigm originally developed to assist nurses in organizing and carrying out the education process (Rega, 1993). This model is appropriate for all health professional educators. The acronym stands for

Analyze the learner.

State the objectives.

Select the instructional methods and materials.

Use the instructional methods and materials.

Require learner performance.

Evaluate the teaching plan and revise as necessary.

The Contemporary Role of the Nurse as Educator

Over the years, organizations governing and influencing nurses in practice have identified teaching as an important responsibility (Dreeben, 2010; Lewenson et al., 2016). For nurses to fulfill the role of educator—regardless of whether their audience consists of patients, family members, nursing students, nursing staff, or other agency personnel—they must have a solid foundation in the principles of teaching and learning.

With significantly more attention being paid to the teaching role of nurses, it is imperative that nurse educators recognize the theories in nursing and educational psychology that provide the frameworks to guide them in understanding how and why people change their health-related behaviors. Dorothy Orem's Self-Care Theory professes that patients and family caregivers are capable of being self-reliant and responsible for their own care, a goal that can be achieved only through patient teaching (Orem, 1991). Other nursing theories—Betty Neuman's Systems Model Theory (Neuman, 1995), Jean Watson's Human Caring Science (Watson, 2012), and Patricia Benner's Novice to Expert Theory (Benner, 1984)—are all foundational to how nurses can best teach and how learners can best learn. Also foundational are behaviorist, cognitive, and other learning theories described in Chapter 3 as they apply to the role of nurses as teachers.

Legal and accreditation mandates as well as professional nursing standards of practice have made the educator role of the nurse an integral part of high-quality care to be delivered by all registered nurses (RNs) licensed in the United States, regardless of their level of nursing school preparation. Given this fact, it is imperative to examine the present teaching role expectations of nurses, irrespective of their preparatory background. The role of educator is not primarily to teach but rather to promote learning and provide for an environment conducive to learning. Also, the role of the nurse as teacher of patients and families, nursing staff, and students certainly should stem from a partnership philosophy (Gleasman-DeSimone, 2012). A learner cannot be made to learn, but an effective approach in educating others is to create the teachable moment, rather than just waiting for it to happen, and to actively involve learners

in the education process (Lawson & Flocke, 2009; Tobiano et al., 2015).

Although all nurses are expected to teach as part of their licensing criteria, many lack formal preparation in the principles of teaching and learning (Donner et al., 2005; Steketee & Bate, 2013). Of course, a nurse needs a great deal of knowledge and skill to carry out the role of educator with efficiency and effectiveness. Although all nurses have always functioned as givers of information, they must now assume a new role by acquiring the skills as a facilitator of the learning process (Dreeben, 2010; Kelliher, 2013). Consider the following questions:

- Is every nurse adequately prepared to assess for learning needs, readiness to learn, and learning styles?
- Can every nurse determine whether the information given is actually received and understood? Are all nurses capable of taking appropriate action to revise the approach to educating the patient if the patient does not comprehend the information provided through the initial approach?
- Do nurses realize that they need to transition their role as educator from being a content transmitter to becoming a process manager, from controlling the learner to releasing the learner, and from being a teacher to becoming a facilitator?

A growing body of evidence suggests that effective education and learner participation go hand in hand (Dreeben, 2010; Kelliher, 2013). As a facilitator, the nurse should create an environment conducive to learning that motivates individuals to want to learn and makes it possible for them to learn (Seelig, 2016; Sykes et al., 2013). Both the educator and the learner should participate in the assessment of learning needs, the design of a teaching plan, the implementation of teaching methods and instructional materials, and the evaluation of teaching and learning. Thus, the emphasis should be on the facilitation of learning from a nondirective rather than a didactic teaching approach (Ackoff & Greenberg, 2008; Donner et al., 2005; Knowles et al., 1998; Mangena & Chabeli, 2005).

No longer should teachers see themselves as simply transmitters of content. Indeed, the role of the educator has shifted from the traditional position of giver of information to that of a process designer and coordinator. This role alteration from the traditional teacher-centered perspective to a learner-centered approach is a paradigm shift that requires educators to possess skill in needs assessment as well as the ability to involve learners in planning, link learners to learning resources, and encourage learner initiative (Kelliher, 2013; Knowles et al., 1998; Mangena & Chabeli, 2005).

Instead of the teacher teaching, the new educational paradigm focuses on the learner learning (Ackoff & Greenberg, 2008). That is, the teacher becomes the guide on the side, assisting the learner in their effort to determine objectives and goals for learning, with both parties being active partners in decision making throughout the learning process. To increase comprehension, recall, and application of information, clients must be actively involved in the learning experience (Adams, 2010; Kessels, 2003; Smith et al., 2013). Glanville (2000) describes this move toward assisting learners to use their own abilities and resources as "a pivotal transfer of power" (p. 58).

Interprofessional Education and Practice

A relatively recent transformative movement in the delivery of patient care and, by extension, patient teaching is the emphasis on **interprofessional education (IPE)**. IPE is now included in many accreditation standards as an educational requirement (Zorek & Raehl, 2013) to prepare health profession students for future interprofessional practice and collaboration (Gilbert et al., 2010; Lutfiyya et al., 2016; WHO, 2010). Major barriers to the implementation and sustainability of IPE

include such issues as time constraints, rigid curriculum structures, desire to maintain professional identity, and limited faculty support.

To best serve consumers of health care, professionals today also must focus on **interprofessional practice**—also known as team-based care, interprofessional collaboration, and collaborative practice—by working more closely together in a collaborative, interdependent manner and in partnership with patients to deliver appropriate, cost-effective, and efficient care within the complex environment of the healthcare system (Hardin et al., 2017; Nester, 2016). Team-based care has been associated with improved healthcare outcomes (Reeves et al., 2013; Zwarenstein et al., 2009) and patient satisfaction (Wen & Shulman, 2014).

In the early 1970s, the IOM called for educating health professionals to function as a team (IOM, 1972). In more recent years, many international and federal reports have specifically advocated for IPE and practice (Frank et al., 2010; IOM, 2001, 2003a, 2003b; Interprofessional Education Collaborative Expert Panel, 2011; WHO, 1988, 2010). As a result, several countries (the United Kingdom, Canada, Australia, and the United States) developed IPE frameworks to guide the education of their health professionals. In the United States, core competencies (Interprofessional Education Collaborative Expert Panel, 2011) were identified by experts representing the various health professions, higher education institutions, and professional associations. These competencies are used by many institutions in this country as a guiding document for developing interprofessional initiatives. Five years later, an update was released that (1) reaffirmed the importance and impact of the core competencies; (2) organized the competencies within a singular domain that addresses the values and ethics of collaboration as well as the roles and responsibilities for communication and teamwork between professionals; and (3) broadened the interprofessional competencies to better achieve the Triple Aim of improving the patient experience, improving the health of populations, and reducing per capita cost of health care (Interprofessional Education Collaborative, 2016).

Direct assessment of these competencies is challenging because of the varying definitions of IPE frameworks and constructs and the lack of clarity about interprofessional outcomes (Reeves et al., 2013; Thistlethwaite et al., 2014). It is important, however, that validated tools be designed to effectively translate IPE teaching to practice (Havyer et al., 2016). Currently, researchers are focusing on developing and testing assessment and evaluation tools to measure IPE outcomes (Lie et al., 2017; Lockeman et al., 2016; Nisbet et al., 2017; Thistlethwaite et al., 2016; West et al., 2015).

Creating a linkage between IPE and collaborative practice will result in a climate whereby "all participants learn, all teach, all care, and all collaborate" (Josiah Macy Jr. Foundation, 2013, p. 1). To achieve the goal of safe, high-quality care, a collaborative process is required whereby all team members have equal power. The silos that exist in the education and practice settings are difficult barriers to overcome because of the entrenched professional identities and power differentials. However, interdisciplinary cooperation and teamwork are essential to improve the health outcomes of patients and to achieve a more highly functional healthcare system (Hassmiller, 2014; Meleis, 2016; Tang et al., 2018).

Patient-Centered Care

A trend that often goes hand in hand with the interprofessional practice movement is the focus on **patient-centered care (PCC)**. Over the past 25 years, approaches to patient care have been transitioning from paternalistic care to more patient partnership-based care (Pomey et al., 2015). This is a logical transition given the prevalence of chronic diseases and the emphasis on containing

healthcare costs (Schlesinger & Fox, 2016). The rising incidence of chronic illness is challenging the traditional healthcare delivery models that were developed after World War II to primarily provide acute care and manage infectious diseases (Pomey et al., 2015). The role of nurses and other health professionals in managing chronic disease includes supporting and guiding patients as they carry out self-care activities, as opposed to the strictly healing practices approach that occurred previously (Karazivan et al., 2015).

In PCC, nurses and other healthcare professionals work to reach a shared understanding with patients and to more fully respond to their needs (Araki, 2019; Ben & Hochman, 2017; Stewart et al., 2000). PCC is defined as "health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers" (Australian Commission on Safety and Quality in Health Care [ACSQHC], 2011, p. 1). Patient-centric care, person-centered care, patient engagement, and the patient-as-partner approach are all forms of PCC. These approaches support the development of patient competency in care, guide clinical decision making, and require some surrendering of control by the health professional. They recognize that the patient as well as the healthcare provider possess special expertise (Karazivan et al., 2015).

Patients who actively participate in healthcare decision making have better health outcomes (Arnetz et al., 2010; Coleman et al., 2004; Coleman et al., 2006; Hibbard & Greene, 2013; Weingart et al., 2011) and more positive experiences of care (Weingart et al., 2011). According to Coulter (2012) and Domecq et al. (2014), patient participation can be a useful approach to ensure that appropriate care is provided in the current environment of strained resources. Hassmiller and Bilazarian (2018) found that consumer engagement focusing on compassionate interactions was associated with increases in treatment savings and patient safety in terms of length of stay and reduced medication errors. Systematic reviews demonstrate a positive relationship between PCC and reduced morbidity, improved quality of life, and increased adherence to management protocols (Casimir et al., 2013; Epstein et al., 2010, Hibbard & Greene, 2013) as well as a possible relationship between PCC and positive health behavior and health status (Dwamena et al., 2012). Shared decision making, expert patients, therapeutic education, and self-management are all examples of ways to involve patients in their own care (Karazivan et al., 2015).

A number of national and international health agencies emphasize PCC in healthcare delivery (ACSQHC, 2011; Center for Advancing Health, 2010; JCAHO, 2003; National Health Service Commissioning Board, 2012; WHO, 2016b). In addition, the IOM published a signal report titled *Crossing the Quality Chasm: A New Health System for the 21st Century* (IOM, 2001). This report called for urgent and fundamental change to close the quality gap by redesigning the healthcare system in the United States. In this report, PCC was identified as an essential dimension of high-quality care and as a clear focus of new models of delivering care, such as primary care patient-centered medical homes and accountable care organizations.

In response to the concern for safe, better-quality care, the Nursing Alliance for Quality Care (NAQC)—a partnership of the leading health and nursing organizations in the United States— began advocating in 2010 for the highest-quality consumer-centered care by working with patients, nurses, and policymakers to encourage and promote optimum health care to consumers. In 2012, the NAQC issued an initiative with nine core principles as part of its drive to address care coordination, to promote patient engagement during care, and to integrate patients and their families in the decisions of their care (NAQC, 2012). A year later, the NAQC published a white paper updating these principles and providing a new strategic plan and road map

for patient and family engagement with outcomes to be achieved. According to the NAQC (2013), the following principal assumptions should be used as a guide to provide PCC:

1. There must be an active partnership among patients, their families, and the providers of their health care.
2. Patients are the best and ultimate source of information about their health status and retain the right to make their own decisions about care.
3. In this relationship, there are shared responsibilities and accountabilities among the patient, the family, and clinicians that make it effective.
4. While embracing partnerships, clinicians must nevertheless respect the boundaries of privacy, competent decision making, and ethical behavior in all their encounters and transactions with patients and families. These boundaries protect recipients as well as providers of care. This relationship is grounded in confidentiality, where the patient defines the scope of the confidentiality.
5. This relationship is grounded in an appreciation of the patient's rights and expands on the rights to include mutuality. Mutuality includes sharing of information, creation of consensus, and shared decision making.
6. Clinicians must recognize that the extent to which patients and family members are able to engage or choose to engage may vary greatly based on individual circumstances, cultural beliefs, and other factors.
7. Advocacy for patients who are unable to participate fully is a fundamental nursing role. Patient advocacy is the demonstration of how all of the components of the relationship fit together.
8. Acknowledgment and appreciation of culturally, racially, or ethnically diverse backgrounds is an essential part of the engagement process.
9. Healthcare literacy and linguistically appropriate interactions are essential for patient, family, and clinicians to understand the components of patient engagement. Providers must maintain awareness of the language needs and healthcare literacy level of the patient and family and respond accordingly.

The American Association of Colleges of Nursing (AACN) recently proposed new Essentials of Baccalaureate Education (AACN, 2020 May), which includes a domain on "person-centered care." This domain includes a descriptor, contextual statement, and competencies that would be expected of nurses graduating from a baccalaureate program. The emphasis on person-centered care directly supports the need for effective patient education.

With the national concern about lack of good information on the quality of care, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program was established as a multiyear initiative in 1995 by the Centers for Medicare and Medicaid Services (CMS). The CAHPS national survey mandates that healthcare organizations regularly collect data on consumer involvement in healthcare decision making. In 2005, the Hospital CAHPS (HCAHPS) was developed that is specifically designed for use by hospitals (Agency for Healthcare Research and Quality, 2016). The purpose of the CAHPS and HCAHPS is to increase consumer engagement in healthcare decision making and to measure health outcomes. Also, many studies have focused on how effectively outcomes have been achieved in healthcare organizations by exploring the links between patient experiences and health outcomes as well as the extent to which actionable information has facilitated organizational change (Doyle et al., 2013; Manary et al., 2013).

Even though the focus has moved from paternalistic practices to patient-centered practices, much work still needs to be done to shift healthcare delivery and education culture.

The vision statement from the Josiah Macy Jr. Foundation conference "Partnering With Patients, Families and Communities to Link Interprofessional Practice and Education" sums up the direction of the PCC movement:

> We envision a future in which individuals, families, and communities are understood to be the very reason our healthcare system exists, and that those who are caring, teaching, learning, or otherwise working within the system must partner fully and effectively with them to foster optimal health and wellness for all. (Fulmer & Gaines, 2014, p. 27)

Initiatives in the PCC movement around the globe include such examples as the Patient Expert Programs in the United Kingdom (National Health Service, 2001); Patient Universities in Spain, Germany, and France (Karazivan et al., 2015); the University of Gothenburg Centre for Person-Centered Care in Sweden (Moore et al., 2017); the Center for Patient Partnership in Health Care by the American College of Physicians (American College of Physicians, 2013); and the Patients as Partners approach introduced in Canada in 2007 and further expanded in 2010 to involve patients as full-fledged members of the healthcare team (Bar et al., 2018; Fulmer & Gaines, 2014). In addition, current literature calling for increasing patient involvement in drug development (Getz, 2015; Lowe et al., 2016), medical device development (Hurst et al., 2017), and research (Hamilton et al., 2017) reflects progression of the PCC healthcare initiative.

In a qualitative study by Pomey et al. (2015) about patients' engagement in their health care, patients who were familiar with the Patients as Partners concept described themselves as proactively engaging in three types of practice. The first is a process of continuous learning, the second is an assessment of the quality of the health care they receive, and the third is an adaptation process where the patients build on their learning and assessments to compensate for what they perceive to be optimal or nonoptimal health care. This occurred regardless of whether the health professionals they were working with were open to their role as a partner in their health care. That the patients in this study appeared to play a more active role in their own health care than previous literature suggests is encouraging and indicates that consumers, as well as policy mandates, are helping to change the healthcare culture.

Quality and Safety Education in Nursing

In 2005, the Robert Wood Johnson Foundation (RWJF) funded a national study, the Quality and Safety Education in Nursing (QSEN) project, to educate nursing students with knowledge, skills, and attitudes to improve patient safety and quality in healthcare delivery. During phase I, six competencies were developed (QSEN, 2012):

1. *Patient-centered care:* The patient has control of and is a full partner in the provision of holistic, compassionate, and comprehensive care based on the patient's values, needs, and preferences.
2. *Teamwork and collaboration:* Nurses and other health professionals must collaborate effectively with open communication, respect, and mutual decision making to achieve high-quality care.
3. *Evidence-based practice:* Current evidence must be integrated to support clinical expertise in providing optimal health care.
4. *Quality improvement:* Measure data and monitor patient outcomes to develop changes in methods to continuously improve the quality and safety in healthcare delivery.
5. *Informatics:* Use information technology to effectively communicate, manage knowledge, eliminate error, and support collaborative decision making.

6. *Safety:* Minimize the risk of harm to patients and healthcare providers through self- and system evaluation.

In 2007, the RWJF funded phase II of the QSEN project, which included launching a website (http://QSEN.org) dedicated to teaching strategies and resources. In 2009, the AACN also received funding to complete phase III of the QSEN project, the goal of which was to develop faculty expertise needed to teach the competencies, incorporate the competencies in textbooks, implement innovative teaching strategies, and assist in the licensure and accreditation processes (QSEN, 2012).

In 2012, phase IV of the QSEN was funded by RWJF to support AACN in the development of a new project to establish national competencies to prepare students in graduate education with the knowledge, skills, and attitudes required for advanced practice nurses to effectively improve safety and quality in healthcare delivery (AACN, 2012). Also in this fourth phase, RWJF funded the Academic Progression in Nursing (APIN) project to achieve the IOM (2011) goal of 80% of the nursing workforce being prepared at the baccalaureate level by 2020 (QSEN, 2012).

Quality and safety also have been included as a domain in the newly proposed Essentials of Baccalaureate Education (AACN, 2020 May). The goal is to have nurses entering the workforce who are fully equipped to enhance quality and minimize risks to patients in all aspects of care delivery.

The Institute of Medicine Report: The Future of Nursing

In 2011, the RWJF and the Institute of Medicine partnered to establish recommendations designed to enhance the role of nurses in the delivery of health care. In 2010, the U.S. Congress passed, and President Barack Obama signed into law, the Affordable Care Act, a comprehensive healthcare reform legislation. In response to this transformation of U.S. health care, four key messages were developed by a multidisciplinary committee whose membership represented a variety of healthcare professionals, educators, researchers, policymakers, consumers, advocacy groups, and healthcare institutions (IOM, 2011):

1. Nurses should practice to the full extent of their education and training.
2. Nurses should achieve higher levels of education and training.
3. Nurses should be full partners with health professionals in redesigning health care.
4. Effective workforce planning and policymaking require better data collection.

Based on these four key messages, the report made eight recommendations to achieve a transformation in nursing education and practice (IOM, 2011):

1. Remove scope of practice barriers (addressing key message #1).
2. Expand opportunities for nurses to lead in collaborative improvement efforts (addressing key message #3).
3. Implement nurse residency programs (addressing key message #1).
4. Increase the proportion of nurses with baccalaureate degrees to 80% by 2020 (addressing key message #2).
5. Double the number of nurses with a doctorate by 2020 (addressing key message #2).
6. Ensure that nurses engage in lifelong learning (addressing key message #2).
7. Prepare and enable nurses to lead change to advance health (addressing key message #3).
8. Build an infrastructure for the collection and analysis of data (addressing key message #4).

Certainly, patient education requires a collaborative effort among healthcare team members, all of whom play roles in teaching of greater or lesser importance. Because nurses are prepared to provide a holistic approach

to care delivery, the teaching role is a unique part of nursing's professional domain. Given that consumers have always respected and trusted nurses for their knowledge and advocacy (Williamson, 2016), and nurses tend to be most accessible of all providers due to their continuous contact with patients, nurses are in an ideal position to carry out health education and to clarify information that consumers find confusing by making sense out of nonsense. Amid a fragmented healthcare delivery system involving many providers, the nurse serves as the coordinator of care. By ensuring consistency of information, nurses can support clients in their efforts to achieve the goal of optimal health (Donovan & Ward, 2001; Donovan et al., 2007). They also can assist their nurse colleagues in gaining knowledge and skills necessary for the delivery of professional nursing care.

Barriers to Teaching and Obstacles to Learning

It has been said by many educators that adult learning takes place not by the teacher initiating and motivating the learning process but rather by the teacher removing or reducing obstacles to learning and enhancing the process after it has begun. The educator should not limit learning to the information that is intended but should clearly make possible the potential for informal, unintended learning that can occur each day with every teacher–learner encounter (Carpenter & Bell, 2002; Gregor, 2001). The evidence supports that these teachable moments are not necessarily unplanned or that a coordinated set of circumstances will always lead to positive health change. Instead, it is the interaction between learner and teacher that is central to the development of a teachable moment, regardless of the obstacles or barriers that may be encountered (Konradsen et al., 2012; Lawson & Flocke, 2009).

Unfortunately, nurses must confront many barriers in carrying out their responsibilities for educating others. In addition, learners face a variety of potential obstacles that can interfere with their learning. Conditional factors, such as the environment, the organization's culture, the level of cooperation between the disciplines, beliefs and knowledge of the team members, types of patient education activities, and the patient population, can either enable or hinder the teaching–learning process (Farahani et al., 2013; Friberg et al., 2012).

For the purposes of this text, **barriers to teaching** are defined as those factors that impede the nurse's ability to deliver educational services. **Obstacles to learning** are defined as those factors that negatively affect the ability of the learner to pay attention to and process information.

Factors Affecting the Ability to Teach

The following barriers (**Figure 1-2**) may interfere with the ability of nurses to carry out their roles as educators (Carpenter & Bell, 2002; Donovan & Ward, 2001; Farahani et al., 2013; Friberg et al., 2012; Jahromi, 2016; Livne et al., 2017; Smith & Zsohar, 2013; Tobiano et al., 2015; Wong, 2017):

1. Lack of time to teach is cited by nurses as the greatest barrier to being able to carry out their educator role effectively. Early discharge from inpatient and outpatient settings often results in nurses and clients having fleeting contact with each other. In addition, the schedules and responsibilities of nurses are very demanding. Finding time to allocate to teaching is very challenging in light of other work demands and expectations. Nurses must know how to adopt an abbreviated, efficient, and effective approach to client and staff education first by adequately assessing the learner and then by using appropriate teaching methods and instructional

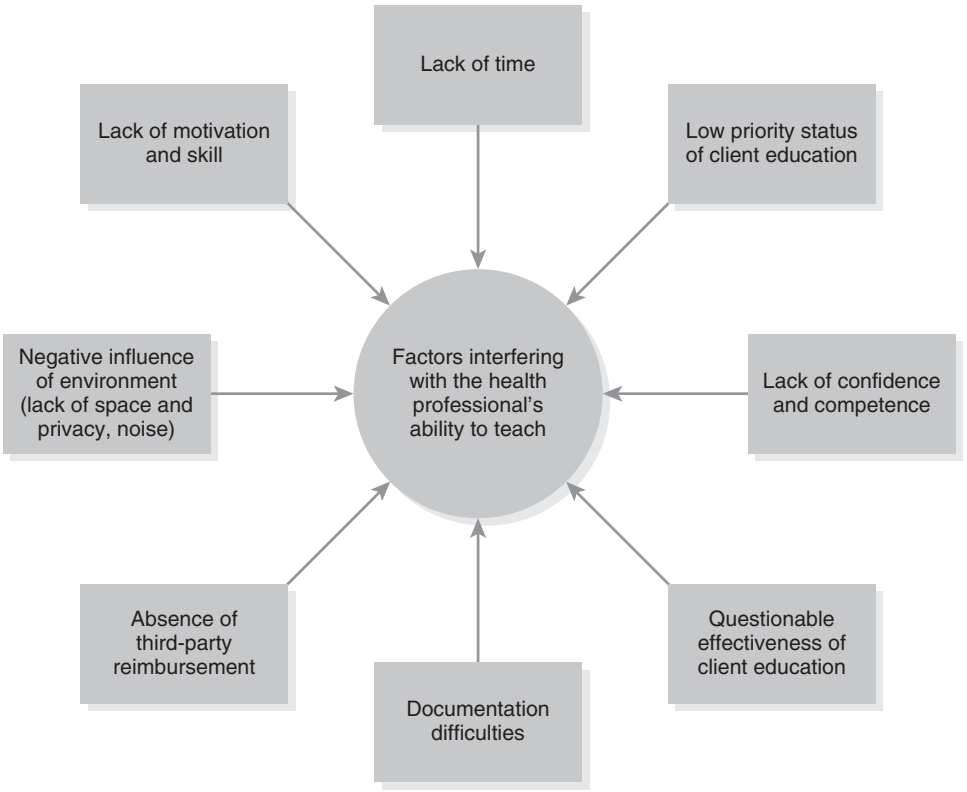

Figure 1-2 Barriers to teaching.

tools at their disposal. Discharge planning is playing an ever-more-important role in ensuring continuity of care across settings.

2. Many nurses and other healthcare personnel admit that they do not feel competent or confident with their teaching skills. As stated previously, although nurses are expected to teach, few have ever taken a specific course on the principles of teaching and learning. Instead, the concepts of patient education are often integrated throughout nursing curricula rather than being offered as a separate course. Frequently, assumptions have been made that nurses are adequately prepared with skills for the teaching role and how to facilitate learning. Only a scant number of studies have recently examined nurses' perceptions of their patient education and nursing staff/student clinical teaching skills (Jack et al., 2019; Kelo, Martikainen, et al., 2013; Lahl et al., 2013; Nyoni & Barnard, 2016), but the conclusions indicate that nurses neither feel nor demonstrate competence and confidence in teaching others. Fortunately, an upswing in interest and attention to the educator role has been gaining significant momentum in graduate nursing programs across the country. Nevertheless, the role of the nurse as educator must continue to be strengthened in both undergraduate and graduate nursing education programs as well as in programs for staff development in the clinical settings based on the findings of these studies.
3. Personal characteristics of the nurse educator play an important role in determining the outcome of a teaching–learning

interaction. Motivation to teach and skill in teaching are prime factors in determining the success of any educational endeavor.

4. Until recently, administrators and supervisory personnel assigned a low priority to patient and staff education. With the strong emphasis of TJC mandates, the level of attention paid to the educational needs of both consumers and healthcare personnel has changed significantly. However, budget allocations for educational programs remain tight and can interfere with the adoption of innovative and time-saving teaching strategies and techniques.
5. The environment in the various settings where nurses are expected to teach is not always conducive to carrying out the teaching–learning process. Lack of space, lack of privacy, noise, and frequent interruptions caused by patient treatment schedules and staff work demands are just some of the factors that may negatively affect the nurse's ability to concentrate and effectively interact with learners.
6. An absence of third-party reimbursement to support patient education by RNs relegates teaching and learning to less than high-priority status. Nursing services within inpatient healthcare facilities are subsumed under hospital room costs and therefore are not specifically or separately reimbursed by insurance payers. However, as of 2013, a new Medicare rule allows for payment of advanced practice registered nurses (APRNs) for the delivery of primary care services in outpatient settings. "With up to 20% of Medicare patients readmitted to hospitals within 30 days of discharge, more value has been placed on effective transitional care and care coordination" by APRNs (Nurse.com, 2012, para. 3). A separate billing code for patient education and counseling by RNs is now included in the American Medical Association's Common Procedural Terminology (CPT) codes, but many restrictions exist in being able to use this code for reimbursement of staff nurse services (STD Related Reproductive Health Training and Technical Assistance Center, 2014). As for health education and wellness programs, Medicare generally does not cover these costs except in specific cases, such as diabetes and kidney disease education, depression screenings, and counseling to stop smoking or for alcohol misuse (U.S. Centers for Medicare & Medicaid Services, n.d.). Thus, under most circumstances when nurses deliver patient education, this therapeutic intervention is not reimbursable by third-party payers. Recently, a new role has been created mainly in primary care practices, known as health education specialists (HES). Given the nursing shortage in primary care settings, the drive to improve health outcomes, and the cost of nursing professionals, HESs are being hired as substitutes to deliver patient education and coaching (Chambliss et al., 2014).
7. Some nurses as well as some physicians question whether patient education is effective in improving health outcomes. They view patients as impediments to teaching when patients do not display an interest in changing behavior, when they demonstrate an unwillingness to learn, or when their ability to learn is in question. Concerns about coercion and violation of free choice, based on the belief that patients have a right to choose and that they cannot be forced to comply, explain why some professionals feel frustrated in their efforts to teach. Unless all healthcare members buy into the utility of patient education (that is, they believe it can lead to significant behavioral changes and increased adherence to therapeutic regimens), some professionals may continue to feel absolved of their responsibility to provide adequate and appropriate patient education.
8. The type of documentation system used by healthcare agencies has an impact on

the quality and quantity of patient teaching. Both formal and informal teaching are often done but not written down because of insufficient time, inattention to detail, and inadequate forms on which to record the extent of teaching activities. Many of the hard-copy forms or computer software used for documentation of teaching are designed to simply check off the areas addressed rather than to allow for elaboration of what has been accomplished. In addition, most nurses do not recognize the scope and depth of teaching that they perform daily. Communication among healthcare providers regarding what has been taught needs to be coordinated and appropriately delegated so that teaching can proceed in a timely, smooth, organized, and thorough fashion.

Factors Affecting the Ability to Learn

The following obstacles (**Figure 1-3**) may interfere with a learner's ability to attend to and process information (Beagley, 2011; Billings & Kowalski, 2004; Farahani et al., 2013; Jahromi, 2016; Kessels, 2003; McDonald et al., 2004; Weiss, 2003):

1. Lack of time to learn as a result of rapid patient discharge from care and the amount of information a client is expected to learn can discourage and frustrate the learner, impeding their ability and willingness to learn.
2. The stress of acute and chronic illness, anxiety, and sensory deficits in patients are just a few problems that can diminish

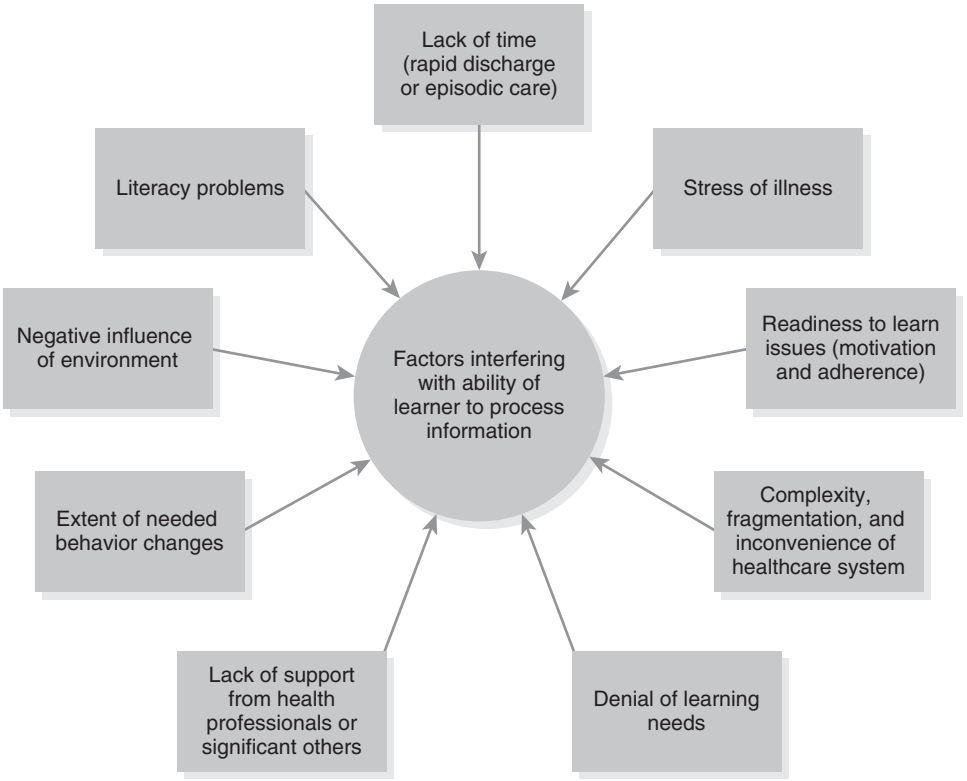

Figure 1-3 Obstacles to learning.

learner motivation and interfere with the process of learning. However, illness alone seldom acts as an impediment to learning. Rather, illness is often the impetus for patients to attend to learning, contact healthcare professionals, and take positive action to improve their health status.

3. Low literacy and functional health illiteracy have been found to be significant factors in the ability of clients to make use of the written and verbal instructions given to them by providers. Almost half of the American population reads and comprehends at or below the eighth-grade level, and an even higher percentage suffers from health illiteracy.
4. The negative influence of the hospital environment itself, which results in loss of control, lack of privacy, and social isolation, can interfere with a patient's active role in health decision making and involvement in the teaching–learning process.
5. Personal characteristics of the learner have major effects on the degree to which behavioral outcomes are achieved. Readiness to learn, motivation and adherence, developmental-stage characteristics, and learning styles are some of the prime factors influencing the success of educational endeavors.
6. The extent of behavioral changes needed, both in number and in complexity, can overwhelm learners and dissuade them from attending to and accomplishing learning objectives and goals.
7. Lack of support and lack of ongoing positive reinforcement from the nurse and significant others serve to block the potential for learning.
8. Denial of learning needs, resentment of authority, and lack of willingness to take responsibility (locus of control) are some psychological obstacles to accomplishing behavioral change.
9. The inconvenience, complexity, inaccessibility, fragmentation, and dehumanization of the healthcare system often result in frustration and abandonment of efforts by the learner to participate in and comply with the goals and objectives for learning.

Questions to Be Asked About Teaching and Learning

To maximize the effectiveness of patient, staff, and student education, the nurse must examine the elements of the education process and the role of the nurse as educator. Many questions arise related to the principles of teaching and learning, especially given the pressures to contain costs and to improve learner outcomes. The following are some of the important questions that this text addresses:

- How can members of the healthcare team work together more effectively to coordinate educational efforts?
- What are the ethical, legal, and economic issues involved in patient and staff education?
- Which theories and principles support the education process, and how can they be applied to change the behaviors of learners?
- Which assessment methods and tools can nurse educators use to determine learning needs, readiness to learn, and learning styles?
- Which learner attributes negatively and positively affect an individual's ability and willingness to learn?
- What can be done about the inequities (in quantity and quality) in the delivery of education services?
- How can teaching be tailored to meet the needs of specific populations of learners, such as those with diverse cultural backgrounds, low literacy skills, physical and mental disabilities, and different socioeconomic and educational levels?
- To what extent does teaching improve health status and reduce the costs of health care?

- Which instructional methods and materials are available to support teaching efforts?
- Which elements must the nurse as educator account for when developing and implementing teaching plans?
- Under which conditions should nurses use certain teaching methods and materials?
- Which common mistakes do nurses make when teaching others?
- How can teaching and learning be best evaluated?

State of the Evidence

The literature on patient and staff education, from both a research- and non-research-based perspective, is particularly extensive in nursing. The non-research-based literature on patient education is prescriptive in nature and tends to offer anecdotal tips on how to take individualized approaches to teaching and learning. A computer literature search, for example, reveals literally thousands of nursing and allied health articles and books on teaching and learning that are available, ranging from the general to the specific.

Although many research-based studies are being conducted on teaching specific population groups about a variety of topics, only recently has the field focused its attention on how to most effectively teach persons with long-term chronic illnesses. Nurses must conduct much more research on the benefits of patient education as they relate to the potential for increasing quality of life, enabling patients to lead a disability-free life and manage themselves independently at home, and decreasing the costs of health care through anticipatory teaching approaches. Studies from acute care settings tend to focus on preparing a patient for a procedure, with emphasis on the benefits of information in alleviating anxiety and promoting psychological coping. The evidence does suggest that patients cope much more effectively when taught exactly what to expect (Adams, 2010; Donovan & Ward, 2001; Dreeben, 2010; Mason, 2001; Wong et al., 2010).

More research is needed on the benefits of teaching methods and instructional tools that use Information (Digital) Age technologies such as the World Wide Web, the internet, social media, podcasts, webcasts, and webinars as methods to access health information for both patient and staff education. The use of Information Age technology has had such a dramatic effect on health education that a new field has emerged: consumer informatics (American Medical Informatics Association, 2017). Researchers in the field of consumer informatics are working to find ways to use technology to strengthen the relationships between patient and healthcare provider and to teach and empower patients dealing with healthcare issues (Darvish et al., 2014; Nazi et al., 2016).

These new approaches to information dissemination require a role change for the educator, from being a giver of information to becoming a resource facilitator, as well as a shift in the role of the learner, from being a passive recipient to becoming an active partner. The rapid advances in technology for teaching and learning also require educators to have a better understanding of generational orientations and experiences of the learner (Billings & Kowalski, 2004). Because 25% of American adults ages 65 and older do not use the internet (Perrin & Atske, 2021), more investigation needs to be done regarding how to help older clients bridge the digital divide and the information literacy gap. The American Medical Informatics Association (AMIA) is dedicated to transforming health care to improve quality of care provided by health professionals and help consumers make better healthcare decisions (AMIA.org).

Physiologic and neuroendocrine variation in brain function by sex, the influence of socioeconomics on learning, and the strategies of teaching cultural groups and populations with disabilities need further exploration as well (see Chapters 8 and 9). Findings from interdisciplinary research on the influence of

biological sex on learning remain inconclusive, although neuroscience continues to explore sex-linked variability in brain functioning and development. Research on the influence that socioeconomics has on learning reveals it plays a significant factor, but the underlying mechanisms of its effects are still unclear. More research needs to be done on the extent to which teaching can improve health status of individuals and communities, decrease the incidence of disease, and enhance the quality and safety of healthcare delivery.

Despite the questions that remain unanswered, nurses are expected to teach diverse populations with complex needs and a range of abilities in both traditional settings and nontraditional, unstructured settings. For more than 30 years, nurse researchers have been studying how best to teach patients, but much more research is required (Adams, 2010; Mason, 2001). In addition, relatively few studies have examined nurses' perceptions about their role as educators in the practice setting (Friberg et al., 2012). We need to establish a stronger theoretical basis for intervening with clients throughout "all phases of the learning continuum, from information acquisition to behavioral change" (Donovan & Ward, 2001, p. 211). Also, emphasis needs to be given to research in nursing education to ensure that the nursing workforce is prepared for a challenging, complex, and uncertain future in health care (Benner et al., 2010; Committee on Quality of Health Care in America & IOM, 2001; IOM, 2011; Meleis, 2016).

In addition, nurses as educators should further investigate the cost-effectiveness of educational efforts in reducing hospital stays, decreasing readmissions, improving the personal quality of life, and minimizing complications of illness and therapies. Furthermore, given the number of variables that can potentially interfere with the teaching–learning process, additional studies must be conducted to examine the effects of environmental stimuli, the factors involved in readiness to learn, and the influences of learning styles on learner motivation, adherence, comprehension, and the ability to apply knowledge and skills once they are acquired. One notable void is the lack of information in the research database on how to assess motivation. Chapter 6 proposes parameters to assess motivation but notes the paucity of information specifically addressing this issue.

Over 30 years ago, Oberst (1989) delineated the major issues in patient education studies related to the evaluation of the existing research base and the design of future studies. The four broad problem categories that she identified remain pertinent today:

1. Selection and measurement of appropriate dependent variables (educational outcomes)
2. Design and control of independent variables (educational interventions)
3. Control of mediating and intervening variables
4. Development and refinement of the theoretical basis for education

Summary

Nurses can be considered information brokers—educators who can make a significant difference in how patients and families cope with their illnesses and disabilities, how the public benefits from education directed at prevention of disease and promotion of health, and how staff and student nurses gain competency and confidence in practice through education activities that are directed at continuous, lifelong learning. As the United States moves forward in the 21st century, many challenges and opportunities lie ahead for nurse educators in the delivery of health care.

The teaching role is becoming even more important and more visible as nurses respond to the social, economic, and political trends affecting health care today. The foremost challenge for nurses is to be able to demonstrate, through research and action, that definite links exist between education and positive

behavioral outcomes of the learner. In this era of cost containment, government regulations, and healthcare reform, the benefits of client, staff, and student education must be made clear to the public, healthcare employers, healthcare providers, and payers of healthcare benefits. To be effective and efficient, nurses must be willing to embrace IPE and be able to practice collaboratively with one another to provide consistently high-quality education to the audiences they serve. They also must embrace PCC and recognize the expertise that patients bring to the provider–patient relationship.

Nurses can demonstrate responsibility and accountability for the delivery of care to the consumer in part through education based on solid principles of teaching and learning. The key to effective education of the varied audiences of learners is the nurse's understanding of and ongoing commitment to the role of educator.

Review Questions

1. Which key factors influenced the growth of patient education during its formative years?
2. How far back in history has teaching been a part of the nurse's role?
3. Which nursing organization was the first to recognize health teaching as an important function within the scope of nursing practice?
4. How did the concept of patient education change in the 1960s and 1970s?
5. Which legal mandate universally includes teaching as a responsibility of nurses?
6. How have the ANA, NLN, ICN, AHA, TJC, and Pew Commission influenced the role and responsibilities of the nurse as educator?
7. What is the current focus and orientation of patient education?
8. Which social, economic, and political trends today make it imperative that patients be adequately educated?
9. What are the similarities and differences between the education process and the nursing process?
10. What are three major barriers to teaching and three major obstacles to learning?
11. Which factor serves as both a barrier to teaching and an obstacle to learning?
12. What is the present status of research- and non-research-based evidence pertaining to education?

CASE STUDY

As a clinical nurse educator at Utopia Hospital, part of your duties is to instruct nurses in the most up-to-date processes to improve patient safety and outcomes. Recently, due to an increase in readmission rates at your hospital for heart failure patients, you have been tasked with developing patient education goals based on feedback from the professional nursing staff that patients must meet before discharge. You set out to find out how these nurses, of which more than half are bachelor's degree prepared or higher, are currently educating patients on heart failure medications, lifestyle changes, and self-monitoring techniques. In the process, you sense a definite interest and motivation from the nursing staff in wanting to improve their teaching skills and the quality of care they are providing, but also you hit a few roadblocks. Frequently, you hear nurses say, "I don't really know what or how much to tell patients when they ask me about heart failure," "I don't have time to educate patients throughout the day," and "I always try my best to teach, but I don't know if my efforts make much of a difference." Because the nursing staff

obviously has some strong feelings about the education department's efforts, you believe a strengths, weaknesses, opportunities, and threats (SWOT) analysis is a good place to begin to gather information from your colleagues about the issues and problems they are facing.

1. As a prelude to the SWOT analysis, identify the goals of patient and staff education.
2. Identify the strengths and opportunities that currently are available when completing these two elements of the SWOT analysis.
3. Use the section titled "Barriers to Teaching and Obstacles to Learning" as a beginning framework for the weaknesses and threats section of the SWOT analysis and then describe five potential barriers to teaching and five potential obstacles to learning that your staff might identify.
4. Provide possible solutions to the barriers and obstacles identified that would serve to enhance patient education.

References

Ackoff, R. L., & Greenberg, D. (2008). *Turning learning right side up: Putting education back on track.* Prentice Hall.

Adams, R. J. (2010, October 14). Improving health outcomes with better patient understanding and education. *Risk Management and Healthcare Policy, 3*, 61–72. https://doi.org/10.2147/RMHP.S7500

Agency for Healthcare Research and Quality. (2016, October). *About CAHPS*. https://www.ahrq.gov/cahps/about-cahps/index.html

American Association of Colleges of Nurses. (2012). *Graduate-level QSEN competencies: Knowledge, skills, and attitudes*. http://www.aacn.nche.edu/faculty/qsen/competencies.pdf

American Association of Colleges of Nursing. (2020, May). *DRAFT Essentials domains, descriptors, contextual statements, and competencies*. https://www.aacnnursing".org/Portals/42/Downloads/Essentials/DRAFT-Domains-Descriptors-Competencies-May-2020.pdf

American Association of Colleges of Nursing. (2020, September). *Fact sheet: Nursing faculty shortages.* https://www.aacnnursing.org/news-information/fact-sheets/nursing-faculty-shortage

American College of Physicians. (2013, August 8). *American College of Physicians creates Center for Patient Partnership in Healthcare to advance collaboration between physicians and patients*. https://www.acponline.org/acp-newsroom/american-college-of-physicians-creates-center-for-patient-partnership-in-healthcare-to-advance

American Hospital Association. (1973). Statement on a patient's bill of rights. *Hospitals*, *47*(4), 41.

American Hospital Association. (1976). Statement on the role and responsibilities of hospitals and other health care institutions in personal and community health education. *Health Education*, *7*(4), 23.

American Medical Informatics Association. (2017). *Consumer health informatics*. http://www.amia.org/applications-informatics/consumer-health-informatics

American Nurses Association. (2015). *Scope and standards of practice* (3rd ed.). Nursebooks.org.

American Nurses Association. (2020, January 6). ANA president proud of nurses for maintaining #1 spot in Gallup's 2019 most honest and ethical professions poll. https://www.nursingworld.org/news/news-releases/2020/american-nurses-association-president-proud-of-nurses-for-maintaining-1-spot--in-gallups-2019-most-honest-and-ethical-professions-poll/

Andersson, S., Svanström, R., Ek, K., Rosén, H., & Berglund, M. (2015). The challenge to take charge of life with long-term illness: Nurses' experiences of supporting patients' learning with the didactic model. *Journal of Clinical Nursing*, *24*(23–24), 3409–3416. http://dx.doi.org/10.1111/jocn.12960

Araki, M. (2019). Patient-centered care and professional nursing practice. *Journal of Biomedical Research and Clinical Investigation*, *1*(1), 1004–1009. https://doi.org/10.31546/JBRCI.1004

Arnetz, J. E., Winblad, U., Hoglund, A. T., Lindahl, B., Spangberg, K., Wallentin, L., Wang, Y., Ager, J., Arnetz, B. B. (2010). Is patient involvement during hospitalization for acute myocardial infarction associated with post-discharge treatment outcome? An exploratory study. *Health Expectations*, *13*(3), 298–311. https://doi.org/10.1111/j.1369-7625.2009.00588.x

Australian Commission on Safety and Quality in Health Care. (2011). *Patient-centred care: Improving quality and safety through partnerships with patients and consumers*. https://www.safetyandquality.gov.au/publications-and-resources/resource-library/patient-centred-care-improving-quality-and-safety-through-partnerships-patients-and-consumers

Bar, S., Grant, K., Asuri, S., & Holms, S. (2018, February 6). British Columbia Ministry of Health Patients as Partners: A transformational approach. http://journals.sagepub.com/doi/abs/10.1177/0840470417744569

Bartlett, E. E. (1986). Historical glimpses of patient education in the United States. *Patient Education and Counseling*, *8*, 135–149. https://doi.org/10.1016/0738-3991(86)90085-6

Beagley, L. (2011). Educating patients: Understanding barriers, teaching styles, and learning techniques. *Journal of PeriAnesthesia Nursing, 26*(5), 331–337. http://dx.doi.org/10.1016/j.jopan.2011.06.002

Ben N., M., & Hochman, O (2017, April). Patient-centered care in healthcare and if implementation in nursing. *International Journal of Caring Sciences*, *10*(1), 596–600.

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Addison-Wesley.

Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). *Educating nurses: A call for radical transformation*. Jossey-Bass.

Berwick, D. M. (2014). *Promising care: How we can rescue health care by improving it*. Jossey-Bass.

Billings, D. M., & Halstead, J. A. (2019). *Teaching in nursing: A guide for faculty* (6th ed.). Elsevier.

Billings, D., & Kowalski, K. (2004). Teaching learners from varied generations. *Journal of Continuing Education in Nursing*, *35*(3), 104–105. http://dx.doi.org/10.3928/0022-0124-20040501-06

Cangelosi, P. R., Crocker, S., & Sorrell, J. M. (2009). EXPERTtoNOVICE: Clinicians learning new roles as clinical nurse educators. *Nursing Education Perspectives*, *30*(6), 367–371.

Carpenter, J. A., & Bell, S. K. (2002). What do nurses know about teaching patients? *Journal for Nurses in Staff Development*, *18*(3), 157–161. http://dx.doi.org/10.1097/00124645-200205000-00009

Casimir, Y., Williams, M., Liang, M., Pitakmongkolkul, S., & Slyer, J. (2013). Effectiveness of patient-centered self-care education for adults with heart failure on knowledge, self-care behaviors, quality of life, and readmissions: A systematic review protocol. *JBI Database of Systematic Reviews and Implementation Reports*, *11*(8), 107–128. https://doi.org/10.11124/jbisrir-2013-920

Center for Advancing Health. (2010). *A new definition of patient engagement: What is engagement and why is it important?* https://integrationacademy.ahrqdev.org/products/literature-collection/literature/new-definition-patient-engagement-what-engagement-and-why

Chachkes, E., & Christ, G. (1996). Cross cultural issues in patient education. *Patient Education and Counseling*, *27*, 13–21. http://dx.doi.org/10.1016/0738-3991(95)00785-7

Chambliss, M. L., Lineberry, S. N., Evans, W. M., & Bibeau, D. L. (2014). Adding health education specialists to your practice. *Family Medicine Management*, *21*(2), 10–15. http://www.aafp.org/fpm/2014/0300/p10.html

Cipriano, P. F. (2007). Stop, look, and listen to your patients and their families. *American Nurse Today*, *2*(6), 10.

Coleman, E. A., Parry, C., Chalmers, S., & Min, S. J. (2006). The care transitions intervention: Results of a randomized controlled trial. *Archives of Internal Medicine 166*(17), 1822–1828. https://doi.org/10.1001/archinte.166.171822

Coleman, E. A., Smith, J. D., Frank, J. C., Min, S. J., Parry, C., & Kramer, A. M. (2004). Preparing patients and caregivers to participate in care delivered across settings: The care transitions interventions. *Journal of the American Geriatrics Society*, *52*(11), 1817–1825. https://doi.org/10.1111/j.1532-5415.2004.52504.x

Coleman, Y. A., & Desai, R. (2019). The effects of a clinical ladder program on professional development and job satisfaction of acute care nurses. *Clinical Journal of Nursing Care Practice*, *3*, 044-048. https://www.heighpubs.org/hjncp/cjncp-aid1016.php

Committee on Quality of Health Care in America, & Institute of Medicine (2001). *Crossing the quality chasm: A new health system for the 21st century*. Health and Medicine Division, National Academy of Sciences. http://www.nationalacademies.org/hmd/Reports/2001/Crossing-the-Quality-Chasm-A-New-Health-System-for-the-21st-Century.aspx

Coulter, A. (2012). Patient engagement: What works? *Ambulatory Care Management*, *35*(2), 80–89. http://dx.doi.org/10.1097/JAC.0b013e318249e0fd

Darvish, A., Bahramnezhad, F., Keyhanian, S., & Navidhamidi, M. (2014, November). The role of nursing informatics on promoting quality of health care and the need for appropriate education. *Global Journal of Health Science*, *6*(6), 11–18. https://www.ncbi.nlm.gov/pmc/articles/PMC4825491/

Davidhizar, R. E., & Brownson, K. (1999). Literacy, cultural diversity, and client education. *Health Care Manager*, *18*(1), 39–47. http://dx.doi.org/10.1097/00126450-199909000-00007

Dineen-Griffin, S., Garcia-Cardenas, V., & Benrimoj, S. (2019). Helping patients help themselves: A systematic review of self-management support strategies in primary health care practice. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6675068/

Domecq, J. P., Prutsky, G., Elraiyah, T., Wang, Z., Nabhan, M., Shippee, N., Brito, J. P., Boehmer, K., Hasan, R., Firwana, B., Erwin, P., Eton, D., Sloan, J., Montori, V., Asi, N., Dabrh, D, M., Hassan, M. (2014). Patient engagement in research: A systematic review. *BMC Health Services Research*, *14*(89). https://doi.org/10.1186/1472-6963-14-89

Donner, C. L., Levonian, C., & Slutsky, P. (2005). Move to the head of the class: Developing staff nurses as teachers. *Journal for Nurses in Staff Development*, *21*(6), 277–283.

Donovan, H. S., & Ward, S. (2001). A representational approach to patient education. *Journal of Nursing Scholarship*, *33*(3), 211–216. https://doi.org/10.1111/j.1547-5069.2001.00211.x

Donovan, H. S., Ward, S. E., Song, M. K., Heidrich, S. M., Gunnarsdottir, S., & Phillips, C. M. (2007). An update on the representational approach to patient education. *Journal of Nursing Scholarship*, *39*(3), 259–265. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2526460/

Doyle, C., Lennox, L., & Bell, D. (2013). A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *British Medical Journal Open, 3*(1). https://doi.org/10.1136/bmjopen -2012-001570

Dreeben, O. (2010). Historical outlook of patient education in American health care. In O. Dreeben, *Patient education in rehabilitation* (pp. 9–16). Jones & Bartlett Publishers.

Dwamena, F., Holmes-Rovner, M., Gaulden, C. M., Jorgenson, S., Sadigh, G, Sikorski, A., Lewin, S., Smith, R. C., Coffey, J., Olomu, A., (2012). Interventions for providers to promote a patient-centered approach in clinical consultations. *Cochrane Library.* https://doi.org/10.1002/14651858.CD003267.pub2

Epstein, R. M., Fiscella, K., Lesser, C. S., & Stange, K. C. (2010). Why the nation needs a policy push on patient-centered health care. *Health Affairs*, *29*(8), 1–26. https://doi.org/10.1377/hlthaff.2009.0888

Falvo, D. F. (2004). *Effective patient education: A guide to increased compliance* (3rd ed.). Jones and Bartlett Publishers.

Farahani, M. A., Mohammadi, E., Ahmadi, F., & Mohammadi, N. (2013). Factors influencing the patient education: A qualitative research. *Iranian Journal of Nursing and Midwifery Research*, *18*(2), 133–139. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3748569/

Fereidouni, Z., Sabet Sarvestani, R., Hariri, G., Kuhpaye, S. A., Amirkhani, M., & Kalyani, M. N. (2019). Moving into action: The master key to patient education. *Journal of Nursing Research,* 27(1), e6. https://doi.org/10.1097/jnr.0000000000000280

Ferrer, L. (2015, October). *Engaging patients, carers and communities for the provision of coordinated/integrated health services: Strategies and tools*. World Health Organization. http://www.euro.who.int/__data/assets/pdf_file/0004/290443/Engaging-patients-carers-communities-provision-coordinated-integrated-health-services.pdf

Frank, J., Chen, L., Bhutta, Z. A., Cohen, J., Crisp, N., Evans, T., Fineberg, H., Garcia, P., Ke, Y., Kelley, P., Kistnasamy, B., Meleis, A., Naylor, D., Pablos-Mendez, A., Reddy, S., Scrimshaw, S., Sepulveda, J., Serwadda, D., Zurayk, H. (2010). Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world. *Lancet*, *376*, 1923–1958. http://dx.doi.org/10.1016/S0140-6736(10)61854-5

Friberg, F., Granum, V., & Bergh, A. L. (2012). Nurses' patient-education work: Conditional factors: An integrative review. *Journal of Nursing Management, 20*(2), 170–186.http://dx.doi.org/10.1111/j.1365-2834.2011.01367.x.

Friedman, A. J., Cosby, R., Boyko, S., Hatton-Bauer, J., & Turnbull, G. (2011). Effective teaching strategies and methods of delivery for patient education: A systematic review and practice guideline recommendations. *Journal of Cancer Education, 26*, 12–21. https://doi.org/10.1007/s13187-010-0183-x

Fukada, M. (2018). Nursing competency: Definition, structure and development. *Yonago Acta Medica*, *61*(1), 1–7.

Fulmer, T., & Gaines, M. (2014). *Partnering with patients, families, and communities to link interprofessional practice and education.* Josiah Macy Jr. Foundation. https://macyfoundation.org/assets/reports/publications/jmf_partneringwithpfc.pdf

Gantz, N. R., Sherman, R., Jasper, M., Choo, C. G., Herrin-Griffith, D., & Harris, K. (2012). Global nurse leader perspectives on health systems and workforce challenges. *Journal of Nursing Management*, *20,* 433–443. https://doi.org/10.1111/j.1365-2834.2012.01393.x

Getz, K. A. (2015). Establishing return-on-investment expectations for patient-centric initiatives. *Therapeutic Innovation & Regulatory Science*, *49*(5), 745–749. https://doi.org/10.1177/2168479015579521

Gilbert, J. H., Orchard, C., & Bainbridge, L. (2010). *National interprofessional competency framework*. Canadian Interprofessional Health Collaborative, University of British Columbia, Vancouver. https://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf

Gillespie, M., & McFetridge, B. (2006). Nursing education: The role of the nurse teacher. *Journal of Clinical Nursing*, *15*, 639–644. https://doi.org/10.1111/j.1365-2702.206.01344.x

Glanville, I. K. (2000). Moving towards health oriented patient education (HOPE). *Holistic Nursing Practice*, *14*(2), 57–66. http://dx.doi.org/10.1097/00004650-200001000-0010

Gleasman-DeSimone, S. (2012). *How nurse practitioners educate their adult patients about healthy behaviors: A mixed method study* (Unpublished doctoral dissertation). Capella University.

Gregor, F. M. (2001). Nurses' informal teaching practices: Their nature and impact on the production of patient care. *International Journal of Nursing Studies*, *38*(4), 461–470. https://www.ncbi.nlm.nih.gov/pubmed/11470104

Grueninger, U. J. (1995). Arterial hypertension: Lessons from patient education. *Patient Education and Counseling*, *26*, 37–55. https://doi.org/10.1016/0738-3991(95)00750-t

Hamilton, C. B., Hoens, A. M., Backman, C. L., McKinnon, A. M., McQuitty, S., English, K., & Li, L. C. (2017). An empirically based conceptual framework for fostering meaningful patient engagement in research. *Health Expectations*, *21*, 396–406. https://doi.org/10.1111/hex.12635

Hardin, L., Kilian, A., & Spykerman, K. (2017, June). Competing health care systems and complex patients: An inter-professional collaboration to improve outcomes and reduce health care costs. *Journal of Interprofessional Education & Practice*, 7, 5-10. https://www.sciencedirect.com/science/article/pii/S2405452616301033

Hassmiller, S. (2014, December). The top five issues for nursing in 2015. *Future of Nursing, Campaign for Action, the Center to Champion Nursing in America.* http://www.rwjf.org/en/culture-of-health/2014/12/the_top_five_issues.html

Hassmiller, S., & Bilazarian, A. (2018). The business, ethics, and quality cases for consumer engagement in nursing. *Journal of Nursing Administration*, *48*(4), 184–190. http://dx.doi.org/10.1097/NNA.0000000000000579

Havyer, R. D., Nelson, D. R., Wingo, M. T., Comfere, N. I., Halvorsen, A. J., McDonald, F. S., & Reed, D. A. (2016).

Addressing the interprofessional collaboration competencies of the Association of American Medical Colleges: A systematic review of assessment in undergraduate medical education. *Academic Medicine*, *91*(6), 865–888. http://dx.doi.org/10.1097/ACM.0000000000001053

Health Catalyst Editors. (2020, February 18). The top three 2020 healthcare trends and how to prepare. https://www.healthcatalyst.com/insights/2020-healthcare-trends-and-how-to-prepare

Health Services and Mental Health Administration, Committee on Educational Tasks in Chronic Illness. (1972). *A model for planning patient education; An essential component of health care* (DHEW publication no. HSM 72-4023). American Public Health Association.

Hibbard, J., & Greene, J. (2013). What the evidence shows about patient activation: Better health outcomes and care experiences: Few data on costs. *Health Affairs (Millwood)*, *32*(2), 207–214. https://doi.org/10.1377/hlthaff.2012.1061

Hurst, F. P., Chianchiano, D., Upchurch, L., Fisher, B. R., Flythe, J. E., Castillo, L. C., Hill, T., Neuland, C. Y. (2017). Stimulating patient engagement in medical device development in kidney disease: A report of a kidney health initiative workshop. *American Journal of Kidney Diseases*, *70*(4), 561–569. doi:10.1053/j.ajkd.2017.03.013

Institute of Medicine. (1972). *Educating the health team*. National Academy of Sciences.

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. National Academies Press.

Institute of Medicine. (2003a). *Priority areas for national action: Transforming health care quality*. National Academies Press.

Institute of Medicine. (2003b). The core competencies needed for health care professionals. In *Health professions education: A bridge to quality* (pp. 45–73). National Academies Press.

Institute of Medicine Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing. (2011). *The future of nursing: Leading change, advancing health*. National Academies Press.

International Council of Nurses. (2015). *ICN Biennial Report 2014-2015*. https://www.icn.ch/who-we-are/icn-annual-reports

Interprofessional Education Collaborative. (2016). *Core competencies for interprofessional practice: 2016 update*. https://hsc.unm.edu/ipe/resources/ipec-2016-core-competencies.pdf

Interprofessional Education Collaborative Expert Panel. (2011). *Core competencies for interprofessional collaborative practice: Report of an expert panel*. https://www.pcpcc.org/sites/default/files/resources/Core%20Competencies%20for%20Interprofessional%20Collaborative%20Practice.pdf

Jack, B. A., Kinloch, K., & O'Brien, M. R. (2019). Teaching nurses to teach: A qualitative study of nurses' perceptions of the impact of education and skills training to prepare them to teach end-of-life care. *Journal of Clinical Nursing*, *28*(9-10), 1819–1828. https://onlinelibrary.wiley.com/doi/full/10.1111/jocn.14788

Jackson, J. (2015, April). Faculty interview paper. Master's student in the Educator track at Le Moyne College, Syracuse, NY.

Jahromi, Z. (2016). A study of the barriers and facilitators of patient education from the viewpoint of nursing students at Jahrom College of Nursing. *Bangladesh Journal of Medical Science*, *15*(3), 471–476. https://doi.org/10.3329/bjms.v15i3.30201

Johnson & Johnson. (2016, January 26). The importance of interprofessional collaboration in healthcare. https://nursing.jnj.com/getting-real-nursing-today/the-importance-of-interpreofessional-collaboration-in-healthcare

Joint Commission on Accreditation of Healthcare Organizations. (1976). *Accreditation manual for hospitals*. Author.

Joint Commission on Accreditation of Healthcare Organizations. (2001). *Patient and family education: The compliance guide to the JCAHO standards* (2nd ed.). Author. https://www.jointcommission.org/assets/1/6/2001_Pain_Standards.pdf

Joint Commission on Accreditation of Healthcare Organizations. (2003). Patients as partners: Maximizing the effectiveness of your safety program with patient participation. *Joint Commission Perspectives on Patient Safety*, *3*(5), 1.

Josiah Macy Jr. Foundation. (2013, January 17-20). *Transforming patient care: Aligning interprofessional education with clinical practice redesign*. Conference recommendations. Atlanta, GA. https://macyfoundation.org/publications/transforming-patient-care-aligning-interprofessional-education-with-clinica

Karazivan, P., Dumez, V., Flora, L., Pomey, M-P., DelGrande, C., Ghadiri, D. P., Fernandez, N., Jouet, E., Vergnas, O, L., Lebel, P. (2015). The patient-as-partner approach in health care: A conceptual framework for a necessary transition. *Academic Medicine*, *90*(4), 437–441. http://dx.doi.org/10.1097/ACM.0000000000000603

Kelliher, F. (2013, December). Nurses and patient education. *AFDET (Association Française pour le Développement de l'Éducation thérapeutique)*. https://www.connecting-nurses.com/-/media/Project/One-Sanofi-Web/Websites/Global/Connecting-Nurses/Home/disease-knowledge/nurse-practice-education/afdet-nurses-patient-education.pdf?la=en&hash=A12CCD03152529F99272DCA0AD3EF837

Kelo, M., Eriksson, E., & Eriksson, I. (2013). Pilot educational program to enhance empowering patient education of school-age children with diabetes. *Journal of Diabetes & Metabolic Disorders*, *12*(1), 16. https://doi.org/10.1186/2251-6581-12-16

Kelo, M., Martikainen, M., & Eriksson, E. (2013). Patient education of children and their families: Nurses' experiences. *Pediatric Nursing, 39*(2), 71–79.

Kessels, R. P. C. (2003). Patients' memory for medical information. *Journal of the Royal Society of Medicine*, *96*, 219–222.

Klestzick, K. R. (2005). *Results in from landmark nurse educator certification examination*. http://www.nln.org/newsroom/news-releases/news-release/2005/12/20/results-in-from-landmark-nurse-educator-certification-exam

Knowles, M. S., Holton, E. F., & Swanson, R. A. (1998). *The adult learner: The definitive classic in adult education and human resource development* (5th ed., pp. 198–201). Gulf Publishing.

Konradsen, H., Nielsen, H. T., Larsen, M. T., & Hansen, C. (2012). Patient participation in relation to life style changes—A literature review. *Open Journal of Nursing*, *2*(2), 27–33. https://doi.org/10.4236/ojn.2012.22005

Lahl, M., Modic, M. B., & Siedlecki, S. (2013, July–August). Perceived knowledge and self-confidence of pediatric nurses as patient educators. *Clinical Nurse Specialist Journal*, 188–193. http://dx.doi.org/10.1097/NUR.0b013e3182955703

Lawson, P. J., & Flocke, S. A. (2009). Teachable moments for health behavior change: A concept analysis. *Patient Education and Counseling, 76*, 25–39. http://dx.doi.org/10.1016/j.pec.2008.11.002

Lea, D. H., Skirton, H., Read, C. Y., & Williams, J. K. (2011). Implications for educating the next generation of nurses on genetics and genomics in the 21st century. *Journal of Nursing Scholarship, 43*(1), 3–12.

Levy, L. S., Sexton, P., Willeford, K. S., Barnum, M. G., Guyer, M. S., Gardner, G., & Fincher, A. L. (2009). Clinical instructor characteristics, behaviors and skills in allied health care settings: A literature review. *Athletic Training Education Journal*, *4*(1), 8–13. https://academic.oup.com/ptj/article/87/7/833/2742162

Lewenson, S. B., McAllister, A., & Smith, K. (2016). *Nursing history for contemporary role development*. Springer.

Licata, C. (2014, April 27). *How to facilitate a successful clinical instructor-student outpatient clinical experience*. https://www.pthaven.com/news_article/show/380119-how-to-facilitate-a-successful-clinical-instructor-student-outpatient-clinical-experience

Lie, D. A., Richter-Lagha, R., Forest, C. P., Walsh, A. & Lohenry, K. (2017). When less is more: Validating a brief scale to rate interprofessional team competencies. *Medical Education Online*, *22*(1314751), 1–10. https://doi.org/10.1080/10872981.2017.1314751

Liu, Y., Yu, S., & Yuan, Y. (2016). Effect of health education and nursing intervention on compliance of patients with lung transplantation. *Chest*, *149*(4), A603. doi: https://doi.org/10.1016/j.chest.2016.02.630

Livne, Y., Peterfreund, I., & Sheps, J. (2017). Barriers to patient education and their relationship to nurses' perceptions of patient education climate. *Clinical Nursing Studies, 5*(4). http://www.sciedupress.com/journal/index.php/cns/article/view/11672. http://dx.doi.org/https://doi.org/10.5430/cns.v5n4p65

Lockhart, J. S. (2016). Healthcare trends and changes in nursing professional development. In J. S. Lockhart, *Nursing professional development for clinical educators* (pp. 1–16). Oncology Nursing Society. https://onf.ons.org/book/nursing-professional-development-clinical-educators/chapter-1-healthcare-trends-and-changes

Lockeman, K. S., Dow, A. W., DiazGranados, D., McNeilly, D. P., Nikol, D., Koehn, M. L., & Knab, M. S. (2016). Refinement of the IPEC Competency Self-Assessment survey: Results from of multi-institutional study. *Journal of Interprofessional Care*, *30*(6), 726–731. https://doi.org/10.1080/13561820.2016.1220928

Lowe, M. M., Blaser, D. A., Cone, L., Arcona, S., Ko, J. Sasane, R., & Wicks, P. (2016). Increasing patient involvement in drug development. *Value Health*, *19*(6), 869–878. https://doi.org/10.1016/j.jval.2016.04.009

Lutfiyya, M. N., Brandt, B. F., & Cerra, F. (2016). Reflections from the intersections of health professionals' education and clinical practice; The state of the science of interprofessional education and collaborative practice. *Academic Medicine*, *91*(6), 766–771.

Manary, M. P., Boulding, W., Staelin, R., & Glickman, S. W. (2013, January 17). The patient experience and health outcomes. *New England Journal of Medicine, 368*, 201–203. https://doi.org/10.1056/NEJMp1211775

Mangena, A., & Chabeli, M. M. (2005). Strategies to overcome obstacles in the facilitation of critical thinking in nursing education. *Nurse Education Today*, *25*, 291–298.

Marcus, C. (2014). Strategies for improving the quality of verbal patient and family education: A review of the literature and creation of the EDUCATE model. *Health Psychology and Behavioral Medicine, 2*(1), 482–495. https://doi.org/10.1080/21642850.2014.900450

Martin, G. (2021, January 1). Top 10 emerging trends in health care for 2021: The new normal. https://trustees.aha.org/top-10-emerging-trends-health-care-2021-new-normal

Mason, D. (2001). Promoting health literacy: Patient teaching is a vital nursing function. *American Journal of Nursing*, *101*(2), 7.

May, B. J. (1999). Patient education: Past and present. *Journal of Physical Therapy Education*, *13*(3), 3–7. https://doi.org/10.1097/00001416-199910000-00002

McDonald, D. D., Wiczorek, M., & Walker, C. (2004). Factors affecting learning during health education sessions. *Clinical Nursing Research*, *13*(2), 156–167. https://doi.org/10.1177/1054773803261113

McKenna, L., Irvine, S., & Williams, B. (2018) "I didn't expect teaching to be such a huge part of nursing": A follow-up qualitative exploration of new graduates' teaching activities. *Nurses Education in Practice*, *32*, 9–13. https://doi.org/10.1016/j.nepr.2018.06.010

McKinley, M. G. (2009). Go to the head of the class; Clinical educator role transition. *AACN Advanced Critical Care*, *20*(1), 91–101. http://dx.doi.org/10.1097/NCI.0b013e31819454ba

Meleis, A. I. (2016) Interprofessional education: A summary of reports and barriers to recommendations. *Journal of Nursing Scholarship*, *48*(1), 106–112. http://dx.doi.org/10.111/jnu.12184

Monterio, L. A. (1985). Florence Nightingale on public health nursing. *American Journal of Public Health*, *75*, 181–186. http://dx.doi.org/10.2105/ajph.75.2.181

Moore, L., Britten, N., Lydahl, D., Naldemirci, O., Elam, M., & Wolf, A. (2017). Barriers and facilitators to the implementation of person-centered care in different healthcare contexts. *Scandinavian Journal of Caring Sciences*, *31*, 662–673. https://doi.org/10.1111/scs.12376

Moses, H., Matheson, D. H. M., Dorsey, E. R., George, B. P., Sadoff, D., & Yoshimura, S. (2013). The anatomy of health care in the United States. *JAMA, 310*(18), 1947–1963.

National Health Service. (2001). *The expert patient: A new approach to chronic disease management for the twenty-first century*. http://webarchive.nationalarchives.gov.uk/20120511062115/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4018578.pdf

National Health Service Commissioning Board. (2012). *Everyone counts: Planning for patients 2013/2014*. https://www.england.nhs.uk/2012/12/everyonecounts/

National League for Nursing. (2006). *Certified Nurse Educator (CNE) 2006 candidate handbook*. http://www.nln.org/facultycertification/index.htm

National League of Nursing Education. (1937). *A curriculum guide for schools of nursing*. Author.

Nazi, K. M., Hogan, T. P., Simon, S. R., & Woods, S. S. (2016). Consumer health informatics: Engaging and empowering patients and families. In *Clinical Informatics Study Guide* (pp. 459–500). https://doi.org/10.1007/978-3-319-22753_19

Nester, J. (2016). The importance of interprofessional practice and education in the era of accountable care. *North Carolina Medical Journal*, *77*(2), 128–132. http://www.ncmedicaljournal.com/content/77/2/128.full

Neuman, B. (1995). The Neuman Systems Model. In B. Neuman, *The Neuman Systems Model* (3rd ed., pp. 3–61). Appleton & Lange.

Nisbet, G., Jorm, C., Roberts, C., Gorden, C. J., & Chen, T. F. (2017). Content validation of an interprofessional learning video peer assessment tool. *BMC Medical Education*, *17*(258), 1–10. https://doi.org/10.1186/s12909-017-1099-5

Nurse.com. (2012, November 5). *CMS rule creates reimbursement opportunities for RNs*. https://www.nurse.com/blog/2012/11/15/cms-rule-creates-reimbursement-opportunities-for-rns/

Nursing Alliance for Quality Care. (2012). *Nursing experts release guiding principles for patient engagement*. http://www.rwjf.org/en/library/articles-and-news/2012/07/nursing-experts-release-guiding-principles-for-patient-engagemen.html

Nursing Alliance for Quality Care. (2013). *Fostering successful patient and family engagement: Nursing's critical role*. https://www.nursingworld.org/~4aa949/globalassets/naqc/naqc_patientengagementwhitepaper.pdf

Nyoni, C. N., & Barnard, A. J. (2016). Professional nurses' perception of their clinical teaching role at a rural hospital in Lesotho. *African Journal of Health Professions Education*, *8*(2), 166–168. https://doi.org/10.7196/AJHPE.2016.v8i2.557

Nyswander, D. V. (1980). Public health education: Sources, growth and educational philosophy. *International Quarterly of Community Health Education*, *1*. 5–18. http://dx.doi.org/10.2190/D584-7361-6380-6692

Oberst, M. T. (1989). Perspectives on research in patient teaching. *Nursing Clinics of North America*, *24*(2), 621–627.

Olshansky, E. (2011). Nursing as the most trusted profession: Why this is important. *Journal of Professional Nursing*, *27*(4), 193–194. http://dx.doi.org/10.1016/j.profnurs.2011.06.007

Orem, D. E. (1991). *Nursing concepts of practice* (4th ed.). Mosby-Year Book.

Orr, R. (1990). Illness as an educational opportunity. *Patient Education and Counseling*, *15*, 47–48. http://dx.doi.org/10.1016/0738-3991(90)90007-8

Perrin, A., & Atske, S. (2021, April 2). 7% of Americans don't use the internet. Who are they? https://www.pewreseearch.org/fact-tank/2021/04/02/7-of-americans-dont-use-the-internet-who-are-they/

Pew Health Professions Commission. (1995). *Critical challenges: Revitalizing the health professions for the twenty-first century: The third report of the Pew Health Professions Commission*. University of California, San Francisco.

Pew Health Professions Commission. (1998). *Recreating health professional practice for a new century: The fourth report of the Pew Health Professions Commission, Center for the Health Professions*. University of California, San Francisco.

Pollack, R. (2017, October 11). 2018 Environmental Scan: Trends that are shaping health care. *Hospitals and Health Networks*. https://www.hhnmag.com/articles/8640-trends-that-are-shaping-health-care

Pomey, M-P., Ghadiri, D. P., Karazivan, P., Fernandez, N., & Clavel, N. (2015). Patients as partners: A qualitative study of patients' engagement in their health care. *PLoS ONE*, *10*(4), e0122499. https://doi.org/10.1371/journal.pone.0122499

Proctor, L. (2007). 5 million lives: IHI launches national campaign to reduce medical harm. https://www.psqh.com/analysis/5-million-lives-ihi-launches-national-campaign-to-reduce-medical-harm

Quality and Safety Education in Nursing. (2012). *Project overview*. http://qsen.org/about-qsen/project-overview/

Reeves, S., Perrier, L., Goldman, J., Freeth, D., & Zwarenstein, M. (2013). Interprofessional education: Effects on professional practice and health care outcomes (update). *Cochrane Database Syst Rev. 3* (CD002213). https://doi.org/10.1002/14651858.CD002213.pub3

Rega, M. D. (1993). A model approach for patient education. *MEDSURG Nursing*, *2*(6), 477–479, 495.

Reinhart, R. J. (2020, October). Nurses continue to rate highest in honesty, ethics. https://news.gallup.com/poll/274673/nurses-continue-rate-highest-honesty-ethics.aspx

Reising, D. L. (2007, February). Protecting yourself from malpractice claims. *American Nurse Today, 39,* 44.

Rifas, E., Morris, R., & Grady, R. (1994). Innovative approach to patient education. *Nursing Outlook, 42*(5), 214–216. http://dx.doi.org/10.1016/0029-6554(94)90021-3

Riffkin, R. (2014, December). Americans rate nurses highest on honesty, ethical standards. http://www.gallup.com/poll/180260/americans-rate-nurses-highest-honesty-ethical-standards.aspx

Rosen, G. (1971). Public health: Then and now. *American Journal of Public Health*, *61*(7), 1277–1279. http://dx.doi.org/10.2105.ajph.61.7.1277-a

Rosen, G. (1977). *Preventive medicine in the United States, 1900–1995*. Prodist.

Roter, D. L., Stashefsky-Margalit, R., & Rudd, R. (2001). Current perspectives on patient education in the U.S. *Patient Education and Counseling*, *44*, 79–86.

Salminen, L., Stolt, M., Koskinen, S., Katajisto, J., & Leino-Kilpi, H. (2013). The competence and the cooperation of nurse educators, *Nurse Education Today*, *33*(11), 1376–1381.

Salmond, S. W., & Echevarria, M. (2017). Healthcare transformation and changing roles for nursing. *Orthopedic Nursing*, *36*(1), 12–25. https://doi.org/10.1097/NOR.0000000000000308

Santo, A., Tanguay, K., & Purden, M. (2007). The experience of families with the home care of children after spinal fusion surgery. *Journal of Orthopaedic Nursing*, *11*(3), 204–212.

Sarasohn-Kahn, J. (2013). A role for patients: The argument for self-care. *American Journal of Preventive Medicine*, *44*(1), S16–S18. https://www.sciencedirect.com/science/article/pii/S0749379712006411

Schlesinger, L., & Fox, J. (2016, November 21). Giving patients an active role in their health care. *Harvard Business Review.* https://hbr.org/2016/11/giving-patients-an-active-role-in-their-health-care

Seelig, T. (2016). *Teaching—It's about inspiration, not information*. https://medium.com/@tseelig/teaching-its-about-inspiration-not-information-1f64ddf019e7

Shi, L., & Singh, D.A. (2015). *Delivering health care in America: A systems approach* (6th ed.). Jones & Bartlett Learning.

Smith, J. A., & Zsohar, H. (2013). Patient-education tips for new nurses. *Nursing 2013*, *43*(10), 1–3. https://doi.org/10.1097/01.NURSE.0000434224.51627.8a

Smith, M., Saunders, R., Stuckhardt, L., & McGinnis, J. M. (Eds.). (2013, May). *Best care at lower cost: The path to continuously learning health care in America* (pp. 189–226). National Academies Press. http://www.nationalacademies.org/hmd/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx

STD Related Reproductive Health Training and Technical Assistance Center. (2014, January). RN billing & coding FAQ: Clinic flow, codes, and levels of service. http://stdtac.org/wp-content/uploads/2016/05/RN-Billing-FAQ_STDTAC-1.pdf

Steketee, C., & Bate, F. (2013). Using educational design research to inform teaching and learning in the health professions. *Issues in Educational Research*, *23*(2), 269–282. http://www.iier.org.au/iier23/steketee.pdf

Stewart, M., Brown, J. B., Donner, A., McWhinney, I. R., Oates, J., Weston, W. W., & Jordan, J. (2000). The impact of patient-centered care on outcomes. *Journal of Family Practice*, *49*(9), 796–804.

Sullivan, L. W., & Bristow, (4), e17342L. R. (2007, March). *Summary proceedings of the national leadership symposium on increasing diversity in the health professions*. Sullivan Alliance.

Sykes, C., Durham, W., & Kingston, P. (2013). Role of facilitators in delivering high quality practice education. *Nursing Management*, *19*(9), 16–22. https://doi.org/10.7748/nm2013.01.19.9.16.s9513

Tang, C. J., Zhou, W. T., Chan, S. W-C., & Liaw, S. Y. (2018). Interprofessional collaboration between junior doctors and nurses in the general ward setting: A qualitative exploratory study. *Journal of Nursing Management*, *26*(1), 11–18. https://doi.org/10.1111/jonm.12503

Thistlethwaite, J. E., Dallest, K., Moran, M., Dunston, R., Roberts, C., Eley, D., Bogossian, F., Forman, D., Bainbridge, L., Drynan, D., Fyfe, S. (2016). Introducing the individual Teamwork Observation and Feedback Tool (iTOFT): Development and description of a new interprofessional teamwork measure. *Journal of Interprofessional Care*, *30*(4), 526–528. https://doi.org/10.3109/13561820.2016.1169262

Thistlethwaite, J. E., Forman, D., Matthews, L. R., Rogers, G. D., Steketee, C., & Yassine, T. (2014). Competencies and frameworks in interprofessional education: A comparative analysis. *Academic Medicine*, *89*(6), 869–875. https://doi.org/10.1097/ACM.0000000000000249

Timmers, T., Janssen, L., Kool, R. B., & Kremer, J. A. M. (2020). Educating patients by providing timely information using smartphone and tablet apps: Systematic review. *Journal of Medical Internet Research, 22*(4), e17342. https://doi.org/10.2196/17342

Tobiano, G., Bucknell, T., Marshall, A., Guinane, J., & Chaboyer, W. (2015). Nurses' view of patient participation in nursing care. *Journal of Advanced Nursing, 71*(12): 2741–2752.

U.S. Centers for Medicare & Medicaid Services. (n.d.). Your Medicare coverage: Yearly "wellness" visits. https://www.medicare.gov/coverage/yearly-wellness-visits

U.S. Department of Health and Human Services. (2015). About the Affordable Care Act. http://www.hhs.gov/healthcare/rights/law/index.html

U.S Department of Health and Human Services. (2020). *Healthy People 2030*. https://health.gov/healthypeople

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (1990). *Healthy People 2000*. http://www.cdc.gov/nchs/healthy_people/hp2000.htm

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2000). *Healthy People 2010*. http://www.cdc.gov/nchs/healthy_people/hp2010.htm

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). *Healthy People 2020*. http://www.cdc.gov/nchs/healthy_people/hp2020.htm

U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health. (2017, April). Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. https://www.healthypeople.gov/2020/about/history-development/healthy-people-2030-advisory-committee

Vennum, K. (2017). Healthcare in 2017: Amid the uncertainty, these changes are certain. *Becker's Hospital Review.* https://www.beckershospitalreview.com/hospital-management-administration/healthcare-in-2017-amid-the-uncertainty-these-changes-are-certain.html

Veterans Administration. (1953). *Patient education and the hospital program* (TB 10–88). Author

Ward, J. (2012). A guide to patient teaching and education in nursing. http://www.nursetogether.com/guide-patient-teaching-and-education-nursing

Watson, J. (2012). *Human caring science: A theory of nursing.* Jones and Bartlett.

Weingart, S. N., Zhu, J., Chiappetta, L., Stuver, S. O., Schneider, E. C., Epstein, A. M, David-Kasdan, J, A., Annas, C, L., Fowler Jr, F, J., Weissman, J. S. (2011). Hospitalized patients' participation and its impact on quality of care and patient safety. *International Journal for Quality in Health Care*, *23*(3), 269–277. https://doi.org/10.1093/intqhc/mzr002

Weingarten, V. (1974). Report of the findings and recommendations of the President's Committee on Health Education. *Health Education Monographs*, *1*, 11–19.

Weinstein, R. S., Brandt, B. F, Gilbert, J. H. V., & Schmitt, M. H. (2013). Bridging the quality chasm: Interprofessional teams to the rescue? Editorial. *The American Journal of Medicine 126*(4), 276–277. https://doi.org/10.1016/j.amjmed.2012.10.014

Weiss, B. D. (2003). *Health literacy: A manual for clinicians*. American Medical Association & American Medical Association Foundation.

Wen, J., & Shulman, K. A. (2014). Can team-based care improve patient satisfaction? A systematic review of randomized controlled trials. *PLoS ONE*, *9*(7), e100603. https://doi.org/10.1371/journal.pone.0100603

West, C., Veronin, M., Landry, K., Kurz, T., Watzak, B., Quiram, B., & Graham, L. (2015). Tools to investigate how interprofessional education activities link to competencies. *Medical Education Online*, *20* (28627). https://doi.org/10.3402/meo.v20.28627

Williamson, E. (2016, December). Nurses rank #1 once again in Gallup poll for ethics and honesty. https://www.nurse.com/blog/2016/12/21/nurses-rank-1-once-again-in-gallup-poll-for-ethics-and-honesty/March 23, 2021

Wingard, R. (2005). Patient education and the nursing process: Meeting the patient's needs. *Nephrology Nursing Journal*, *32*(2), 211–214. https://pubmed.ncbi.nln.gov/15889805/

Witt, C. (2011). Continuing education: A personal responsibility. *Advances in Neonatal Care*, *11*(4), 227–228. http://dx.doi.org/10.1097/ANC.0b013e31822648f3

Wong, E. M. L., Chan, S. W. C., & Chair, S. Y. (2010). Effectiveness of an educational intervention on levels of pain, anxiety and self-efficacy for patients with musculoskeletal trauma. *Journal of Advanced Nursing*, *66*(5), 1120–1131. http://dx.doi.org/10.1111/j.1365-2648.2010.05273.x

Wong, M. (2017, June 29). The vital role nurses play in patient care. *Physician-Patient Alliance for Health & Safety.* http://ppahs.org/2017/06/vital-role-nurses-play-patient-care/March 23, 2021

World Health Organization. (1988). *Learning to work together for health: Report of a WHO Study Group on Multiprofessional Education of Health Personnel: The team approach.* http://www.who.int/iris/handle/10665/37411 March 23, 2021.

World Health Organization. (2010). *Framework for action on interprofessional education and collaborative practice.* http://www.who.int/iris/handle/10665/70185 March 23, 2021.

World Health Organization, All-Party Parliamentary Group on Global Health. (2016a, October). *Triple impact: How developing nursing will improve health, promote gender equality and support economic growth.* World Health Organization. https://www.who.int/hrh/com-heeg/digital-APPG_triple-impact.pdf?ua=1&ua=1 March 23, 2021.

World Health Organization. (2016b). *Patient engagement: Technical series on safer primary care.* Author. http://apps.who.int/iris/bitstream/handle/10665/252269/9789241511629-eng.pdf

Zorek, J., & Raehl, C. (2013). Interprofessional education accreditation standards in the USA: A comparative analysis. *Journal of Interprofessional Care*, *27*(2), 123–130.

Zwarenstein, M., Goldman, J., & Reeves, S. (2009). Interprofessional collaboration: Effects of practice-based interventions on professional practice and healthcare outcomes. *Cochrane Database Syst Rev*, *3*(CD000072). https://doi.org/10.1002/14651858.CD000072.pub2