THE HEALTH WORKSHOP: DESIGN TO EVALUATE A PROTOTYPE IN PRIMARY NURSING CARE *

MONA KRAVITZ †
Research Associate

RATIONALE FOR DEMONSTRATION AND EVALUATION

The health status of Canadians remains relatively stable, in spite of massive illness detection and treatment measures and aggressive campaigns to provide "prudent" information about how people ought to live their lives. According to Health and Welfare Canada (1974) we have made marginal gains in the last two decades in altering the rates of dying, and sickness and disability. Health promotion is low in the scheme of things and, when considered, is fractionated as the preventive component of medical regimens: exercise is prescribed as part of the treatment plan to recover from heart attack, weight reduction is advised to ward off hypertension. Popular opinion conveys the idea that the attributes of healthy living are well known, that the line to health is simple and direct. Well-being can be achieved through compliance with the latest medical suggestion and adherence to an aesthetic style of life. If we eliminate cigarettes, reduce alcohol and calories, do moderate exercise, see the doctor regularly and drive with care, good health will follow.

The Workshop ethos takes issue with this undue emphasis on correcting deficits in people's behaviour [1]. Workshop nursing seeks, instead, to recognize and built potential. Health is seen as a variable in its own right, quite distinct from that of illness and worthy of the largest part of attention in clinical and research endeavors. Health situations may entail or-

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* The Workshop service was funded for two years in a middle income suburban community as a Special Health Care Program (Research Programs Directorate, Health and Welfare, Canada No. 605-1300-12). This sector was selected because it was representative of people who consume large portions of expensive medical services for lifestyle-related difficulties; families with young children predominate to form a study group with considerable potential for change; existing models for improving health care are based largely on information from the medically indigent of disadvantaged populations. The Workshop closed in August, 1979 owing to a lack of funding.

† Mona Kravitz is a research associate on leave from the faculty of the McGill University School of Nursing to complete a Ph.D. in epidemiology and health.

[1] The program is conceived as a learning centre. Clients do not need a specific problem or crisis to become a member. Staff include nurses with preparation at the Master's level, practitioners prepared through a generic baccalaureate program, a health librarian, a community development worker, administrative and support personnel. Physicians and other professionals (e.g., social workers, nutritionists, educational psychologists, media persons) are not formally located in the Workshop but practise *in situ* in a specialized resource capacity.

dinary events of daily life or crisis situations including management of illness or disability (Gottlieb, 1981) [2]. The Workshop program is a nursing response to society's need for services which augment health in addition to those aimed at preventing and curing disease. The program is framed as a community-based learning resource where families and nurses actively pursue agenda of health work: exploring questions germane to well-being, making sense of available health information, searching for and testing health practices, noticing and mobilizing unexploited opportunity and potential. The goal is for members to augment their skill in managing the spectrum of situations affecting everyday family and community life (e.g., becoming a parent, moving to a new community, integrating illness, growing old, finding one's way through the health system.) The nurse works with Workshop members in discovering productive approaches to health and illness contingencies. The task for evaluation was to explore the work of generalizing this innovation — to provide evidence to support or to negate its value.

Can a nursing service directed toward long-term family health strengthen the health care system, and at what cost?

OVERVIEW OF THE RESEARCH PLAN

Questions central to evaluation are as follows:

1. Given potential for change, do families utilizing the Workshop service achieve a higher level of competence in health behaviour than non-utilizer families?
2. Do families who utilize the Workshop service maintain or achieve satisfactory levels of health function?
3. Is the Workshop a viable type of service in particular sorts of communities?

Major variables identified in these questions are described and analysed along the following dimensions:

1. Competence in Health Behaviour as assessed through a repertoire of responses in situations affecting health —
   (a) problem-solving style
   (b) utilization of resources
   (c) perceived skill in health care decisions
2. Health Status — A composite of ordinary impairments (patterned after a modified version of Grogono's Index for measuring Health Status).

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2 Laurie Gottlieb's taxonomy for the content of health work is available in Allen, M., Frasure-Smith, N., & Gottlieb, L. 'Models of nursing for a changing health care system: A comparative study in three ambulatory care settings — Part II: Appendix.' Montreal, McGill University School of Nursing, 1981.

3. Viability of Service —
   (a) community awareness of health opportunities,
   (b) participation in shaping the Workshop concept,
   (c) cost of a unit of service per unit of health outcomes.

A quasi-experimental design was planned to test the hypotheses implied in questions (1) and (2). Individual studies (Community Awareness Telephone Survey, Utilization Study, Cost/Benefit Comparisons, Corroborative Evidence Projects) yield data to establish an overall point of view on the question of viability. Prognostic stratification of clients (Potential for Change)** and of nurses (Approach to Nursing)*** permit a more detailed analysis of family data. Client outcomes are examined in relation to degree of susceptibility of the Workshop member to the nursing manoeuvre. The study of nursing approach helps us appraise outcomes in relation to degree of implementation of the practice model in demonstration.

CRITERIA FOR EVALUATION: WORKING HYPOTHESES

1. COMPETENCE IN HEALTH BEHAVIOUR
   a. *Problem-solving style*

Clients who have used the Workshop service are more likely to learn to manage health situations than Non-Utilizers of The Workshop service.

Clients who have used The Workshop service will learn to solve health problems more effectively than Non-Utilizers of The Workshop service.

Dimensions on which the client's problem-solving approach is evaluated are as follows:

1. Type of Situation — Focus of client in the situation;
2. Context of Situation — Client perception of the unit within which the situation exists;
3. Perspective — Client perception of the extent and complexity of the situation;
4. Assessment — Sources of information and knowledge client draws on to identify the situation;
5. Plan — Attributes within individual/family upon which client bases his action responses;
6. Time Frame — Scheduling of health work for individual/family;
7. Evaluation — Client's method of identifying outcomes of health work.

** Potential for Change involves: interest in learning about health and in changing health behaviour; history of success/failure in school, work, social and family life; and concentration of illness/disability.

*** Another self-administrated questionnaire was created and pre-tested to aid in locating type and level of nursing style as defined by the Model in demonstration.

The chart which follows depicts "valued" attributes of the Problem-solving style expected in Workshop Users as well as "less valued" attributes of the Problem-solving style expected in Non-Utilizers. Each pair is followed by two examples: one valued behavior (+) and one less valued behavior (−).

b. *Utilization of resources*

Clients who have used The Workshop service will perceive a larger number of sources of assistance in health matters than Non-Utilizers of The Workshop service.

Clients who have used The Workshop service will make "better" use of health care resources than Non-Utilizers of The Workshop service: less reliance on physicians for non-medical situations, more reliance on self, family, neighbours, community supports, with periodic assistance from the nurse.

c. *Perceived skill in health-care decisions*

Clients who have used The Workshop service will assess their ability to solve health problems as higher than Non-Utilizers of The Workshop service.

2. *Health Status*

Clients who have benefited from The Workshop service (who have learned to notice and mobilize health care resources in an effective manner) will maintain or achieve satisfactory levels of health function.

Here we have a fruitful basic research question. Can Competence in Health Behaviour stand on its own as an indicator or predictor of health, or is its usefulness dependent on its association with "illness" status (health defined as the absence of impairement)? What does it mean when Competence and Health Status fail to coincide? How do we interpret the situation where family and nurse define the individual as healthy, the individual judges himself to be healthy, and the doctors consider the individual to be unhealthy (assuming that family, individual and nurse use the criterion, the ability to cope with health and illness contingencies)?

3. *Viability of Service*

a. *Community awareness of health opportunities*

X percent of citizens (families, individuals) residing in the catchment are knowledgeable of The Workshop's essential goals, activities and policies.

b. *Participation in shaping The Workshop concept*

X percent of citizens residing in the catchment area use The Workshop as a *health* resource. Service statistics monitor the nature and extent of lay and professional involvement with the service.

c. *Cost of a unit of service per unit of health outcome*

The cost of a unit of service is calculated and appraised in relation to

VALUED ATTRIBUTES Workshop Users	*LESS VALUED ATTRIBUTES* Non-Utilizers
Type of Situation	
Health Situation The client focusses on *health* aspects of the situation, that is, on the individual/family's *accommodation* to events of daily living with customary, unusual, and crisis situations including illness and hospitalization. Examples: + Health is a state of wellness which continually develops. We learn how to be healthy through trying to manage everyday stresses over time. Every time we experience a health problem, we learn something to help us cope better with other problems in the future.	Illness Situation The client focusses on the *illness* aspects of the situation, that is, medical conditions and disease including diagnosed psychiatric illness referring to etiology, pathology, symptomatology, diagnosis, treatment, etc. – Health is a state of wellness where disease and other unusual events are absent. We can achieve health by preventing illness and by following good health habits. We need to come into a health service for regular check-ups, take required vaccinations and follow orders when we are ill.
Context of Situation	
Family The client perceives the situation within the context of the *family* and as a phenomenon of the family (or group). Examples: + I try to get other family members involved in health problems: It is better to work on problems together.	Individual The situation is viewed as belonging to the *individual*; it may affect the family and vice versa. – I try to cope with health problems alone: I do not like to burden other family members.
Perspective	
Longterm The client views the situation as an *open* system; the situation develops, changes, influences and is influenced by other life events.	Episodic The client views the situation as a *closed* system with beginning and end, and isolated from other happenings.

VALUED ATTRIBUTES Workshop Users	*LESS VALUED ATTRIBUTES* Non-Utilizers
Perspective (Cont'd.)	
Examples: + Health problems are tied up with how I run my life: Becoming healthy is a life-long process.	– People run into health problems from time to time: When this happens, I work hard to correct the situation.
Assessment	
Exploratory	A Priori
The client employs an *exploratory* method: observes and gathers information and evidence from the individual/family, and makes use of other sources of information and knowledge — library, neighbours, professionnals — seeking the most reasonable explanation of the situation.	The client employs an *a priori* method; the client makes use of existing knowledge and experience to define the situation.
Examples: + When faced with a health problem, I do a lot of detective work before I decide what the problem is. I discuss issues with other people, do some reading on the subject and think about similar experiences from the past.	– When faced with a health problem, I seek the best advice I can get from health professionals. I rely heavily on expert opinion to clarify the situation for me.
Plan	
Potential	Deficiency
The client recognizes and utilizes the *strengths* and *positive* forces in the individual/family upon which to build and develop the plan of action.	The client concentrates on the *deficiencies*, lacks and failures in the individual/family upon which to establish the plan of action.

VALUED ATTRIBUTES Workshop Users	*LESS VALUED ATTRIBUTES* Non-Utilizers

Plan (Cont'd.)

Examples:

+ We try to use the strong points we have in coming up with a health plan.

– We try to overcome the weak points we have in coming up with a health plan.

Time Frame

Wait

The client times health work based on a continuing assessment of the individual/family's *readiness.*

Examples:

+ Often what to do is clear but the timing of the plan is wrong. We hold the plan until it seems ready for us.

Zoom

The client adopts the *professional's time schedule* for implementing the plan.

– Once the plan is clear, it is important to follow it as quickly as possible. The longer the delay, the harder it is to get along.

Evaluation

Individual/Family Outcomes

The client notes the *individual/family's responses* and *outcomes* to the plan and fashions further health work on these developments.

Examples:

+ The health professional and the family agree on specific goals. My family tries to achieve these goals. If the plan does not work, we try to figure out why so that we can build a better plan.

Professional Objectives

The client notes discrepancies between the individual/family's *outcomes* and the *expected outcomes* of the *professionals*; further planning is based on strengthening the original plan and reinforcing its method.

– The health professional sets specific goals which I agree with. My family tries to achieve these goals. If the plan does not work, we look at where we slipped up and try again. You cannot expect to succeed on the first try.

outcomes produced (quantity by type), then the range of choices among service options for specific health situations is costed. What is the purchasing power, for example, of a visit to The Workshop as compared with a visit to the hospital emergency department for help in managing a family member with chronic illness? What are the "choices foregone" in each set of utilization decisions? (Respondents are asked to indicate their first and second choice for assistance with an array of coping events. They may select friends, neighbours and other types of lay assistance, specify from a variety of health or other types of professionals, or choose no help at all. Once we are clear on the "value" of specific responses we can calculate, in dollar terms, the consequences of utilization decisions.)

Plan For Data Collection and Analysis

The field situation precludes a classical experiment with random assignment to contrasting treatment groups. Instead, a Quasi-Experimental design is established to approximate control as much as possible. The use of Solomon Blocks as outlined by Campbell and Stanley (1963) helps with major threats to validity, especially the effect of testing.

*QUASI-EXPERIMENT**

Outcomes: Competence in Health Behaviour, Health Status

Group	Pre-test	Post-test (6 months)?
1. Workshop Users N = ?	+	Competence Hi Health Status Hi
2. Community Non-Users N = "	+	Competence Lo
3. Workshop Users N = ?	–	Competence Hi Health Status Hi
4. Community Non-Users N = "	–	Competence Lo

Sample size depends on (among other factors, e.g., funds, manpower, number of variables in final measures) the size of the difference in outcomes desired. How much of a difference between comparison groups is clinically important?

In assessing the results, clients will be stratified according to their 'potential for change'. In measuring the variable, interest and involvement in learning about health, changing health behaviour and working

* All groups are measured for Potential for Change and Competence in Health Behaviour. Only Workshop Users are tested for health status. Groups (1) and (2) receive pre- and post-tests. Groups (3) and (4) are not pre-tested. All groups are followed forward in time.

with ideas are investigated. Items such as the following may be included:

— How interested are you, is your family as a whole, in learning to be healthy? (ordinal response options to two separate questions)

— Thinking about how you and your family deal with health matters, would you like to:
  ( ) Continue In The Same Way
  ( ) Change Health Practices Somewhat
  ( ) Make Major Changes In Health Practices

— Are you an "Ideas Person"? (By this I mean a person who likes to think and talk about the things that influence health?) (ordinal response options)

— How successful have you been in the following areas? School, Work, Social Life, Family Life (ordinal response options)

— Have you and/or your family experienced much illness or disability? If yes, please describe the situation(s) and indicate whether a hospital stay was necessary.

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* Complete Bibliography available from the School of Nursing, McGill.

RESUME

'L'Atelier A Votre Santé': Evaluation d'un prototype de soins infirmiers primaires

Cet article présente un modèle d'évaluation d'un service de soins infirmiers communautaires-type: 'L'Atelier à Votre Santé'. Le Projet de recherche vise à déterminer la pertinence, l'utilité et la rentabilité d'un tel service au sein de la collectivité qu'il dessert ainsi que la mesure dans laquelle les familles ayant recours à ce service sont en meilleure santé que les

autres. On évalue le comportement des familles en matière de santé en examinant leur façon de résoudre des problèmes, leur utilisation des ressources et la perception de leur capacité à prendre des décisions relatives à la santé. Quant à la rentabilité du service, elle est évaluée selon la connaissance qu'en ont les membres de la collectivité, la participation des citoyens au façonnement du concept de 'L'Atelier' et les coûts d'une unité de mesure de service par unité de mesure de résultats relatifs à la santé.

L'auteur, Mona Kravitz, est chargée de recherche à l'Ecole de sciences infirmières de l'Université McGill, en congé d'études pour l'achèvement de son doctorat en épidémiologie et santé.

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