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Nurses' Perceptions of Shared Medical Appointments

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Nurses' Perceptions of Shared Medical Appointments

by

Kristin Monza

A thesis submitted to the faculty of
Gardner-Webb University School of Nursing
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Abstract

With the increased economic burdens placed on Americans in recent years, the topic of healthcare has been in the forefront. As healthcare reform embraces the country, healthcare organizations are forced to re-examine their business structure more accurately to reflect the changing culture and patient population. The Shared Medical Appointment (SMA) is a model in the chronic disease setting, and many of the benefits and proficiencies have been studied but no studies have assessed nurse experiences or perception of SMAs. The purpose of this study was to determine the Registered Nurse's experience with and perception of SMAs. A descriptive exploratory design using a questionnaire (Nurse Perceptions of Shared Medical Appointments) assessed the convenience sample of 29 nurses enrolled in a nursing program during the fall of 2012 and spring of 2013. Data was analyzed using descriptive statistics and a frequency analysis was conducted on each response. Nurses have little experience with SMAs but found the factors provided by SMAs such as patient satisfaction, patient education, peer support, time with the provider, behavior changes, family support, self-care management, and inpatient readmissions to benefit their patient population. Nurses recommended SMAs in their area of practice. SMAs provide a creative approach to effective management of patients with chronic diseases. Nurses should be informed on the benefits, implementation, and structure of SMAs to enhance support and increase the use within various patient populations to optimize nursing care, increase patient satisfaction, and meet the changing needs of the healthcare organization.

Keywords: Shared Medical Appointment, nurse perception, group visit, chronic disease

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CHAPTER I

Introduction

The changes in healthcare, associated with the various alterations in government and economic policies, have become more evident in recent years. With the increased economic burden placed on Americans in recent years, the topic of healthcare has been in the forefront. The government has made numerous attempts to make healthcare obtainable for citizens in all socioeconomic classes but the cost of medical care remains at an all-time high.

As healthcare reform embraces the country, healthcare organizations are forced to reexamine their business structures to embrace the changing culture and patient population. We are now living in an era of chronic care with a vast majority of healthcare dollars spent treating these critical diseases. Patients are seeking treatment for diseases that will last them decades and possibly the rest of their lives (Noffsinger, 2009). The financial burden can be severe for those suffering from chronic disease, as the price of specialty care visits can be overwhelming and often leads to worsening conditions and noncompliance. Chronic disease affects approximately 133 million Americans and accounts for more than 75% of health care costs (Centers for Disease Control and Prevention [CDC], 2009). Quality of life requires various lifestyle modifications including, but not limited to diet, medication, exercise, and financial interventions.

Approximately, one in four patients living with a chronic disease experience significant limitations in daily activities. These patients require constant medical management from specialist services, requiring multi-symptom relief and caregiver support. They also have a high incidence of comorbidities such as diabetes, renal failure,

hypertension, obesity, dementia, and chronic obstructive pulmonary disease. Many patients lack the support and guidance needed to abide the self-care management skills required to maintain and improve their overall quality of life, and educational opportunities are scarce for both the patient and family members. In both the acute care settings and traditional follow-up appointments, patients often receive a solitary teaching session to cover material that will impact their lives and quality of living. These patients are often seeking the best possible quality of life, despite the struggles they face that impact themselves, their job, and their families (Noffsinger, 2009). Nurses and healthcare providers are expected to adapt to this culture change while also maintaining high quality, cost effective care to this chronic care population.

Justification of the Research

Chronic diseases are non-communicable illnesses that are prolonged in duration, do not resolve spontaneously, and are rarely cured completely. While healthcare attempts to place an emphasis on prevention, chronic diseases currently cause seven in ten deaths each year in the United States (CDC, 2009). Examples include heart disease, cancer, stroke, diabetes, and arthritis to name a few. Early diagnosis and proper treatment can improve quality of life and life expectancy for those living with these diseases. Proper treatment includes medication management, dietary restrictions, and exercise requirements (CDC, 2009). It is extremely important that patients understand their disease, have proper follow up with their specialty physician, and understand when and how to communicate with their physicians. Because of the unstable condition of these patients, providing effective and efficient education in the acute care setting can often be challenging, making the efficiency of the follow-up appointment invaluable.

Unfortunately, healthcare providers, physicians, and nurses are suffering from the ongoing changes in healthcare. Nurses are challenged with the nursing shortage, complex and culturally diverse patients, technological advancements, increased workloads and economic constraints in all managed care environments (Turler, 2007). These obstacles can hinder effective patient education and care to these suffering patients.

As a result of chronic disease and unsatisfactory healthcare, Edward Noffsinger introduced a care delivery model known as shared medical appointments (SMA) or group visits, which address many of these issues faced by the chronically ill patient population, healthcare providers, and organizations. SMA's are group visits in which multiple patients are seen simultaneously by the physician, in a supportive group setting. The delivery of medical care is the primary focus but these group appointments integrate the support of other patients, while providing the opportunity for patient education and emotional support in the presence of a multidisciplinary team (Noffsinger, 2009). Research has found SMAs to improve productivity, chronic disease management, patient satisfaction, physician satisfaction, patient education, and cost efficiency but no research has addressed the nurse's role in SMAs or their perception of the SMA model.

Purpose

Chronic disease must be thoroughly understood by the patient and their family members in order to manage the disease properly and preserve quality of life. SMA's can increase patient and provider satisfaction due to improved job performance, better cost control and productivity, access, and efficiencies. This will allow the provider to tend to the patient holistically, able to address both mind and body (Noffsinger, 2009). SMA's ensure greater time with the physician, minimal wait time, a relaxed pace, time to have

your questions answered, and the opportunity to learn from others suffering from the same chronic disease and lifestyle changes. SMA's could benefit numerous patient populations with improved care and education from the nurses, but most healthcare providers have never heard of SMAs and are unaware of the benefits they provide. The purpose of this study was to determine nurses' experience with SMAs and their overall recommendation of SMAs in their area of practice. Specifically, it was to determine how the SMA model related to patient education, peer and family support, time with the physician, behavior changes, and inpatient readmissions.

Thesis Question

This study was conducted to determine the following:

What is the Registered Nurse's experience with and perception of shared medical appointments?

Theoretical Framework

The organizational changes being made to accommodate the recent reform allows the opportunity for growth amongst one of the most essential roles in healthcare, i.e. the nurses, which led Marilyn Anne Ray's Theory of Bureaucratic Caring as the theoretical framework used to guide this study. "Nursing is holistic, relational, spiritual, and ethical caring that seeks the good of self and others in complex, community, organization, and bureaucratic cultures" (Coffman, 2006, p. 124). Marilyn Anne Ray's Theory of Bureaucratic Caring originated as a grounded theory from a qualitative study of caring in the organizational culture. The research discovered nurses and other professionals struggled with the paradox of serving the corporate needs of the bureaucracy while serving the caring needs of the patients (Ray, 2006). The Theory of Bureaucratic Caring,

often referred to as a holographic theory, implies multiple systems are interconnected with caring in the whole of the organizational culture and are developed to understand the various structures of caring within a complex organization (Coffman, 2006). SMAs create an environment supported by the concepts of Ray's theory of bureaucratic caring, which exemplifies the significance of spiritual and ethical care in relation to the economic, educational, physical, and social-cultural dimensions of complex healthcare organizations (Turkel, 2007). Nurses face cultural changes within organizations as a result of the various economic restraints and reform efforts. Ray's theory challenges nurses to renew their perceptions of everyday nursing and to use creative processes during this change to discover how nursing can be practiced in modern health-care environments (Coffman, 2006). Implementation of SMAs allows nurses the opportunity to provide spiritually-ethical care to the patient while also addressing the interconnected dimensions of physical, economical, educational, and socio-cultural concepts. This study employed a newly designed questionnaire to assess the nurse's perceptions of SMAs related to the concepts. The questionnaire measured each concept on a five-point Likert scale ranging from one (strongly disagree) to five (strongly agree). A CTE diagram was developed to display how the concepts were measured and to identify how Ray's Theory of Bureaucratic Caring guided the study (Appendix A).

Physical processes of SMAs were addressed with nurses' perceptions of patient satisfaction. Physical factors are the physical state of being, including biological and mental patterns (Coffman, 2006). Because the mind and body are interrelated, each pattern influences the other (Ray, 2006). SMA's are designed to manage chronically ill patients because they have the potential to provide more time with the physician,

unconstrained access to care, greater patient education, and more attention to psychosocial needs who face mind and body needs (Noffsinger, 2009). Nurses' perception of patient education opportunities in SMAs addressed the theoretical concept of education. The Theory of Bureaucratic Caring defines educational factors related to the meaning of caring as formal and informal programs used to convey information that teach and share information (Coffman, 2006).

The SMA incorporates the socio-cultural factors including ethnicity and family structures, intimacy with friends and family, communication, social interaction and support, community, and society (Coffman, 2006). The lifestyle modifications needed when managing a chronic disease often feel like an endless list of responsibilities. Patients feel overwhelmed and hopeless which can lead to failure. Providing a group setting in which patients find themselves among others suffering from the same disease and modifications delivers emotional support and can increase self-efficacy. Nurses' perceptions of peer support, family support, behavior changes, and self-care management in SMAs demonstrated the socio-cultural concept.

Healthcare providers have a responsibility to ensure patients understand: the status of their health, the self-regulatory skills necessary to improve their health, the motivation to ensure outcomes are met, and the consequences of non-compliance. Nursing perception of SMAs on patient readmission addresses the economic concept. Economic factors include financial guidelines imposed by managed care organizations and allocation of scarce human and material resources to maintain the economic viability of the organizations (Coffman, 2006).

Summary

The purpose of this study was to determine nurses' experience with and perception of SMAs. The concepts measured were guided by the Theory of Bureaucratic Caring, upholding spiritually-ethical caring of the patient as the centralized focus. With the impending economic changes in today's healthcare culture, SMA's could benefit numerous patient populations with improved care and education from the nurses. In addition, this study was to determine nurse's familiarity, if any, with SMAs and their perception of how the care model relates to patient education, peer and family support, time with the physician, behavior changes, and inpatient readmissions. An overall recommendation of the SMA model and how it pertains to their area of practice was also to be determined.

CHAPTER II

Literature Review

The SMA is a proven model in the chronic disease setting and many of its benefits and proficiencies have been studied. The purpose of this study was to determine the Registered Nurses' experience with and perception of SMAs. A literature review was conducted on 20 studies to identify the benefits of SMAs in various health care practices, nurse's perceptions of patient care, and the role of the Registered Nurse in SMAs. The concepts supported by the Theory of Bureaucratic Caring including caring, physical, economical, socio-cultural, and educational factors were addressed in the research. Sources used in the literature search included Cumulative Index for Nursing and Allied Health Literature (CINAHL Plus), Health Source: Nursing Academic Edition, Academic OneFile, and EBSCO Discovery Service. Terms included various grouping of the terms shared medical appointments, group visits, shared medical visits, nurse perception, patient, and caring.

Shared Medical Appointments/ Group Visits

SMAs have been used in various chronic disease settings and are commonly used in the diabetes population. Diabetes is one of the leading chronic diseases in the United States affecting an estimated 23.6 million people in the United States (CDC, 2009). Simmons and Kapustin (2011) conducted a systematic review of the evidence from clinical trials involving group visits for the management of diabetes with findings supporting the use of SMAs among the chronically ill, diabetes population. The literature measured the concepts of patient satisfaction, education, patient outcomes, financial impact, and quality of life. A total of eight studies met the inclusion criteria of patient

education and elements of the group visit (GV). The data found diabetes GV to be a viable alternative to the traditional appointment, demonstrating a positive financial impact with increased productivity, decreased emergency room visits, and decreased in total health care costs. Simons and Kapustin (2011) found a lack of standardization in what “group visits” consist of and what level of professional collaboration is needed to obtain the same results. Further research was recommended in the area of financial considerations, recommending innovative techniques such as SMA’s, virtual encounters, and social media to create patient-centered learning environments.

To broadly examine the various GV interventions, Jaber, Brakmajer, and Trilling (2006) conducted a qualitative review of current research of all GV articles published from 1974 to 2004. The review was conducted on research studies of GVs using PubMed and MedLine databases. The articles were organized sequentially and described the effect of all reviewed interventions including patient satisfaction, health services utilization, quality of care, health behaviors, physical function, depression, quality of life, disease specific outcomes, physician satisfaction, and cost of care. Studies differed in the GV model but the research found a consensus among the data that GVs improve satisfaction, quality of life, and quality of care indicators. Findings were also consistent with a decrease in health care utilization, particularly emergency department and specialist visits and some found a decrease in rates of hospitalization or readmission. GV impact on healthy behaviors, self-efficacy, and disease outcomes were inconsistent because of the differences in study structure and content of care. Overall, the study found GVs to be a favorable approach to chronic care management for the motivated patient, providing time for education and a means for productive and profitable medical care. The review

recommended the need for future studies to explore the feasibility and reproducibility of the GV model in primary care practices in order to better define the structure and process of care, the content of the visit, and appropriate outcome measures.

More specifically, a systematic review studied the effectiveness of GV for patients with diabetes (Riley & Marshall, 2010). A comprehensive search of databases included research studies, systematic reviews, and articles that included systematic evaluation of GVs and education or comparison with traditional outpatient care. After eliminating the exclusion criteria, 12 articles were reviewed. While many of the benefits of GV were identified, the GVs failed to demonstrate consistent statistical improvement in clinical outcomes (A1C, BP or lipids). GVs did show significant evidence of cost containment with reduction of inpatient and emergency department admissions, and results showed an improvement in patient satisfaction. The physician conducted the group education provided in many of the studies and there was no reference to the specific educational models used. Only one study evaluated the cost of GV, and the review found most studies to be short in duration. Results lacked any specific model for GV and were found inconsistent regarding improved patient outcomes. The researchers recommended that the GV model become standardized and should be applied across a variety of situations. Further testing for the GV model was recommended to determine the most effective approach and the most effective provider team to facilitate the GV.

Although heart failure is prominent among the chronically ill, only minimal research exists on SMAs in the heart failure population. Because SMAs provide education and support needed to improve knowledge and self-care among patients with heart failure, Yehle, Sands, Rhynders, and Newton (2009) conducted a longitudinal

experimental research study of self-care knowledge and self-care behaviors among community-living heart failure patients. Some were randomly assigned to a nurse-led SMA and were compared to the standard one-on-one appointment. Participants consisted of 34 community-living adults with a diagnosis of systolic or diastolic heart failure and living in central Indiana. The intervention and control group completed the Heart Failure Knowledge Test and Self-Care Heart Failure Index at baseline and again after eight weeks. The study found an improvement in knowledge in the intervention group but not a significant improvement in self-care. Future interventions suggested further research and focus on self-efficacy and compared to prior research found self-care behaviors could improve as a function of confidence instead of knowledge alone. The study also recommended further research using larger sample sizes in multiple settings and the duration of measurement longer than eight weeks. The study also suggested a potential for improved knowledge and self-care when education and support are provided in SMAs.

The benefits of a multidisciplinary SMA for complicated heart failure patients were identified in a pilot study by Lin, Cavendish, Boren, Ofstad, and Seidensticker (2008). Questionnaires administered to patients enrolled in a heart failure clinic at baseline and again at six months measured patient satisfaction, self-care management, depression, and quality-of-life. The questionnaires confirmed an increase in medication compliance and a statistically significant improvement in depression and self-care according to the Beck Depression Inventory and Self-Care Management Index results. Results suggest that using the SMA model increased patient satisfaction, improves quality of life, and reduces the number of hospitalizations. The study recommended

further research to determine the efficacy among younger patients due to a small sample size, preselected patients, and consisted of older men.

The financial burden is among the many misfortunes associated with managing a chronic disease, especially among the uninsured patient population. To examine a more detailed patient population, Clancy, Dismuke, Magruder, Simpson, and Bradford (2008) conducted a randomized controlled clinical trial to evaluate whether attending diabetes GV leads to lower medical care charges for inadequately insured patients with type 2 diabetes (DM). The study was conducted at the Adult Primary Care Center, Medical University of South Carolina Charleston serving approximately 6,000 inadequately insured patients. Patients with uncontrolled type 2 DM (A1C greater than 8.0%) were identified and invited to participate. Data was obtained from financial records for 186 patients. Of enrolled patients, 96 were randomized to receive care in GVs and 90 to receive usual care for 12 months and charges for GV and usual care were identical. Charges included outpatient visits, ED visits, and inpatient stays. By estimating a treatment effect model of charges and specialty group visits, results found a statistically significant savings in outpatient charges due to reduction in the use of more expensive specialty visits among a GV population with DM. It was hypothesized that this may be due to the longer duration with the provider during a GV. Because this study had six different providers in the GVs, the researchers found patient compliance was not provider dependent. Providers did participate in both arms of the study, which researchers stated could have been a weakness of the study because providers may have adopted some of the GV strategies. Only local inpatient, outpatient and ED charges were collected in the data, which could also have weakened results. Providers were not randomized. The study

found that after 12 months, all GV providers and their patients chose to continue with GVs.

Though studies have reported no significant relationship between clinical outcomes and GVs, Clancy, Peng, Okonofua, Yeager, and Magruder (2007) conducted a 12 month randomized controlled trial of diabetic patients to evaluate the effect of GV on clinical outcomes, specifically with 10 American Diabetes Association (ADA) guidelines. This study was based on findings from a previous study by the same researchers published in 2003, which showed a trend towards improved clinical outcomes and better adherence to ADA process-of-care in GV patients compared to regular visits. The current study was designed with more patients, multiple providers, and longer duration (12 months) to better evaluate the effectiveness of GVs in terms of quality of care and clinical outcomes in disadvantaged patients with type 2 diabetes. Results found certain clinical outcomes did not differ significantly at both six months and 12 months. At 12 months, patients receiving care in GVs exhibited greater compliance with ADA process of care indicators, higher sex, and higher age appropriate cancer screenings without differences in medical outcomes. Overall the study found GVs can improve quality of care for diabetic patients, but modifications may be necessary to achieve statistically significant clinical outcomes.

The percentage of children and adolescents with a chronic condition has increased from 1.8% in the 1960s to more than 7% in 2004 (CDC, 2009) and warrants review of SMAs among the pediatric population. The SMA addresses the challenges of providing health care to children with asthma and their caregivers. Schmucker, 2006, found these challenges to include: patient access, treatment of emotional, behavioral, psychological

and lifestyle factors, ongoing support, ongoing education, partnerships between the patient and the clinician, clinician satisfaction, and economic feasibility as cited in Wall-Haas, Kulbok & Kirchgessner, and Rovnyak (2012). In a study by Wall-Haas et al. (2012), SMAs were used as a tool to improve quality of care and service for children with asthma and their caregivers. This study implemented the first nurse practitioner-led Pediatric Asthma SMA in April 2008. The SMA included patients ages 2 to 18 years with asthma from the pediatric asthma population at Harvard Vanguard Medical Associates in Massachusetts and their caregivers. Eleven SMA sessions for children with asthma and their caregivers were held with a total attendance of 56, involving 51 individual children and included both new patients and repeat patients. Eight components of patient satisfaction with SMA were measured using a patient satisfaction survey designed by Dr. Edward Noffsinger. High levels of satisfaction were reported in each area. When patients compared the SMA to past appointments, more than half of the participants rated the SMA higher and the remainder rated the appointments the same. Overall, the study found SMAs to be a productive tool to improve patient satisfaction and provide the ideal setting necessary to improve outcomes for children suffering from asthma.

Obesity has become a major health concern in adults and children, one in every three adults and nearly one in every five young people aged 6–19 are obese (CDC, 2009). Greer and Hill (2011) developed and implemented a pilot program designed for shared medical GV targeting metabolic syndrome prevention in the ethnically diverse patient populations. The convenience sample of 22 patients with metabolic syndrome attended two community-based free clinics in Florida serving the uninsured. One group contained primarily Caucasian and African American patients; the other population was comprised

of primarily Hispanic patients. Participants completed a pre and post-knowledge based test that encompassed information on healthy lifestyle changes and disease processes associated with metabolic syndrome. Each session was analyzed at weeks one, five and ten to assess knowledge and clinical data including weight and body mass index.

Descriptive analysis was conducted of pre and post-knowledge based test at each SMA, and patient satisfaction was evaluated at end of program. There were no statistically significant differences in weight or BMI on weeks one and five, but there was a statistical significance in reduced waist circumference in both clinics at week 10. Knowledge base improved in both clinics and both sites received high scores for patient satisfaction.

Researchers found these results demonstrate SMAs to be an effective model to provide intense patient education, promote peer support, and facilitate health related behavior changes. The researchers recommended further studies to be conducted on other patient populations including insured patients.

The effects of SMAs on patient exercise and goal-setting behavior changes were analyzed with a pretest, posttest quasi-experimental study after experiencing four monthly SMAs (Dickman, Pintz, Gold, & Kivlahan, 2011). The SMAs were initiated for patients with diabetes and hypertension at the Jeanie Schmidt Free Clinic in Fairfax County, Virginia as an option for patients with the goals of providing consistent quality care, improving access to care, and providing patient support with their chronic diseases. The SMAs were facilitated in English, Spanish, and bilingually (English and Spanish). Participants completed a questionnaire of their self-managing behaviors and behavioral action plan at each SMA. Results showed a statistically significant increase in exercise time after participating in the SMA, and all SMA participants identified and agreed to

strive toward a measurable goal. Ninety-seven percent of the patients reported achieving the goal or almost achieving the goal. There were no statistically significant differences in self-managing behaviors in the English, Spanish, or bilingual SMA. The study found SMAs to be an effective means of reducing the burden of the chronic disease among patients and healthcare organizations, but researchers stated that SMAs must be tailored to the individual needs of the patient, including language, literacy level, culture, and life experiences.

Nurses' Perception of Patient Care

Although the benefits and advantages of SMAs in relation to patient care have been studied, the current literature does not address nurses' perception of SMAs. As a result, the search for current literature explored nurses' perception of various aspects of patient care. The literature relates the aspects of care to the concepts of the theoretical framework and identifies potential implications for SMAs specifically developed to meet the needs of the patient from the nurses' perspective.

Considering the nurses' responsibility to provide holistic care for the mind and body, McSherry and Jamieson (2011) shared descriptive findings from an online survey commissioned by the Royal College of Nursing to ascertain nurse's perceptions of spirituality and spiritual care. Nurses uphold a professional requirement to achieve competence in the delivery of spiritual care and to meet the spiritual needs of their patients. Recently society has questioned the role of the nurse in delivering spiritual care. In an attempt to identify what nurses' feel is required to provide spiritual care, an online survey was developed incorporating the Spirituality and Spiritual Care Rating Scale. The 4,054 members completed the survey within three weeks and used descriptive statistics,

frequencies, and percentages to identify pertinent findings. The preliminary analysis confirmed that nurses across the United Kingdom consider spirituality to be a fundamental aspect of nursing. Among 83% of respondents, 40% agreed and 43% strongly agreed that spirituality and spiritual care are fundamental aspects of nursing. Majority of respondents, 34% agreed and 56% strongly agreed, that providing spiritual care enhances the overall quality of nursing care. The findings indicate nurses recognize that attending to the spiritual needs of patients enhances the overall quality of nursing care. However, the majority of nurses still feel that they lack educational preparedness and require more guidance and support from governing bodies to enable them to support and effectively meet their patients' spiritual needs. These findings suggest spiritual care should be considered a factor to consider when implementing SMAs in a practice.

To support caring as the essence of nursing and to maintain patient satisfaction, nurses and patients need to agree on what constitutes nurse caring behaviors. To fully understand the concept of the nurse-patient relationship, each of their interpretations of caring was examined. Using a comparative and descriptive design, Zamanzadeh, Azimzadeh, Rahmani, and Valizadeh (2010) directed a study aimed at determining the caring behaviors which oncology patients and oncology nurses perceive to be the most important in an Iranian oncology center Northwest of Iran. A convenience sample of 200 patients and 40 nurses were studied over a period of four months in 2009 using the Caring Assessment Questionnaire. The questionnaire consisted of 50 caring behaviors that were categorized into six subscales. The overall mean was calculated for each subscale to determine the rank distribution of the subscales, and the Mann-Whitney U test analysis of variables was used to compare patients' and nurses' scores on subscales. Based

on the ranking, the oncology patients and nurses perceived highly physical aspects of caring. The nurses' and patients' perceived behaviors determined the nurse's competency in professional knowledge and care surveillance to be more important than psychosocial skills. Both groups ranked the six subscales in the same order and were in strong agreement in priority behaviors. Researchers implied this may be a result of the long-term nurse-patient relationship in the oncology field. The results also indicate that nurses be aware of the need to validate the effect their intended care has on patients, which can result in the goal of the patient feeling cared for. The research recommended that to deliver holistic care, oncology nurses must value the affective, emotional aspect of caring.

Bergh, Karlsson, Persson, and Friberg (2012) studied nurses perceptions of conditions for patient education in a cross sectional survey. The study focused on organization, environment, and professional cooperation aspects of patient education and if those conditions differ between nurses working in primary, municipal, or hospital care. A newly designed questionnaire was developed, based on a literature review, which identified five factors to be significant and included nurses' competence, education environment, health care organization, interdisciplinary cooperation, collegial teamwork, and patient education activities. Participants included 701 nurses working in primary care, municipal care, and hospital care in the southwestern part of Sweden. Results found that a large part of nurse's patient related work consists of patient education but the conditions for this work differ between primary care, municipal care, and hospital care. Nurses in primary care had better conditions and more managerial support. Primary care reported spending significantly more time in patient teaching than nurses in municipal

care and hospital care. In all groups, the nurses stated that they “often” had time for patient education but they had less time for “teaching” than for providing “information.” Nurses at hospitals and within municipal care could “never” to “occasionally” teach without being interrupted. There were significant differences when assessing the cooperation among nurses and physicians. One-third of the nurses were “occasionally”, “often” or “always” unsure of whom to address and what to teach. The results also revealed that patient education in hospital care is often given in disturbing environments, in the patient’s room, or in the presence of other patients which indicated a lack of privacy could threaten a patient’s integrity and confidentiality. The study recommended that to optimize patient education, there should be room for conversation in every work place setting, and nurses should be more active in structuring their practice to ensure patient education is consistently delivered. The study recommended organizations to assign the education responsibility to one person in the workplace in order to improve the quality of knowledge, understanding, and clinical skills, in addition to contributing to a desirable patient experience.

Challenges and opportunities for communication exist for healthcare providers caring for seriously ill patients and their families. Proper communication can be a catalyst to facilitate decisions regarding advanced treatment options such as hospice and palliative care. Boyd, Merkh, Rutledge, and Randall (2011) assessed oncology nurses’ attitudes toward end-of-life care and their experiences caring for terminally ill patients. Using a descriptive correlational survey, 31 oncology nurses who worked in inpatient and outpatient areas of a Magnet designated hospital in southern California, completed the adapted version of the Caring for Terminally Ill Patients Nurse Survey. Results found that

nurses have a fairly positive attitude toward hospice and are having discussions about prognosis with terminally ill patients. Most nurses agreed that patients would benefit from earlier initiation of hospice care. Nurses also reported missed opportunities for discussions and patient referrals to hospice. On average, nurses cared for more than seven terminally ill patients during a three-month period and discussed hospice care with a third of these patients and family members. The study concluded that the nurses' attitude toward hospice could be indicative of the lack of conversations, but found the lack of patient and family member acceptance to be the most important barrier to discussion of hospice. Researchers concluded that it is important for organizations to develop strategies that enable nurses to have a stronger voice for patients and family members, and provide tools to enhance discussions related to end-of-life. They felt this would decrease patient resistance and increase the likelihood of nurse-initiated discussions. This is a prime topic to consider when caring for the chronically ill patient population.

The healthcare organizations are victims to so many financial obligations and economic changes. The national reduction in registered nurses resulted from healthcare organizations attempt to hamper the increasing healthcare costs. Schreuders, Bremner, Geelhoed, and Finn (2012) led a research study to explore the nurses' perception of the significant impact, if any, nursing care has on nurse sensitive outcomes. An exploratory survey used a convenience sample of nurses attending a three-day nursing conference in Australia. The 73 participants were asked to indicate how much of an impact they thought nursing care (using a Likert scale) had on each of 13 clinical indicators and to select the three clinical indicators for patient outcomes most influenced by nursing care. The results suggest that nurses' educational background and work role may influence

their perception of the impact of nursing care on patient outcomes. Nurses with postgraduate degrees and those with a clinical work role had higher mean scores for the impact of nursing care on patient outcomes. All nurses reported that pressure ulcers and surgical wound infection were most affected by nursing care. Participants suggested falls, medication errors, pain management, and patient education as some of the clinical indicators that provide appropriate measures of nursing care. The researchers found patient education and discharge information as two indicators that have not been widely studied, reflect core nursing care and could be identified as positive outcome indicators when measuring optimal nursing care. The outcome of hospital readmission was suggested by 12% of participants but was not included in this study. Of the 74 participants, 32 suggested one or more additional clinical indicators they thought were related to nursing care including mental health, physiological outcomes, and patient education.

Individualized care is an essential factor for patients and nurses, especially among the chronic disease population. Suhonen, Gustafsson, Katajisto, Valimaki, and & Leino-Kilpi (2010) studied nurses' perception of individualized care, factors associated with these perceptions, and their perceptions of the establishment of individualized care in different types of healthcare organizations. A cross-sectional, descriptive and exploratory design using the Individualized Care Scale-Nurse (ICS) questionnaire surveyed 544 nurses working in a hospital district in Finland. Nurses perceived that they supported patient individuality well and that the care they provided took into account patient individuality. The study results found nurses' background variables were not associated with their perceptions of individualized care delivery. Results found mental health ward

nurses had the most positive perceptions and nurses working in primary health long-term care had the lowest perceptions. Findings identified that healthcare organizations and work environments may have an influence on individualized patient care delivery. Nurses perceived that they generally supported patient individuality well through nursing activities and maintained patient's control over their decisions. Patients' personal life situations were perceived as less supported by nurses.

The concepts of caring, respect and human presence are commonly studied in nursing literature. Papastavrou et al. (2012) used a descriptive and correlational research design to examine the differences between nurse and patient perception of the frequency of respect and human presence in clinical care. A convenience sample of 1,537 patients and 1,148 nurses from six European countries participated in the study. The study used the Caring Behaviors Inventory-24 questionnaire based on Jean Watson's Transpersonal Caring Theory which measures four factors of assurance of human presence, knowledge and skill, respectful deference to others, and positive connectedness. Results demonstrated differences of opinion between nurses and patients are statistically significant on all items. The results of this study revealed that there is a lack of convergence between nurse and patient opinion on the perceived frequency of respectful behaviors in clinical care and caring behaviors that convey assurance of human presence. The most important finding is that nurses report performing certain nursing behaviors more frequently than patients perceive, in almost all of the questions asked. These results imply nurses should frequently evaluate the difference between patients and nurses to critique their own attitudes and maintain sensitivity towards patient needs. Also, organizations should develop strategies to help nurses set goals to address their human

presence within the group of patients cared for.

The research identifies the nurse's various perceptions of care including spirituality, end-of-life communication, and how it affects nurse sensitive outcomes. Nursing perceptions of care should be considered when implementing and designing the structure of the SMA model.

Nurse's Role in SMA

Based on the success of family education classes for patients prior to cardiac surgery, a pilot study was conducted in Cleveland, Ohio, implementing SMAs in a Cardiac Surgery Outpatient Clinic (Harris, 2010). The researcher theorized that SMAs would be an effective strategy for patients after heart surgery to provide timely medical care after discharge and acquire support, education, and increased access to medical care after discharge. The results of this study were notable because the SMAs were fully nurse-led by a group of cardiothoracic nurses. After a few months of conducting weekly SMAs, a patient satisfaction survey was developed and 34 participants were surveyed. Findings revealed that 92% would recommend SMA to other patients and 82% would prefer an SMA rather than an individual visit. These findings were consistent with the physician-led SMA satisfaction surveys in the same organization. Implementing and sustaining the model by keeping staff enthusiastic and patients interested were some of the obstacles identified with the SMA model. Further outcomes to measure how SMAs enhance patient self-efficacy and behavior change and to reduce depression and anxiety were recommended for future research studies. The survey results were consistent with the physician-led satisfaction scores inferring that nurse-led SMAs may be a more efficient and cost effective model to provide care in an environment where budget may

dictate how care is provided.

Jessee and Rutledge (2012) used a quasi-experimental design in the non-randomized, prospective study to identify barriers to participating in a diabetes program and determine the effectiveness of a multidisciplinary nurse practitioner coordinated team (NPCT) group visit on the health, knowledge, and self-efficacy of patients with type-two diabetes. The researchers enrolled participants from southwest Virginia, 11 participants in the NPCT intervention group and 15 participants in the comparison group. The participants completed the researcher designed Diabetes Knowledge Tests and the Diabetes Empowerment Scales prior to the intervention and after the intervention was completed. The intervention group had better clinical outcomes, greater knowledge, and better self-efficacy following the group visit than the standard care groups. The barriers to care identified included fuel, time, family, work, and transportation. The study found NPCT group visits to be an effective means of integrating diabetes self-management education and medical management in a family practice clinic in medically underserved areas.

Watts et al. (2009) developed a qualitative case analysis to describe the roles of nurse practitioners (NP) in SMAs for patients with chronic disease based on the chronic care model (CCM). Interviews were conducted with all staff participants and the convenience sample of patients attended one of three disease-specific SMAs (diabetes, hypertension, and heart failure). The six structural components of the CCM evaluated were: (1) identifying the skills of self-management; (2) decision support; (3) delivery system design; (4) clinical information systems; (5) community resources; and (6) organizational support. “Because nurse practitioners are trained to think holistically, to

foster team building (a factor in implementing planned care), and to educate and motivate patients, they are particularly needed in SMAs” (Watts et al., 2009, p. 171). Findings revealed NPs had the greatest role in self-management, decision support, and delivery system design. Other factors identified in successful chronic disease SMA’s (diabetes, hypertension, and heart failure) include strong peer support and patient-centered care through motivational teaching. With the increase in chronic disease, healthcare systems are increasingly challenged to provide necessary care and empower patient compliance. NPs can define and expand their roles and opportunities to engage patients and other health professionals in the process of achieving healthful behavioral changes. NPs are positioned to foster patient-centered care. Findings suggest that NPs can improve outcomes in chronic health care management by providing efficient, cost-effective, and evidence-based health care with a focus on prevention, elimination of barriers to care, and self-management.

Summary

The literature identifies the various benefits and efficiencies of the SMA in relation to patient outcomes of various chronic disease populations, the benefits of nurse-led SMAs and nurse perceptions of various aspects of patient care. No research has studied the nurses’ experience or perceptions of SMAs, which warrants the conduction of this study.

CHAPTER III

Methodology

SMA's are replacing the traditional appointments in many chronically ill patient populations because of benefits offered to the patient and family members. Patients find support from peers, longer time with their physician, and an environment that fosters education and self-efficacy. The purpose of this study was to determine if nurses had used SMA's in their practice and if they found SMA's beneficial for patient education, peer support, time with the physician, and family support, reduced inpatient readmissions and if they would they recommend SMA's in their area of practice.

Implementation

The Nurses' Perceptions of Shared Medical Appointments questionnaire was created for the study (Appendix B). The questionnaire assessed nurses' experience with SMA's and nurses' perceptions of SMA's compared to the traditional appointment. The questionnaire addressed the following issues: patient education, peer support, greater time with the provider, behavioral changes, family support, self-care management, inpatient readmissions, and nurse recommendations. The questionnaire was created using the determinants of the theoretical framework addressing the economic, educational, physical, and social-cultural dimensions of care.

Setting

The study was conducted via online survey and submitted to nursing students enrolled at a University via campus email and paper questionnaire. The questionnaire was submitted and approved by the University's Institutional Review Board and dispersed via

email to the students. The questionnaire results were obtained and generated in a Microsoft Excel document per University Creative Services.

Sample

A convenience sample of participants was surveyed from a University School of Nursing program. Questionnaires were administered via email from a member of the University Creative Services department to ensure anonymity and decrease bias. All nursing students enrolled in the University School of Nursing during the fall 2012 and spring 2013 semester were eligible. As a result of few responses, the questionnaire was again dispersed to 24 students enrolled in an on-campus nursing course. Thirty-six students were enrolled in the doctorate program, 120 students were enrolled in the master's program and 24 students were present on campus at the time the questionnaire was dispersed.

Design

A descriptive exploratory design used the Nurses' Perceptions of Shared Medical Appointments Questionnaire to measure the nurses' perceptions of shared medical appointments. The questionnaire measured the Registered Nurses' experience and their perception of SMAs compared to the traditional appointment. Also measured was how SMAs related to patient satisfaction, patient education, peer support, increased time with the provider, behavior changes, family support, self-care management, inpatient readmissions, and the nurses' overall recommendation. The 15-item questionnaire measured each factor using a 5-point Likert scale ranging from Strongly Agree to Strongly Disagree and could be completed in five minutes. The questionnaire results were obtained via email in a Microsoft Excel spreadsheet from a member of the

University Creative Services. The data was numerically coded and used Microsoft SPSS (Statistical Package for Social Sciences) to analyze descriptive statistics, frequencies and percentages.

Protection of Human Subjects

Prior to submitting the questionnaires, the researcher obtained permission from the University's Internal Review Board (IRB). Participants were informed of the questionnaire and it was identified as a part of a graduate school thesis. A consent form accompanied the questionnaire and the completion of the questionnaire was voluntary and doing so agreed upon informed consent (Appendix C).

Instruments

The researcher designed questionnaire was piloted and face validity was determined by a panel of four Registered nurses (RN) including two advance practice nurses, a bachelor's prepared RN and an associated prepared RN. Each nurse had a background in cardiac nursing and specialized in heart failure patient management. Three of the nurses were involved in the implementation of SMAs for the chronically ill, heart failure population at an urban quaternary facility.

Data collection

Once face validity was determined, the questionnaire was sent to the Chair of Graduate Programs in the School of Nursing and Chair of the RN to BSN Program, who submitted the questionnaire to their advisees during the Fall 2012 semester. Students were asked to complete the survey using an online survey tool that they received via email or using pen and paper and return at their earliest convenience. Data was collected on each participant that completed the questionnaire. The responses were collected by the

University Creative Services department and submitted to the researcher via Microsoft Excel spreadsheet.

Data Analysis

The data was numerically coded by the researcher and had statistical support from a faculty member of the School of Nursing. A quantitative analysis was conducted using SPSS Version 16 for Windows, and descriptive statistics and a frequency analysis were conducted on each questionnaire response.

Summary

Literature has found SMAs beneficial for various patient populations. The purpose of this study was to determine nurses' experience with and perceptions of the SMA model. A descriptive exploratory design explored nurses' perceptions of SMAs to determine the support of nurses, if any, implementing the SMA model in their patient population. The Nurses' Perceptions of Shared Medical Appointments questionnaire was designed for the study.

CHAPTER IV

Results

In a descriptive exploratory study, a researcher designed questionnaire assessed the Registered Nurses' experience with and perception of SMAs. The questionnaire also assessed the nurses' perceptions of patient satisfaction, education, peer and family support, behavior and self-care management, inpatient readmissions and overall recommendations of SMAs.

Sample Characteristics

The 29 nurses who completed the questionnaire averaged 13.4 years' experience, ranging from two to 34 years, 82.8% of the participants were Bachelor prepared, 10.3% had an Associate degree, and 6.9% had a Master's degree (Figure 1, Table 1). Of the 29 nurses questioned, 89.7% worked in a practice that did not offer SMAs; 10.3% worked in a practice that did offer SMAs. These findings supported the response regarding the nurses' knowledge of SMAs which found 24.1 % of the participants had heard of SMAs; 75.9% had not (Figure 2, Table 2). The 29 nurses worked in various settings including inpatient, outpatient, long-term and acute care (Figure 3). There were three participants that did not describe their area of practice or years of service. The three non-responding participants held an Associate's degree and each worked in a practice that offered an SMA.

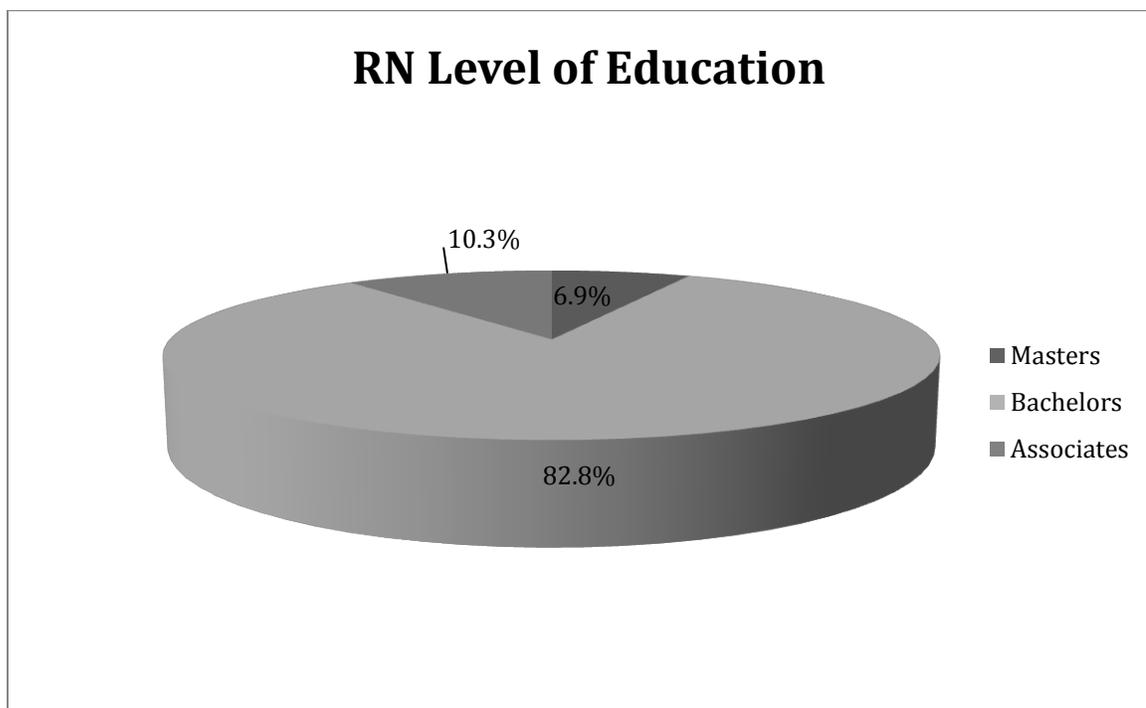


Figure 1. RN Level of Education

Table 1

Frequency analysis of RN Level of Education

Level of Education	Percentage (frequency)
Masters	6.9% (2)
Bachelor's	82.8% (24)
Associates	10.3% (3)

Table 2

Frequency Analysis of RN Experience with SMA

Experience with SMA	Percentage (frequency)
Offer SMA	10.3% (3)
Did not offer SMA	89.7% (26)
RN heard of SMA	24.1% (7)
RN not heard of SMA	75.9% (22)

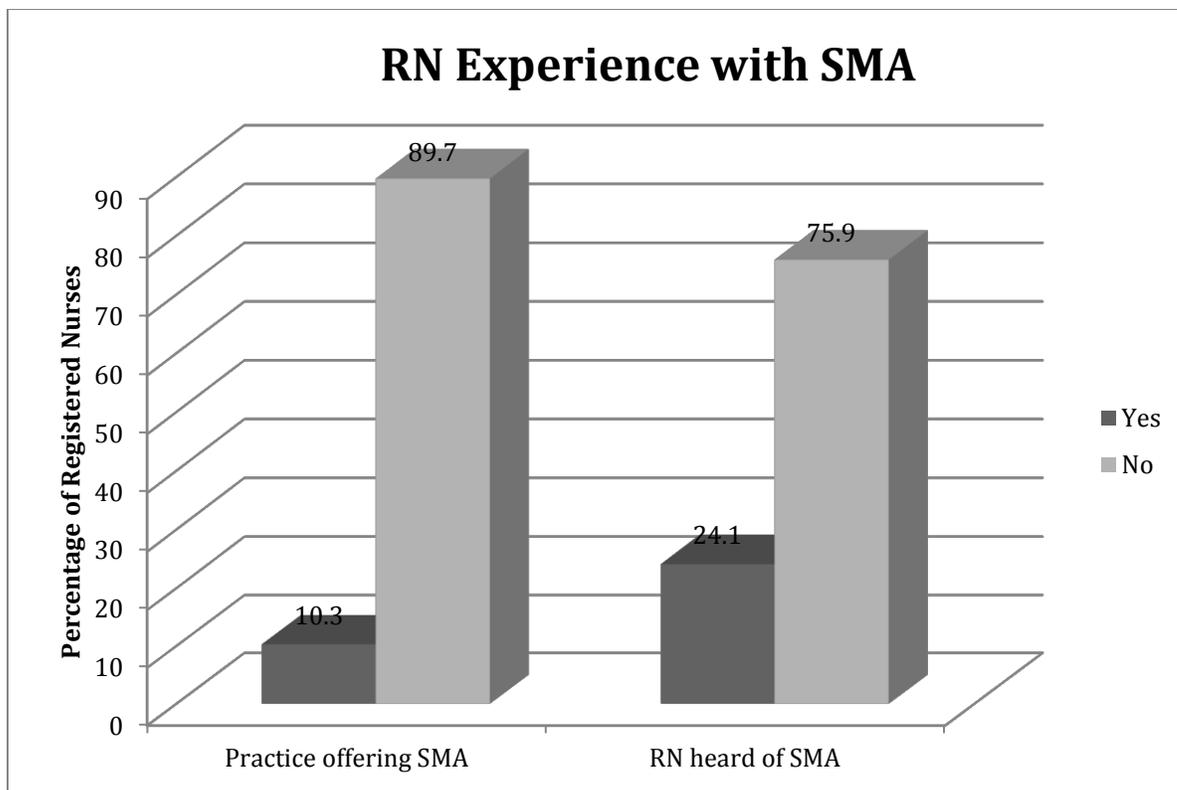


Figure 2. RN Experience with SMA

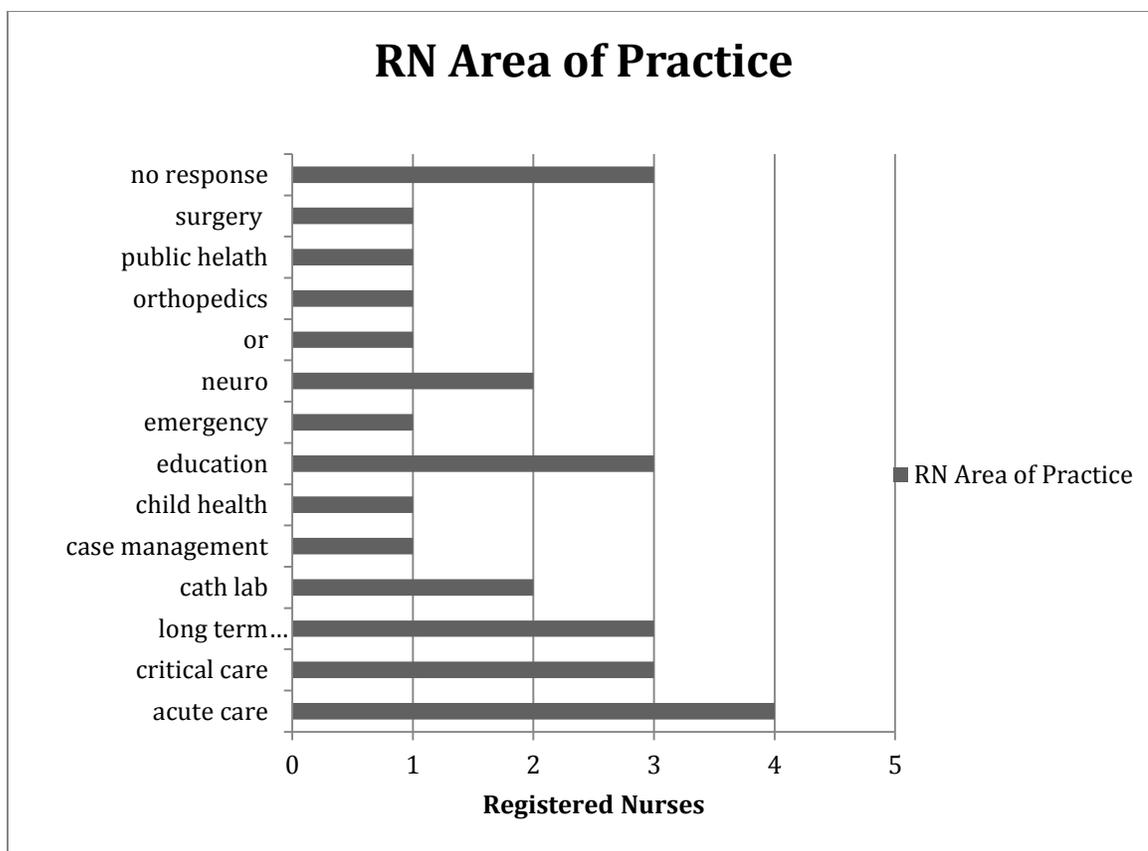


Figure 3. RN Area of Practice

Major Findings

In a frequency analysis, 20.7% of nurses perceived patients to be more satisfied with the SMA compared to the traditional appointment, 3.4 % did not perceive patients to be more satisfied with SMA compared to the traditional medical appointment and 76% remained neutral. Majority of nurses questioned, (51.7%) agreed their patient population would benefit from SMAs, while the remaining 48.2% either disagreed (24.1%) or remained neutral (24.1%).

The questionnaire found 68.9% of the nurses questioned thought SMAs could provide more opportunities for patient education in their area of practice; 10.3%

disagreed and 20.7% remained neutral. Majority of nurses found the peer support provided in a SMA beneficial to their patient population: 75.9% agreed, 13.8% disagreed, 10.3% neutral

Using Noffsinger's model of SMAs, appointments occur between 60 and 90 minutes, allowing greater opportunity for education and greater time with the physician. Results found that 58.6% of the participants presumed their patient population to be more satisfied with the time increase compared to 17.2% who disagreed and 24.1% remained neutral. Of the respondents, 93.1% perceived their patients to be satisfied with greater time with the physician. Zero participants' perceived patients to be dissatisfied with greater time with the physician and 6% remained neutral.

Twenty-one participants (72.4%) thought the peer support offered by SMAs could better facilitate behavior changes among their patient population, 10.3% disagreed, and 17.2% remained neutral. Participants were informed that family members attend the SMA with the patient to provide support in self-care management skills and behavior changes. Twenty-five nurses (86.2%) perceived the support of family provided in the SMA will lead to better self-care management and zero participants disagreed. When questioned if participants thought integrating SMAs in their area of practice could decrease inpatient readmissions, twenty participants (69%) agreed, three participants (10.3%) disagreed and five individuals (17.2%) remained neutral. Overall, the majority of the nurses (65.5%) reported they would recommend implementing SMA in their practice: 17.2% disagreed and 17.2% remained neutral (Table 3).

Table 3

Frequency Analysis of Nurses' Perceptions of SMAs

Survey Question	Percentage (frequency) n=29		
	Agree	Disagree	Neutral
Do you think patients were more satisfied with the shared medical appointment compared to the traditional medical appointment?	20.7% (6)	3.4% (1)	76% (22)
Do you think your patient's population would benefit from shared medical appointments?	51.7% (15)	24.1% (7)	24.1% (7)
Do you think that a shared medical appointment could provide more opportunities for patient education in your practice?	68.9% (20)	10.3% (3)	20.7% (6)
Do you think that the peer support provided in a shared medical appointment could benefit your patient population?	75.9% (22)	13.8% (4)	10.3% (3)
Most shared medical appointments last between 60 and 90 minutes, offering greater time with the provider. Do you think your patient population would be more satisfied with the time increase?	58.6% (17)	17.2% (5)	24.1% (7)
Do you think your patient population would be more satisfied with the greater time with the physician?	93.1% (27)	0% (0)	6.9% (2)
Do you think the peer support offered by the shared medical appointment could better facilitate behavior changes amongst your patient population?	72.4% (21)	10.3% (3)	17.2% (5)
Both patient and family members attend the shared medical appointment. Do you think the family support could lead to better self-care management?	86.2% (25)	0% (0)	13.8% (4)
Do you think integrating shared medical appointments in your practice could decrease inpatient readmissions?	69% (20)	10.3% (3)	17.2% (5)
Would you recommend implementing shared medical appointments in your practice?	65.5% (19)	17.2% (5)	17.2% (5)

Summary

The results from the Nurse's Perception of Shared Medical Appointments questionnaire had numerous neutral responses and found that a significant amount of participants (75.9%) had never heard of SMAs and 89.7% did not work in a practice that offered SMAs. The findings further indicated that the participating Registered Nurses have an overall positive perception of the benefits of SMAs with more positive perceptions (Strongly agree) than negative perceptions (Strongly disagree).

CHAPTER V

Discussion

This descriptive study was designed to determine the Registered Nurses' experience with and perception of SMAs. The findings were based on the 29 responses of Registered Nurses from various education, work experience and clinical backgrounds.

Implications of Findings

This study provided several implications for research and results found nurses agree more than disagree with the benefit of each SMA concept questioned. Concepts questioned include patient satisfaction, patient benefit, patient education, peer support, appointment time increase, greater time with the provider, behavior change, self-care management, family support, decrease in readmissions, and an overall recommendation of implementing SMA in their particular area of practice.

Results found 20.7% of nurses' surveyed perceived patients to be more satisfied with the SMA compared to the traditional appointment, supporting findings by previous research (Harris, 2010; Simmons & Kapustin, 2011; Riley & Marshall, 2011). Majority of nurses (51.7%) agreed their patient population would benefit from SMAs. The study found 68.9% of the nurses agreed SMAs could provide more opportunities for patient education in their area of practice, 10.3% disagreed and 20.7% remained neutral. These findings imply SMAs could be an effective model for providing comprehensive patient education. This is supported by the literature that found patients knowledge base improved with the implementation of SMAs (Greer & Hill, 2011). SMAs provide delegated time, space and personnel to provide patient education and literature. Nurses agree with this environment and find it effectively optimizes patient education (Bergh et

al., 2012). Data found nurses to perceive the SMA model beneficial for patient education, which is congruent with the literature that identified nurses' agreement that with delegated space, time and personnel, patient education could be optimized. Various patient populations can benefit from implementing SMAs in their practice. Literature supports SMAs for chronic care management (Jaber et al., 2006; Watts et al., 2009) including the diabetes population (Simmons & Kapustin, 2011; Jessee & Rutledge, 2012), asthma population (Wall-Haas et al., 2012) and the heart failure patient population (Lin et al., 2008; Yehle et al., 2009). Majority of nurses (75.9%) found the peer support provided in a SMA beneficial to their patient population. Greer & Hill (2011) supported this, finding SMAs to be an effective model to promote peer support and facilitate health related behavior changes. Watts et al., 2009 emphasized peer support and patient centered care as a factor in successful chronic disease SMAs. Results found that 58.6% of the participants assessed their patient population to be more satisfied with the time increase of the 90 minute SMA and 93.1% perceived their patients to be satisfied with greater time with the physician. The importance of adequate time for patient care, education, and the cooperation between the nurse and physician are supported in previous literature and confirmed by nurses who identified these missed opportunities with patient communication (Boyd et al., 2011).

Twenty-one participants (72.4%) thought the peer support offered by SMAs could facilitate behavior changes among their patient population. Similar results were supported by patients attending physician-led SMAs (Lin et al., 2008; Greer & Hill, 2011) and nurse-led SMAs (Watts et al., 2009). Twenty-five nurses (86.2%) perceived the support of family provided in the SMA to lead to better self-care management and zero

participants disagreed. Previous research supports increased self-care management in SMAs (Lin et al., 2008; Dickman et al., 2011; Jessee & Rutledge, 2012). Results indicate further research to focus on self-efficacy in SMAs (Yehle et al., 2009) and further studies to assess the relationship between family support in SMAs and self-care management. Study results found that 20 participants (69%) agreed, three participants (10.3%) disagreed and five individuals (17.2%) remained neutral when asked if they thought integrating SMA in their area of practice could decrease inpatient readmissions. A great amount of literature relates SMAs to positive financial outcomes and several studies have also proven SMAs to decrease emergency room admissions (Simmons & Kapustin, 2011; Jaber et al., 2006) and inpatient readmissions (Jabet et. al, 2006; Clancy et al., 2008). The study found that overall the majority of the nurses (65.5%) reported they would recommend implementing SMAs in their practice. Literature supports patients recommending SMAs in their specialty area (Harris, 2010) but no research supports nurses' recommendations of SMAs.

Application to Theoretical Framework

Marilyn Anne Ray's Theory of Bureaucratic Caring originated as a grounded theory from a qualitative study in the organizational culture. The research discovered nurses and other professionals struggled with the paradox of serving the corporate needs of the bureaucracy versus serving the caring needs of the patients (Ray, 2006). "Nursing is holistic, relational, spiritual, and ethical caring that seeks the good of self and other in complex community, organization and bureaucratic cultures" (Coffman, 2006, p. 124). The results of this study found the Theory of Bureaucratic Caring to be a supportive framework for the SMA model. Results found the concepts of the theory support the

nurse's caring role and caring needs of the patient, while also meeting the corporate needs of the organization. Nurses perceived the concepts supported by the theory to benefit patient satisfaction, patient education, peer support, greater time with physician, family support, behavior change, self-care management, and decreased readmissions among their patient population.

Limitations

In an attempt to avoid bias in the results, questionnaires were submitted confidentially. Three results were submitted partially completed. In future studies, it should be required to complete each aspect of the questionnaire as the partially completed caused a great weakness in the study results, making it unable to identify the area of practice conducting SMAs. The study's sample size was small and limited to the nursing students and staff at the University school of nursing. Other limitations included the weakness of the questionnaire itself. More open-ended questions could better enhance understanding of the nurse's perception.

Implications for Nursing

The economic and political dimensions of bureaucratic caring can be used to guide nursing practice. Positive patient outcomes are necessary for organizational survival in today's competitive market forcing nurses to embrace the caring philosophy and retain focus on the bottom line (Ray, 2006). Nursing practice must seek the opportunities to change with the culture of today's healthcare and uphold caring as the core value of the practice. In an environment where economics and cost of health care have become the catalyst to change, of permeating discussions and clinical decisions, nurses have become proactive and use theory-based practice to shape the future of

nursing (Ray, 2006). The study found nurses have little experience with SMAs but found the majority of participants agree their patient population could benefit from patient education, peer support, greater time with the provider, behavior change, better self-care management, and decreased readmissions; all provided by the SMA model. Results found the majority of nurses surveyed recommend SMAs in their practice. SMAs are advantageous for both the patient and practice of nurses in this cost-driven economy. Expanding the use of SMAs among and beyond chronic care populations is also recommended. Implementing SMAs in more practices could increase overall patient satisfaction, continue to meet the needs of the organization while maintaining the care of the patient as the unified goal.

Recommendations

The SMA is a proven model that has been highly effective in various chronic disease settings however research has yet to determine nurses' perception of the model. The participants in this study that had experience with SMAs were all Associates prepared nurses. Based on these findings, further studies are recommended to target the Associate prepared nurse and even more specifically, the nurses working in an outpatient clinical setting where SMAs are beneficial. The significant amount of neutral responses begs the question, "Did the participants need further education of SMAs?" and suggests further studies be done to assess nurses' perceptions of SMA when already utilized in their area of practice. Based on the small sample size of this study and limited responses, further studies should be conducted on a larger population of Registered Nurses. The findings of this study imply nurses find SMAs beneficial and recommend further studies

be conducted to better inform nurses and other healthcare disciplines, providers and organizations of the numerous benefits of SMAs in the chronic disease population.

Conclusion

In the midst of the changing economy and culture of healthcare, nurses are in a position to advocate and optimize patient care with the appropriate tools, setting and support necessary. SMAs provide a creative and innovative approach to effective management of patients with chronic disease. Studies have found SMAs beneficial to the patient, provider and healthcare organization. The results of this study suggest that nurses have little experience with SMAs but found many advantages of SMAs for their patient population. The aim of this study was to assess nurses' experience with and perceptions of SMAs. Doing so could determine if the SMA model should be supported in nursing practice. Further studies should assess nurses' perception of the advantages and disadvantages of patient appointment models. The results from this study indicate that nurses need to be better informed on the benefits, implementation, and structure of SMAs in order to enhance support and increase adoption within patient populations. Implementing SMAs in more practices could optimize nursing care, increase overall patient satisfaction, and meet the challenging and changing needs of the healthcare profession.

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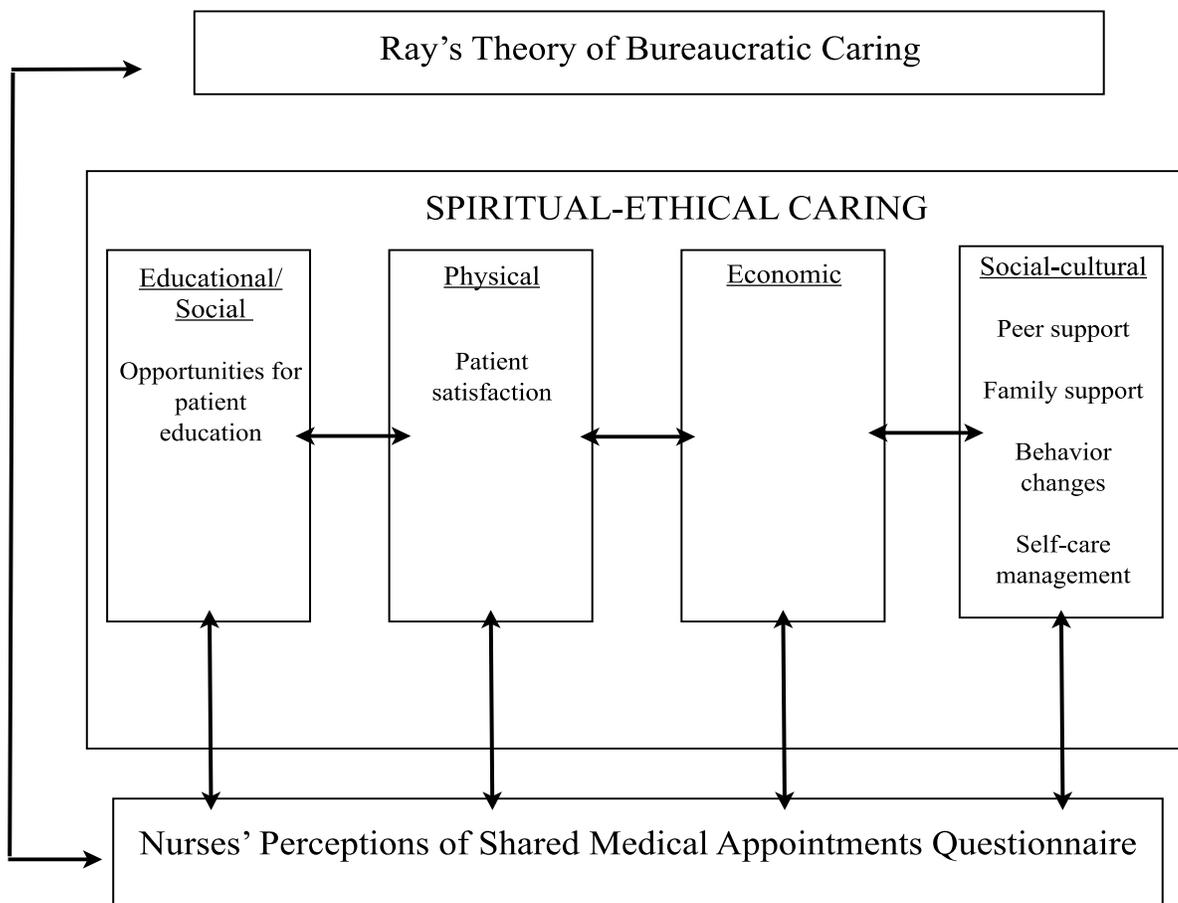
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Appendix A
Theory of Bureaucratic Caring CTE Diagram



Appendix B

Nurses' Perceptions of Shared Medical Appointments Questionnaire

Shared Medical Appointments are group visits in which multiple patients are seen simultaneously by the physician in a supportive group setting. The delivery of medical care is the primary focus but these appointments bring great opportunity for patient education and emotional support in the group setting with the presence of a multidisciplinary team, integrating the support of other patients (Noffsinger, 2009). These appointments have proven to be successful amongst chronically ill populations.

1. What is your area of practice?

2. How many years have you practiced as an R.N.? _____

3. What is your highest level of education?
Associates Bachelors Masters Doctorate

4. Does your practice offer shared medical appointments?
Yes No

5. Have you previously heard of shared medical appointments?
Yes No

Please answer the following questions based on your experience or knowledge about Shared Medical Appointments:

Nurses' Perception of Shared Medical Appointments Questionnaire

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Do you think patients were more satisfied with the shared medical appointment compared to the traditional medical appointment?					
Do you think your patient's population would benefit from shared medical appointments?					
Do you think that a shared medical appointment could provide more opportunities for patient education in your practice?					
Do you think that the peer support provided in a shared medical appointment could benefit your patient population?					
Most shared medical appointments last between 60 and 90 minutes, offering greater time with the provider. Do you think your patient population would be more satisfied with the time increase?					
Do you think your patient population would be more satisfied with the greater time with the physician?					
Do you think the peer support offered by the shared medical appointment could better facilitate behavior changes amongst your patient population?					
Both patient and family members attend the shared medical appointment. Do you think the family support could lead to better self-care management?					

Do you think integrating shared medical appointments in your practice could decrease inpatient readmissions?					
Would you recommend implementing shared medical appointments in your practice?					

References

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Appendix C

Nurses' Perceptions of Shared Medical Appointments Informed Consent

Study Title: Nurse's Perceptions of the Use of Shared Medical Appointments

Investigator: Kristin Monza, BSN, RN

Dear Gardner-Webb Nursing Student,

As part of the requirements for the Master of Science in Nursing Degree, I am conducting a study about nurse's perception of shared medical appointments. You are being invited to take part in this research study. Before you decide to participate in this study, it is important that you understand why the research is being done and what it will involve. Please take the time to read the following information carefully.

The purpose of this study is to examine nurse's perceptions of shared medical appointments in all clinical settings. Your expected time commitment for this study is 5 minutes. You will be asked to complete the survey handed out to you. Please identify the most appropriate response to each question using your best judgment.

The risks of this study are minimal. These risks are similar to those you experience when disclosing information to others. You may decline to answer any or all questions and you may terminate your involvement at any time if you choose. There may be risks that are not anticipated. However, every effort will be made to minimize any risks.

There will be no direct benefit to you for your participation in this study. However, we hope the information obtained from this study may enhance patient satisfaction in various clinical settings. There is no monetary compensation to you for your participation in this study.

If you do not want to be in the study, you may choose not to participate and leave your answers blank. Your participation in this study is voluntary. It is up to you to decide whether or not to take part in this study. If you do decide to take part in this study, your return of the survey will be considered your consent. If you decide to take part in this study, you are still free to withdraw at any time and without giving a reason. You are free to not answer any question or questions if you choose. This will not affect your standing as a student or the relationship you have with the faculty.

Your responses will be anonymous and confidential. Please do not write any identifying information on your questionnaire. Should you have any questions about the research or any related matters, please contact the researcher at kmonza@gardner-webb.edu or my professor, Dr. Vickie Walker at vwalker@gardner-webb.edu.

By returning the survey, I confirm that I have read and understood the information. I understand that my participation is voluntary and that I am free to withdraw at any time.