PERCEPTIONS OF ANDRAGOGICAL METHODS IN BEHAVIORAL MEDICINE PATIENT ACCESS OCCUPATIONS

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AUTHORIZATION TO SUBMIT

DISSERTATION

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DEDICATION

This body of work is dedicated to every patient to has sought behavioral medicine treatment and to every person who has tried to help. In the words of the famous Fred Rogers, “anything that’s human is mentionable, and anything that is mentionable can be more manageable. When we can talk about our feelings, they become less overwhelming, less upsetting, and less scary.” Please know that the darkness will fade, and light is just around the corner. My heart is with all of you.

ABSTRACT

This qualitative descriptive study investigated the learning behaviors of non-clinical healthcare employees who work in a role in which they schedule outpatient behavioral medicine patient appointments. The study used Malcolm Knowles' theory of andragogy as a theoretical framework. Eight subjects were interviewed to examine their education exposure, associated perceptions, and thoughts for possible improvements. By identifying characteristics associated with positive and negative forms of education, healthcare leaders around the globe will have an improved concept of how education affects job performance, satisfaction, and non-clinical patient care. This study discovered that while subjects were not substantially exposed to adult learning techniques, such as scenario and simulation-based education, positive perceptions were linked to these tools. In addition, issues pertaining to the internal infrastructure of behavioral medicine organizations were identified as having had a negative impact on implementing innovative education.

Suggestions for improving education and training in this field include enhancing communication between staff and patients, expanding training resources, and creating a culture that supports education for all roles. Themes shown in this study will allow healthcare administrators to evaluate the educational needs of their staff better, and to meet those demands with adequate training and recourses. This research will assist in orienting new personnel, support continued education, and create a patient and employee-focused environment while improving continued education of established personnel.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

Chapter I

Introduction

The importance of providing medical care to a patient is not clinically independent from other holistic factors but is dependent on providing compassionate care using trust, communication, and transparency from all occupations that interact with a patient (Behavioral Health, n.d.). Patients encounter clinical and non-clinical personnel during these appointments that have a direct and indirect effect on treatment (Gallo et al., 2016; Garets & Davis, 2006; Goffman et al., 2017). The importance of constructing a relationship with patients built on trust, compassion, and transparency is imperative to the holistic care received (Gallo et al., 2016; Goffman et al., 2017). However, these relationships are sensitive due to the circumstances surrounding care (Goffman et al., 2017; Leberman & McDonald, 2016; Wiznia et al., 2017). This delicate association is significant in behavioral medicine due to the financial, physical, social, and behavioral attributes unique to this specialty (Corrigan et al., 2014; Kravitz et al., 2006; van Eeghen, Littenberg, Holman, & Kessler, 2016).

This study examined the education received by behavioral medicine schedulers and investigated ways to improve the knowledge, confidence, and experience of these users through education (Corrigan et al., 2014; Kravitz et al., 2006; van Eeghen et al., 2016). Analyzed were the role-based education practices of multidimensional research healthcare institutions for their schedulers to determine how training could be improved (Bobrow et al., 2013; Liabsuetrakul, Sirirak, Boonyapipat, & Pornsawat, 2013).

Behavioral medicine is a complex specialty encompassing social work, psychology, and psychiatry which can be treated through ambulatory practices, inpatient, outpatient treatment

options, community behavioral medicine providers, and treatment clinics (Behavioral Health, n.d.; Gallo et al., 2016; Goffman et al., 2017). Behavioral medicine providers treat an array of differentiating complaints such as homicidal and suicidal ideation, bipolar disorder, drug addiction, and stress (Behavioral Health, n.d). Clinical and non-clinical staff interact with these patients throughout a visit (Kravitz et al., 2006; van Eeghen et al., 2016). However, the training conducted with clinical employees such as nurses, medical assistants, and physicians is more profound than that of non-clinical personnel such as registrars and schedulers (Gallo et al., 2016; Goffman et al., 2017; Kravitz et al., 2006; van Eeghen et al., 2016).

This study sought to identify what training was provided to non-clinical staff employed in a behavioral medicine specialty setting to perform their occupation. This researcher sought to determine what forms of education and education are behavioral medicine schedulers exposed to regarding issues associated with this specialty and patients (Knowles, 1984; Merriam, 2001).

Medical personnel who receive education for their role are likely to obtain it through the form of classroom instruction and electronic learning (Gallo et al., 2016; Lévesque, Hovey, & Bedos, 2013; Rowe, Frantz, & Bozalek, 2012). This curriculum is standardized to maximize the number of users it can accommodate by using generic lesson plans. Users then receive informal preceptor training at their permanent office location (Dieckmann, Friis, Lippert, & Østergaard, 2012; Hermans, Kalz, & Koper, 2013; Sandlin, Wright, & Clark, 2013). This form of siloed education is often not integrated into the clinics due to complex concepts and inadequate training materials that cannot accommodate differentiating processes (Dieckmann et al., 2012; Hermans et al., 2013; Sandlin et al., 2013).

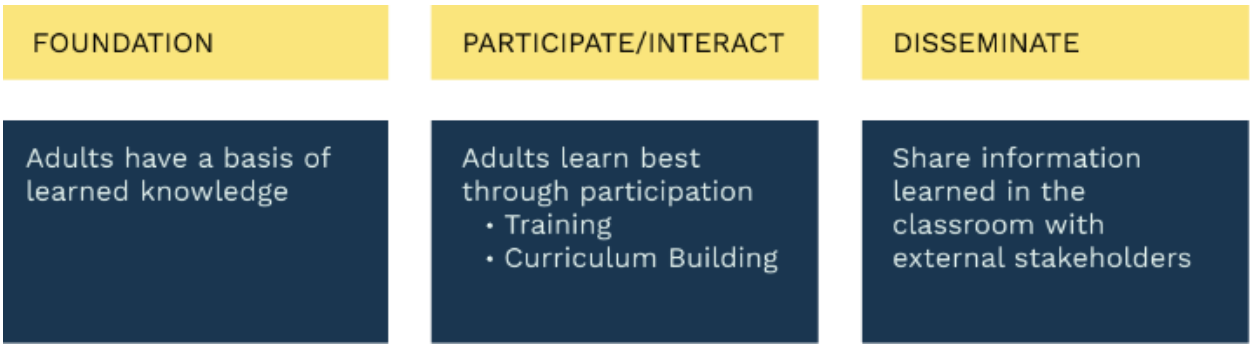
Theoretical Framework

The theory of adult learning, also known as andragogy, focuses on teaching adults how to be engaged, self-directed, and long-term learners (Hewitt-Taylor, 2001; Knowles, 1984; Merriam, 2001). A pivotal point to andragogy is the creation of engagement through the active participation of learners in curriculum building and education dissemination. The theory assumes adults have self-directness, and students will be taught using education methods that involve participation, such as scenario-based exercise, scenario simulations, and teach-backs (Hewitt-Taylor, 2001; Knowles, 1984; Merriam, 2001; Pratt, 1988; Tamura-Lis, 2013). The theory of andragogy is built on the following four principles:

1. Adults should be involved in the planning and evaluation of their education.
2. Past experiences provide the foundation for learning activities.
3. Adults, unlike children, are most interested in building knowledge in topics that have pertinent relevance to their occupation, skills, or personal life.
4. Adult learning is problem-focused rather than based on content (Knowles, 1984).

Figure 1

Theoretical Framework – The Components to The Theory of Adult Learning



Past studies focused on andragogy have found the theory to be useful in the training of clinical staff, such as nurses and physicians, due to the replication of real-life events in training (Devlin et al., 2008; Ford et al., 2016; Wayne et al., 2008; Weaver et al., 2010). These studies have displayed evidence that teaching adults by providing them with exercises containing occupational-specific scenarios creates a high level of learner engagement, participation, and knowledge transfer (Bruppacher et al., 2010; Chen, 2014). These learner aspects are pivotal to learning clinical and non-clinical healthcare workflows.

In the theory of adult learning, the goal is to generate knowledge sharing from teachers to adult learners, and those students then sharing their knowledge with others (Knowles, 1984; Merriam, 2001). Adult learning environments often use scenario-based exercises to teach students information, especially when the content involves a physical process (Bruppacher et al., 2010; Chen, 2014; Macaro, 2006). This type of teaching style has shown improvement in knowledge aptitude, and an increase in situational confidence (Bruppacher et al., 2010; Chen, 2014; Hsu, Chang, & Hsieh, 2015; Macaro, 2006).

Andragogy differentiates itself from the theory of pedagogy in a multitude of ways. Pedagogy is directed towards the teaching of children instead of adults (Hase & Kenyon, 2000). When the target audience changes, the education's delivery, flow, and environment may also need to be modified. For example, when teaching a group of adolescent students about cardiopulmonary resuscitation (CPR) in a school gymnasium, the education transfer is from adult to child (Bobrow et al., 2013). When the same training is provided to a group of nurses, the setting may change to a medical office or hospital, and the instructor will likely be seen as a peer by the students (Bobrow et al., 2013; Creutzfeldt, Hedman, Medin, Heinrichs, & Felländer-Tsai,

2010). This modification will change the instructor-student dynamic (Hase & Kenyon, 2000; Merriam, 2001).

Statement of Problem

Behavioral medicine is unique compared to other sectors of healthcare due to the chronic obstacles that plague patients, clinical and non-clinical staff, and stakeholders (Carnegie & Norris, 2015; Miller & Ambrose, 2016; Reid et al., 2015; Wiznia et al., 2017). Patients in the United States suffering from behavioral medicine symptoms often have limited access to treatment based on their geographic location and access to transportation (Miller & Ambrose, 2016; Reid et al., 2015). High medical costs could further hinder treatment availability (Miller & Ambrose, 2016; Reid et al., 2015; Wiznia et al., 2017). A study conducted in the Journal of Hospital Psychiatry discovered 240 psychiatrists contacted to schedule an appointment, but only 21% were accepting new patients (Wiznia et al., 2017).

Prior research has discovered a prodigious amount of evidence of adverse effects associated with poor patient accountability and meager relationships between patients and clinical and non-clinical staff (Berrouiguet, Baca-García, Brandt, Walter, & Courtet, 2016; Boos, Bittner, & Kramer, 2016; Goffman et al., 2017; Kheirkhah, Feng, Travis, Tavakoli-Tabasi, & Sharafkhaneh, 2015; Reid et al., 2015; Reynolds, Griffiths, Cunningham, Bennett, & Bennett, 2015). Furthermore, a lack of innovation in non-clinical personnel training has worsened these issues and debilitated this education in comparison to clinical training (Proudfoot & Kebritchi, 2017; Reeder & Turner, 2011). Examples of these non-clinical occupations are registration and scheduling staff that create and register patient appointments at inpatient, hospital outpatient departments (HODs), and ambulatory locations (Gallo et al., 2016; Liu, Finkelstein, Kruk, &

Rosenthal, 2017). The specific areas examined in behavioral medicine scheduling education are as follows: (a) the types of education used to train new behavioral medicine scheduling staff; (b) gaps in behavioral medicine scheduling training that exist in the current education (c) and the amount of information retained from training (Croxton, 2014; Leberman & McDonald, 2016; Proudfoot & Kebritchi, 2017).

The demand for quality education in the field of behavioral medicine in the United States has increased exponentially since 2008 (Kash, Spaulding, Johnson, & Gamm, 2014; McAlearney, Hefner, Sieck, Rizer, & Huerta, 2014). This demand is compounded by the unique specialty of behavioral medicine that further emphasizes the importance of quality training for clinical and non-clinical staff (Collet, de Vugt, Verhey, Engelen, & Schols, 2018; Miller & Ambrose, 2016; Reid et al., 2015). Another challenge of clinical and non-clinical education is the standardization across facilities to generate consistent results (Collet et al., 2018; Reid et al., 2015).

A lack of functionality and occupationally integrated training is common among many healthcare and non-healthcare organizations in the United States, as they too have similar education gaps (Cant & Cooper, 2010; Collet et al., 2018). Additionally, traditional training methods such as lecture-based education have shown poor results in healthcare occupations (McNeal, 2010; Paskins & Peile, 2010). These issues stem from traditional learning, not providing the needed engagement, participation, and stimulation to adult learners (Knowles, 1984; Merriam, 2001). Research shows training can have the highest success when educational material is facilitated towards the context to which the target audience represents (Knowles, 1984; Leberman & McDonald, 2016; Liu et al., 2017; Merriam, 2001). The implementation of

alternative educational processes, such as scenario and simulation-based training programs, have shown constructive and positive outcomes (Knowles, 1984; Merriam, 2001; Rosen, Hunt, Pronovost, Federowicz, & Weaver, 2012; Sanford, 2010; Weaver et al., 2010).

The training received by new hires at sizeable multi-location healthcare institutions tends to be sectioned into two parts: system functionality and role responsibilities (Proudfoot & Kebritchi, 2017; Reed et al., 2014; Reeder & Turner, 2011). This research means that users received siloed training on subjects for an occupation that contains integrated demands (Reed et al., 2014; Reeder & Turner, 2011). This process is likely caused by a lack of educators, limited resources, or other efficiency constraints (Reed et al., 2014; Robinson & Dearmon, 2013; Scott, Shah, Wyatt, Makubate, & Cross, 2011). Many healthcare organizations have no standardized educational practice, curriculum, or assessment process for informal peer-to-peer training (Moore, Dickson-Deane, & Galyen, 2011; Moule, Ward, & Lockyer, 2010; Reeder & Turner, 2011).

Behavioral medicine scheduling staff that utilize automatic patient reminder systems (a tool that sends a message to patients reminding them of an upcoming appointment) have correlated to improved patient attendance at appointments (Teo, Forsberg, Marsh, Saha, & Dobscha, 2017). Scheduling staff uses EHRs to send out appointment reminders and to document patient-staff communication. The importance of a patient completing one appointment with a behavioral medicine specialist is imperative to the continuity of care (COC) process, or the process by which care team members manage a patient's ongoing care (Carnegie & Norris, 2015; Miller & Ambrose, 2016; Reid et al., 2015; Wiznia et al., 2017). Patients with a history of poor appointment attendance are more likely to no-show to a scheduled behavioral health

appointment, leading to fewer openings for other patients (Akhigbe, Morakinyo, Lawani, James, & Omoaregba, 2014). However, patients who complete an initial appointment with a specialist are more likely to return for a follow-up appointment compared to no-shows (Reynolds et al., 2015). Evidence supports that behavioral medicine scheduling staff who utilize technological systems efficiently can improve appointment attendance (Akhigbe et al., 2014; Reynolds et al., 2015).

One of the more significant problems with training behavioral health intake staff is the behavioral medicine specialty has far more intricate system features and office processes compared to general medicine (GM) (Behavioral Health, n.d.). These unique features include higher rates of self-pay patients, higher rates of patients suffering from comorbidity issues, and more excellent rates of missing or incomplete demographic information (Behavioral Health, n.d.; Centers for Medicare & Medicaid Services, 2020; Miller & Ambrose, 2016; Taubman, Allen, Wright, Baicker, & Finkelstein, 2014; Wiznia et al., 2017). Additionally, the volume of behavioral medicine outpatient offices is far lower than the number of primary care offices found in the United States (Akhigbe et al., 2014; Gallo et al., 2016; Reynolds et al., 2015).

Many healthcare institutions use a generalized training approach that involves training all personnel under that same role with identical education (Gallo et al., 2016; Wiznia et al., 2017). This process of universal bulk training is often the result of a need for streamlined and cost-efficient training (Behavioral Health, n.d.; Biringer, Hartveit, Sundfor, Ruud, & Borg, 2017; Wiznia et al., 2017). However, the patient characteristics and health morbidities of behavioral medicine patients demand that staff receive education specific to their roles before beginning a new position (Behavioral Health, n.d.; Creutzfeldt et al., 2010; Miller & Ambrose, 2016; Reid et

al., 2015; Wiznia et al., 2017). This evidence highlights the importance of improving role function education for non-clinical employees in this specialty (Carnegie & Norris, 2015; Devlin et al., 2008; Miller & Ambrose, 2016; Nagle, McHale, Alexander, & French, 2009; Reid et al., 2015; Wiznia et al., 2017).

A significant reason for educating staff on the importance of utilizing system tools in behavioral medicine is due to the uniqueness of the patient population, including attributes that display a lack of following assigned direction (Goffman et al., 2017; Miller & Ambrose, 2016; Teo et al., 2017). Moreover, socio-behavioral attributes that negatively correlate to poor decision making have been observed in higher rates among behavioral medicine patients compared to other specialties (Berrouiguet et al., 2016; Gabrielian, Yuan, Andersen, & Gelberg, 2016).

Background

It is crucial to identify and analyze the education received by behavioral medicine scheduling employees to determine if it meets demands (Akhigbe et al., 2014; Carnegie & Norris, 2015; Miller & Ambrose, 2016; Moran, Russinova, Gidugu, & Gagne, 2013; Reid et al., 2015; Wiznia et al., 2017). Training standards that are not adequate to handle specialty processes can have a detrimental result on patient care and associated issues (Akhigbe et al., 2014; Carnegie & Norris, 2015; McKinley & Ruppel, 2014; Miller & Ambrose, 2016; Reid et al., 2015; Wiznia et al., 2017). Consistent patient interaction with schedulers has emphasized users in this role providing high-quality service (Carnegie & Norris, 2015; McKinley & Ruppel, 2014; Miller & Ambrose, 2016). However, organizations tend to put more significant funding, resources, and attention to clinical role education compared to non-clinical (Carnegie & Norris, 2015; McKinley & Ruppel, 2014; Miller & Ambrose, 2016; Wiznia et al., 2017).

A primary example of the importance of improving behavioral medicine scheduling education is the enormous role that these employees fill in the COC process (Carnegie & Norris, 2015; Miller & Ambrose, 2016; Reid et al., 2015; Wiznia et al., 2017). Schedulers are often the first person to encounter a patient, either in-person or over the phone (Carnegie & Norris, 2015; Wiznia et al., 2017). Additionally, patients are typically greeted and checked-in by these individuals (Carnegie & Norris, 2015; Miller & Ambrose, 2016; Reid et al., 2015; Wiznia et al., 2017). These new responsibilities require schedulers to be considerate, attentive and engaging with patients. The risk of a patient becoming frustrated during this process and declining behavioral medicine treatment could result in further mental, emotional, and physical harm (Akhigbe et al., 2014; Carnegie & Norris, 2015; Miller & Ambrose, 2016; Reid et al., 2015; Wiznia et al., 2017).

Findings support the case that SBE has shown to improve healthcare staff knowledge by integrating role processes and systems (Devlin et al., 2008; Ford et al., 2016; Nagle et al., 2009). The Greater Cincinnati area was chosen to be the focus of this study due to its diverse patient population, the researcher's proximal access to data collection, and its saturation of EHR utilization by the medical organizations. During the scouting portion of this study, the researcher highlighted Greater Cincinnati as having leading research institutions comparable to facilities in other major cities (UC Health, 2014).

Research Questions

Questions help define the parameters of what the researcher is attempting to explore (Kaplan & Maxwell, 2005). The research questions that set the parameters of this study are as follows:

1. What types of education have behavioral medicine schedulers received prior to beginning their role?
2. How do behavioral medicine schedulers feel about the adequacy of their education to prepare them for their role?
3. How could behavioral medicine scheduling education be improved?

Description of Terms

One of the difficulties associated with healthcare education is the overlapping of medical topics that integrate with non-clinical staff processes, such as patient appointment scheduling. Furthermore, the dissemination of education-related material without an underlying medical comprehension can cause confusion among learners (Akhigbe et al., 2014; Carnegie & Norris, 2015). Due to this conflict, a comprehensive list of key terms displayed in this study has been provided below, along with their correlating definition.

Ambulatory. Medical care performed in an outpatient setting. This treatment includes visits in which a diagnosis is applied, consultations occur, or procedures are performed (Centers for Medicare & Medicaid Services, 2020).

Behavioral Health. A person's psychological, behavioral, or cognitive self (Behavioral Health, n.d.).

Behavioral Medicine. The field of study encompassing one's holistic mental well-being (Behavioral Health, n.d.).

Continuity of Care (COC). The providing of quality care over time through one or multiple medical providers (Behavioral Health, n.d.).

Electronic Health Record (EHR). A software system that houses the medical records of patients that can be accessed from electronic devices (Streiner, Norman, & Cairney, 2015).

Education. A process of transmitting public information (Knowles, 1984).

Encounter. Patient interaction with a healthcare provider(s) to deliver healthcare service(s) or assessing the health status of a patient (Resource Encounter – Detailed Description, 2018).

End-user. A person or organization that uses a product (Streiner et al., 2015).

Outpatient. Medical care performed while the patient is not admitted to a hospital (Centers for Medicare & Medicaid Services, 2020).

Primary Care Provider (PCP). A medical practitioner who sees patients for common ailments. These roles include a medical doctor (MD), doctor of osteopathy (DO), nurse practitioner (NP), or a physician's assistant (PA) (Centers for Medicare & Medicaid Services, 2020).

Provider. Any person selected to provide healthcare services. Th includes medical doctors (MD), doctors of osteopathy (DO), psychologists, and social workers (Centers for Medicare & Medicaid Services, 2020).

Referral. The referring of a patient to a specialist provider from a PCP (Behavioral Health, n.d.).

Registrar. A person in charge of collecting patient registration information during a medical encounter (Reed et al., 2014; Robinson & Dearmon, 2013).

Scenario-Based Education. A type of education that uses specific scenarios and problem-based exercises targeted to a specific process (Rosen et al., 2012; Sanford, 2010).

Scheduler. Someone who schedules patient appointments (Streiner et al., 2015).

Situ-Simulation. A simulation that occurs in a clinical setting conducted by healthcare staff to replicate real-life scenarios. Often conducted with real or dummy patients (Rosen et al., 2012; Sanford, 2010).

Significance of the Study

There is a significant gap in the established research of non-clinical health education in behavioral medicine (Akhigbe et al., 2014; Carnegie & Norris, 2015; Miller & Ambrose, 2016; Wiznia et al., 2017). While a multitude of studies has shown the success of using SBE in clinical roles, no research has been found to examine the same for non-clinical staff. Furthermore, the need for high-quality behavioral medicine treatment is growing at an alarming rate with significant individual and societal implications (Akhigbe et al., 2014; Carnegie & Norris, 2015; Miller & Ambrose, 2016; Wiznia et al., 2017).

This study sought to determine what education measures were taken to train behavioral medicine scheduling personnel, and the perceptions of staff associated with this education (Ford et al., 2016; Leberman & McDonald, 2016). This information could provide healthcare organizations insight into complex education constraints. The data may provide knowledge to healthcare organizations on what types of education are useful, which could lead to improved treatment of patients in behavioral medicine. Innovative learning techniques, such as SBE, could generate more improved learning outcomes compared to traditional teaching methods (Devlin et al., 2008; Ford et al., 2016; Wayne et al., 2008).

Non-clinical education programs could benefit from the research findings in this study for implementing and maintaining the education curriculum (Devlin et al., 2008; Ford et al., 2016;

Wayne et al., 2008). While this study primarily focused on behavioral medicine schedulers, the findings of this study could also benefit clinical and non-clinical occupations in additional specialties (Devlin et al., 2008; Ford et al., 2016; Wayne et al., 2008).

Overview of Research Methods

The study utilized semi-structured interviews to collect information on the types of education utilized, and perceptions towards current training by scheduling staff at behavioral medicine ambulatory offices located in Cincinnati, Ohio (Craddock, O'Halloran, McPherson, Hean, & Hammick, 2013). This study used a qualitative descriptive data collection tool of an eight-question interview template (see Appendix A) that was used to collect information from volunteer behavioral medicine outpatient schedulers (Neergaard, Olesen, Andersen, & Sondergaard, 2009; Saldaña, 2015; Sandelowski, 2000).

Chapter II

Review of Literature

Introduction

Before World War I, most clinical education was conducted in traditional lecture-based form by which students seldom participated in their learning (McNeal, 2010; Paskins & Peile, 2010). Coincidentally, the advent of war increased the necessity for hands-on training for clinical staff to improve knowledge, decrease anxiety, and improve confidence during actual trauma situations (Allan et al., 2010; Biringer et al., 2017; Creutzfeldt et al., 2010; Steinemann et al., 2011). Healthcare institutions have adopted this format of education and training for clinical personnel, such as nurses and medical students, to improve practitioner skills before patient interactions (Creutzfeldt et al., 2010; Kromann, Jensen, & Ringsted, 2009; Steinemann et al., 2011). However, the same measures have not been implemented into non-clinical positions, such as registration and scheduling (Miller & Ambrose, 2016; Reeves, Perrier, Goldman, Freeth, & Zwarenstein, 2013; Teo et al., 2017). An abundance of role-related problems, such as poor communication with patients and insufficient use of technology, persistently exists in non-clinical healthcare environments that negatively affect patient care (Bloomfield & Jones, 2013; Teo et al., 2017). These issues, coupled with the specific attributes of the behavioral medicine specialty, have created a chaotic structure of ineffective relationships with patients and non-clinical personnel (Freund et al., 2015; Goffman et al., 2017; Miller & Ambrose, 2016; Reeves et al., 2013; Teo et al., 2017).

Limited Behavioral Medicine Resources

The challenges facing patients suffering from behavioral health ailments in resource-limited geographical locations can increase the likelihood of health deterioration (Gabrielian et al., 2016; Gallo et al., 2016). In these locations, the burden of responsibility for treating behavioral health patients often falls on the available resources, such as the emergency department (ED), urgent care, and PCP (Gabrielian et al., 2016; Gallo et al., 2016; Mapelli, Black, & Doan, 2015). The spectrum of behavioral health morbidities can range widely from low severity issues, such as acute anxiety and attention-deficit hyperactive disorder (ADHD) to homicidal and suicidal ideation, extreme depression, and schizophrenia. These issues can erupt when resources are constrained, and available forms of care attempt to treat these cases (Gabrielian et al., 2016; Gallo et al., 2016). One study identified that 50% of all behavioral medicine patients who arrive at the ED do so between the hours of 4 P.M. and midnight, a time when most ambulatory offices are closed (Mapelli et al., 2015; Wiznia et al., 2017). The researcher also discovered from the year 2012 to 2015, the number of behavioral health-related ED cases rose by 85%, displaying an increase in the utilization of outpatient-alternative treatments (Gabrielian et al., 2016; Mapelli et al., 2015; Wiznia et al., 2017).

While a lack of behavioral health resources may plague some geographic locations, evidence shows that limited access is also apparent in resource-abundant areas (Mapelli et al., 2015; Taubman et al., 2014; Wiznia et al., 2017). One study interviewed 240 psychiatrists specializing in post-traumatic stress disorder (PTSD) regarding appointment availability for acute patients (Wiznia et al., 2017). Of these providers, only 21% (n=88) were accepting new patients. Of the available openings, a patient's ability to receive one was strongly correlated to

what type of insurance they possessed. Only 15% of the 88 offices accepted new patients with Medicaid, 34% accepted Medicare, 54% took Anthem BlueCross, and 93% accepted self-pay (Miller & Ambrose, 2016; Taubman et al., 2014; Wiznia et al., 2017). These findings correlate to the unwillingness of providers to negotiate with insurance companies to cover services, and a strong association to not accept government-funded insurance (Centers for Medicare & Medicaid Services, 2020; Taubman et al., 2014; Wiznia et al., 2017). While ambulatory specialists are not required to provide each patient with a visit, EDs must treat any patient who requests to be seen, which could be contributing to higher emergency care volumes (Mapelli et al., 2015; Miller & Ambrose, 2016; Taubman et al., 2014). Proactive care is much more affordable than ED treatments, and this cost savings benefit provides more significant emphasis on improving care access and the processes needed for educating healthcare personnel (Mapelli et al., 2015; Miller & Ambrose, 2016; Taubman et al., 2014; Taylor et al., 2013). Parts of this access include improving the emphasis and quality of non-clinical staff education.

Combating Stigmas Hindering Behavioral Medicine Treatment

Behavioral medicine-related symptoms are often submerged in stigmatizations that can hinder the access and quality of care that patients receive (Corrigan et al., 2014; Kravitz et al., 2006; van Eeghen et al., 2016). These beliefs can reside in the clinical staff assigned to treat patients on a conscious and subconscious level. Additionally, the negative attitudes associated with behavioral medicine can disengage patients from taking an active role in their treatment, further creating a void in care (Corrigan et al., 2014; Kravitz et al., 2006; van Eeghen et al., 2016). This belief was tested with an experiment that was conducted with a male actor who visited 166 primary care (42.2%) and behavioral health specialist (57.8%) offices seeking

treatment for back pain (Corrigan et al., 2014). Survey data were collected from each provider post-visit along with results from the visit. An inverse relationship was observed between providers that had behavioral health stigma perceptions and their level of comfort with treating a patient with associated symptoms such as PTSD, schizophrenia, and substance abuse (Corrigan et al., 2014; Kravitz et al., 2006; Liddy et al., 2014). Furthermore, PCPs that endorsed stigmatization characteristics of behavioral health were less likely to refer a patient to a behavioral medicine specialist (Corrigan et al., 2014). As literature will further attest, a passive perspective of a patient's treatment can have destructive effects on the appointment scheduling process (Corrigan et al., 2014; Kravitz et al., 2006; Liddy et al., 2014; Mapelli et al., 2015; van Eeghen et al., 2016).

Attributes currently inhibiting access to behavioral health treatment include financial hurdles, resource limitations, and the presence of comorbidities (Biringer et al., 2017; Boos et al., 2016). Examined in this review are the confines associated with the appointment scheduling process between a PCP and a behavioral medicine specialist, and how educating staff to handle such difficulties can improve outcomes. Discussed in this research is the flow of behavioral medicine patients being referred to a specialist from a PCP, and the obstacles within this process (Biringer et al., 2017; Boos et al., 2016). Healthcare institutions have overcome these obstacles by improving staff education and implementing patient-centered communication strategies with patients (Biringer et al., 2017; Boos et al., 2016).

The stigmatizations surrounding behavioral health can negatively affect children as well as adults (Corrigan et al., 2014; Gallo et al., 2016; Mapelli et al., 2015). A study published in the *Journal of Psychiatric Services* emphasizes this point of pediatric behavioral medicine clinical

stigmatization. The researcher in this study posed as the parents of children suffering from adolescent depression attempted to schedule an appointment with 264 psychiatric outpatient offices (Gallo et al., 2016). Less than two-thirds of participants could obtain an appointment with a provider. Of the subjects who were not able to make an appointment, 19% were not given a referral to another specialist. Of those parents that made an appointment, most subjects had to make two or more phone calls and talk to two or more people before the appointment was made. Coincidentally, the researcher also discovered that race, ethnicity, urbanicity, and insurance did not present a correlational relationship to appointment scheduling (Gallo et al., 2016; Mapelli et al., 2015).

While the previous research findings cannot be generalized to all behavioral medicine patients, it does provide insight into obstacles that need to be accounted for when training new personnel (Leberman & McDonald, 2016; Proudfoot & Kebritchi, 2017). Additionally, it emphasizes how important it is to create education tapered to the user's specialty in which they will be employed. If not, the user could lose interest in the education being disseminated due to its generic and non-associated context (Corrigan et al., 2014; Hsu et al., 2015).

Educating Staff on the Attributes Associated with Behavioral Medicine Patients

The characteristics commonly found in behavioral medicine are unique compared to general practice and other sub-specialties (Kheirkhah et al., 2015; Olfson, Druss, & Marcus, 2015; Tomar, Jensen, & Pace, 2015). These differences affect the workflows of clinical and non-clinical personnel, and as such, training should be tapered to account for these differences. One unique attribute with behavioral medicine is the frequent association with high-severity encounters; morbidity that could have severe consequences to one's health if not treated

immediately (Kheirkhah et al., 2015; Olfson et al., 2015; Tomar et al., 2015). From 2008 to 2012, medical encounters labeled with a status of "high-severity" rose in the United States by 1.45 million (Olfson et al., 2015; Tomar et al., 2015). High-severity problems in this study included “disruptive behavior disorders, mood disorders, anxiety disorders, and psychoses and developmental disorders” (Olfson et al., 2015, p. 2032). Patients that sought treatment rose to 43.9% by 2012, and low-severity patients that sought treatment rose to 9.6% by the same year. While low-severity patients accounted for the most significant population subgroup, high-severity patients associated with the highest percentage of help seekers (Olfson et al., 2015; Tomar et al., 2015).

While the demand for higher levels of seamless, accessible treatment is continuously growing, the rates of patient absenteeism remains a constant obstacle within behavioral medicine (Avari & Meyers, 2018; Kheirkhah et al., 2015; Olfson et al., 2015; Tomar et al., 2015). When patients present poor attendance, the care and accessibility of fellow patients can suffer (Avari & Meyers, 2018; Kangovi et al., 2013; Kheirkhah et al., 2015; Olfson, Blanco, Wang, Laje, & Correll, 2014). From 1998 to 2008, research was conducted at the Veterans Affairs Medical Center of Houston, Texas, on the effects of patients not attending a scheduled appointment without canceling or rescheduling (Kheirkhah et al., 2015). This behavior is often labeled a no-show. The researcher discovered multiple factors could affect patient attendance, including proximity to the office, financial burdens, appointment forgetfulness, and poor patient-staff communication (Avari & Meyers, 2018; Kheirkhah et al., 2015; Olfson et al., 2014). When a no-show appointment slot does not get filled by another visit, the costs associated with that visit remain. These costs include paying the provider and support staff and the related infrastructure

expenses to keep an office open. It was calculated that the average price of a no-show was $196, and the highest rate of no-shows occurred in specialty offices (Kheirkhah et al., 2015). Clinical staff can be trained to identify these attributes and target the most at-risk patients with more reliable communication techniques. Staff can also use medical record system reports to determine groups of patients with common denominators (Avari & Meyers, 2018; Kheirkhah et al., 2015; Miller-Matero, Hyde-Nolan, Eshelman, & Abouljoud, 2015; Tomar et al., 2015).

For healthcare organizations (HCOs) to combat the issue of poor patient attendance, research has sought to discover behavioral patterns and trends associated with missed appointments, and to incorporate these identifiers into healthcare training (Akhigbe et al., 2014; Paré, Trudel, & Forget, 2014; Patterson, Geis, LeMaster, & Wears, 2013; Santibáñez et al., 2012). If these patterns can be identified, HCOs can create more-robust education for new and established staff (Paré et al., 2014; Santibáñez et al., 2012). Research has discovered common patient characteristics isolated within behavioral medicine that could help construct a predictive behavior model (Paré et al., 2014; Reid et al., 2015; Santibáñez et al., 2012). Patients most likely to miss an appointment often have a comorbid disease burden, and current diagnoses of mood and substance use disorders (Reid et al., 2015). However, historical research has not examined the behavioral medicine subspecialty in comparison to general medicine. This chasm displays a need four additional research on attributing characteristics that could be affecting patients in this field, such as substance abuse disorders, high absenteeism rates, and lack of autonomy (Paré et al., 2014; Reid et al., 2015; Santibáñez et al., 2012).

Five tools associated with decreased no-show appointments among all specialties within healthcare are:

- The promotion of information and resources to patients.
- Improved case management referral process.
- Provide coaching support on how staff can use the system.
- Symptom-focused treatment by developing a patient assessment and directed care plan.
- Comprehensive therapy that addresses a multi-variable patient-centered approach (Reid et al., 2015; Reynolds et al., 2015; Santibáñez et al., 2012).

It was concluded that behavioral medicine organizations who wish to integrate e-resources into their practice model should do so while allocating sufficient resources to the five trends (Akhigbe et al., 2014; Reid et al., 2015; Reynolds et al., 2015; Santibáñez et al., 2012).

Education for new hire behavioral staff should include methods for decreasing missed appointment rates (Akhigbe et al., 2014; Reid et al., 2015; Reynolds et al., 2015; Santibáñez et al., 2012). Specific individual attributes have been identified as character traits of patients who commonly no-show for their scheduled appointment (Boos et al., 2016; Reid et al., 2015). These attributes include individuals who are younger, nonwhite, male or have been diagnosed with behavioral health issues. The researcher also found interventions to improve compliance could be targeted at these individuals to decrease the burden of no-shows on health care systems (Boos et al., 2016; Reid et al., 2015). This reinforces the patient-centered method of appointment responsibility instead of solely on the provider or organization's responsibility (Boos et al., 2016; Reid et al., 2015; Reynolds et al., 2015)

It has been highlighted that the COC model at the primary care level can break down due to patient noncompliance (Boos et al., 2016; Reid et al., 2015). However, it is essential to mention that the evidence does not constitute a cause and effect relationship between any attributes and appointment no-shows, but only a significant relationship (Boos et al., 2016). Medical offices can reject patients if repetitious noncompliance behavior is displayed (Boos et al., 2016; Reid et al., 2015; Reynolds et al., 2015).

The importance of highlighting obstacles attributed to behavioral medicine is essential for educating clinical and non-clinical personnel who represent this subspecialty. To provide these staff with generic or similar training as different specialties would be discounting problems linked to behavioral medicine (Akhigbe et al., 2014; Reid et al., 2015; Reynolds et al., 2015; Santibáñez et al., 2012). Furthermore, the absence of adequately identifying these characteristics in a formal training curriculum could hinder patient-staff relationships and ultimately cause an increase in No Show appointments (Boos et al., 2016; Reid et al., 2015; Reynolds et al., 2015).

One issue associated with poor behavioral health outcomes has been shown to be a lack of understanding of the physical, social, mental, and behavioral issues that patients incur (Avari & Meyers, 2018). One solution which has displayed success when combating physical ailments, such as cancer and dementia, has been improved communication between a provider and a patient's family (Avari & Meyers, 2018). By discussing behavioral health symptoms and possible treatment options in an open forum, providers can build a rapport with a patient's family while developing an understanding of the disease. This does not conflict with the Health Insurance Portability and Accountability Act (HIPAA) regulations if patient identifiers are kept anonymous. Since providers are often gatekeepers to treatment options, it is imperative these

stigmas present in healthcare staff be overcome (Avari & Meyers, 2018; Corrigan et al., 2014; Gallo et al., 2016; Tomar et al., 2015). Evidence has shown when providers are educated on the importance of communicating with family/caregivers, and treatments appear to have higher success rates (Avari & Meyers, 2018; Corrigan et al., 2014; Gallo et al., 2016).

In addition to enforcing healthcare staff communication with patients/caregivers through education, research has shown improving knowledge of treatment success through decreasing stigma perceptions can have a positive holistic outcome for the patient (Avari & Meyers, 2018; Corrigan et al., 2014; Gallo et al., 2016; Hansberry et al., 2017; Tomar et al., 2015). These stigmas can be overcome through additional educational interventions such as highlighting sensitive patient-staff communication and creating SBE curriculum (Avari & Meyers, 2018; Tomar et al., 2015). These methods can be implemented by immersing behavioral medicine staff into scenario-based exercises by designing a curriculum that meets this need (Corrigan et al., 2014; Tomar et al., 2015). The importance of educating clinical staff on the stigmas associated with behavioral health patients can improve a patient's accessibility to treatment and overall outcomes (Avari & Meyers, 2018; Corrigan et al., 2014; Gallo et al., 2016; Tomar et al., 2015).

While the importance of SBE on overcoming stigma-related issues has shown benefits, organizational and cultural changes can also have a significant impact on treatment outcomes (Carnegie & Norris, 2015; Teo et al., 2017; Wiznia et al., 2017). Healthcare organizations are charged with providing adequate training to their staff. However, when a company's culture fails to identify and implement improvement measures through adequate training, the outcomes can have negative impacts on patients (Carnegie & Norris, 2015; Teo et al., 2017; Wiznia et al., 2017). When marginalized cultures or subgroups are provided inadequate resources, such as

infrastructure and policy-driven initiatives, these groups can receive negative ramifications as a result. This applies to healthcare organizations that do not create enough behavioral medicine treatment facilities, staff facilities with plentiful providers, or provide proper education to staff (Carnegie & Norris, 2015; Collet et al., 2018; Teo et al., 2017; Wiznia et al., 2017). When healthcare organizations facilitate a macro approach to improving the outcomes of minority groups, these changes can have immediate positive effects, and create an environment of sustainability (Carnegie & Norris, 2015; Collet et al., 2018; Teo et al., 2017; Wiznia et al., 2017).

Behavioral Medicine-Based Situational Education

Implementing education to clinical and non-clinical employees pertaining to the awareness of issues surrounding behavioral medicine-specific diagnoses has shown to improve a patient's overall experience (Avari & Meyers, 2018; Corrigan et al., 2014; Gallo et al., 2016; Tomar et al., 2015). Scheduling and registration employees are typically the first staff to interact with a patient when arriving at an outpatient or ambulatory setting (Corrigan et al., 2014; Gallo et al., 2016). As discussed in this study, behavioral medicine patients have unique attributes that can differentiate their behaviors, perceptions, and attitudes in contrast with other medical specialties (Reed et al., 2014; Robinson & Dearmon, 2013). These unique patients are better handled by staff that can react to these variables (Avari & Meyers, 2018; Corrigan et al., 2014; Gallo et al., 2016; Tomar et al., 2015).

Education targeted at schedulers in behavioral medicine should be specific enough to accommodate for the most common situations one may face (Corrigan et al., 2014; Gallo et al., 2016). Due to the possible strenuous situations that could arise in this setting, sensitive communication should be a top priority when interacting with patients (Goffman et al., 2017;

Leberman & McDonald, 2016; Wiznia et al., 2017). Being courteous, conscientious, and caring are communication factors taught to schedulers when greeting and communicating with patients (Gallo et al., 2016). Avoiding stressful communication and negative behaviors from the patient is imperative for all parties involved (Goffman et al., 2017; Leberman & McDonald, 2016).

Schedulers and registrars learn in repetitional practice that not all patients fit the same mold, which requires variations to the education they receive (Reed et al., 2014; Robinson & Dearmon, 2013). Specifically, schedulers should be trained on the scenarios in which the non-ideal patient calls to make an appointment or check-in for their appointment. The personal and financial issues often displayed in behavioral medicine patients can lead to scheduling mishaps. Common issues that can impede a typical scheduling workflow are the patient not having a physical address, working telephone number, reliable emergency contact, and no health insurance (Miller & Ambrose, 2016; Taubman et al., 2014; Wiznia et al., 2017). Studies show that these missing pieces more-commonly affect patients seen in behavioral medicine compared to all other specialties (Miller & Ambrose, 2016; Taubman et al., 2014). Schedulers in this field should receive education on the processes to follow when obstacles such as these are encountered.

In addition to providing quality customer service, behavioral medicine schedulers are in a unique position to engage positive behaviors in patients. The importance of a patient receiving treatment for an issue is imperative. However, weak patient-staff interaction can deter patients from continuing to seek assistance (Avari & Meyers, 2018; Corrigan et al., 2014; Gallo et al., 2016; Maxfield, Lewis, & Cannon, 1996; Tomar et al., 2015). Patients tend to follow through with treatment when the process is calm and non-burdensome (Maxfield et al., 1996). Clinical

and non-clinical staff use tactics to engage and sustain engagement with patients while being sensitive to possible signs of aggression (Maxfield et al., 1996). Some of the tactics shown to generate patient engagement from the scheduler role are:

- Using positive greetings such as (a) hello, (b) welcome, (c) how may I help you, and (d) thank you (Avari & Meyers, 2018; Corrigan et al., 2014; Gallo et al., 2016)
- Provide patients with an estimated wait time at check-in (Avari & Meyers, 2018; Corrigan et al., 2014; Gallo et al., 2016).
- Be familiar with the process for scheduling and checking-in patients who do not have certain demographic pieces such as a mailing address, phone number, or health insurance (Avari & Meyers, 2018; Corrigan et al., 2014; Gallo et al., 2016).
- Create an environment where patients feel they have independence and control over the care they will receive (Maxfield et al., 1996).
    - Never tell a patient they are forced to do something.
    - Never threaten to refuse treatment for noncompliance, unless used as a last resort.
- Be accommodating and courteous to patients (Avari & Meyers, 2018; Corrigan et al., 2014; Gallo et al., 2016; Maxfield et al., 1996; Tomar et al., 2015).

These tools should be emphasized when training new and established behavioral medicine schedulers.

Theoretical Framework

SBE is a form of education that utilizes specific scenario-based tools to mimic real-life situations the students may encounter (Devlin et al., 2008; Nagle et al., 2009). Conventional apparatuses used in this format are videos displaying simulations, scenario-based exercises, teach-backs, and follow-up questions (Devlin et al., 2008; Nagle et al., 2009; Tamura-Lis, 2013). Teach-back is a term used to describe a student who teaches material back to the class and instructor to verify understanding and competency. This form of student-led training is commonly used in clinical situations (Tamura-Lis, 2013).

Andragogy is the educating of adult learners, and SBE has been found to be a useful tool in this field (Devlin et al., 2008; Knowles, 1984; Merriam, 2001; Nagle et al., 2009) However, adult learners come with unique obstacles not found in pedagogy (Feng et al., 2013; Knowles, 1984; Motola, Devine, Chung, Sullivan, & Issenberg, 2013; Petty, 2013). Adult learners are unlike younger students who flourish with traditional instruction, lecturing, and a guided process based on an absence of pre-learned knowledge (Feng et al., 2013; Knowles, 1984; Merriam, 2001; Motola et al., 2013). Adult learners tend to thrive when they can participate in learning exercises, and when their feedback is used to tailor education to their specific demands (Knowles, 1984; Merriam, 2001). Educational material tends to be ingested by the learner at higher rates when the principles of andragogy are implemented within the adult training (Knowles, 1984; Merriam, 2001; Ruiz, Mintzer, & Leipzig, 2006).

Data has shown an improvement of knowledge, situational confidence, and lowered anxiety when SBE is used in healthcare and non-healthcare settings with adult students (Allan et al., 2010; Elliott-Kingston, Doyle, & Hunter, 2014; Knowles, 1984; Lévesque et al., 2013).

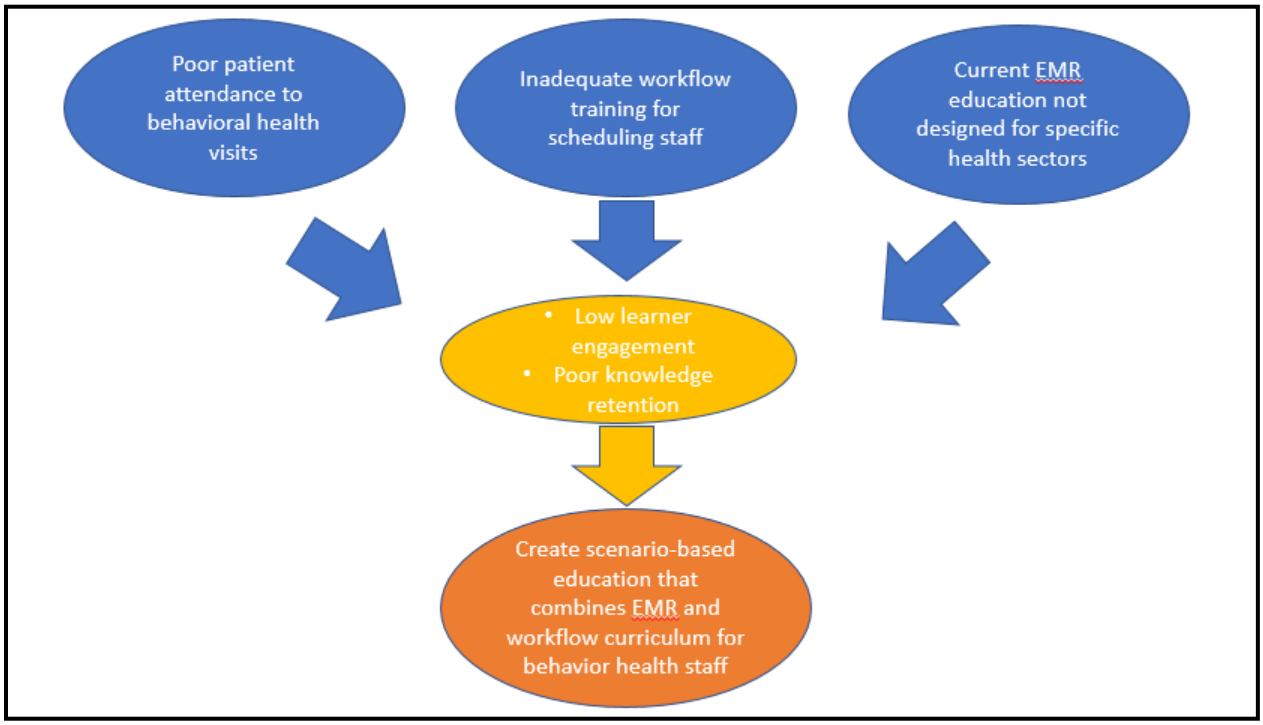
Found mostly in clinical settings, SBE can prepare students for real-life occupational events by submerging them into possible situations they may encounter. SBE is a controlled environment that allows for instructors to test students in various situations with different variables. The most significant benefit of this type of training is the elimination of harm applied to real patients (Allan et al., 2010; Elliott-Kingston et al., 2014; Lévesque et al., 2013).

While the individual student benefits to scenario-based training have been well documented at the clinical level, very little information is known about SBE results on non-clinical adults (Allan et al., 2010; Elliott-Kingston et al., 2014; Lévesque et al., 2013). Additionally, no studies were found that demonstrated testing this educational tool on behavioral medicine non-clinical employees (Devlin et al., 2008; Merriam, 2001; Nagle et al., 2009).

An example of andragogy being applied to behavioral medicine non-clinical staff education is shown below (see Figure 2) (Gallo et al., 2016; Goffman et al., 2017; Knowles, 1984; Liu et al., 2017; Merriam, 2001). The process is based on evidence collected during the review of the literature (Gallo et al., 2016; Goffman et al., 2017; Liu et al., 2017). Some of the common issues found in healthcare organizations related to poor quality or inadequate education are depicted in this figure (Gallo et al., 2016; Goffman et al., 2017; Liu et al., 2017).

Figure 2

Andragogy Theory Applied to Behavioral Medicine Staff Education



Communication and Scheduling in the Continuity of Care Model

Communication is the most crucial variable in the COC model (Miller-Matero et al., 2015; van Eeghen et al., 2016). When communication between clinical staff and patients deteriorates, the resulting treatment can decline (Miller-Matero et al., 2015; Teo et al., 2017; van Eeghen et al., 2016). Educating staff on the importance of COC by emphasizing transparent communication and providing patients with accessible treatment resources is crucial to improvement (Miller-Matero et al., 2015; Teo et al., 2017; van Eeghen et al., 2016).

The COC process is an established protocol for treatment handoff from one care entity to another, and heavily involves scheduling (Biringer et al., 2017; Boos et al., 2016; Lamb, Bower,

Rogers, Dowrick, & Gask, 2012). The initial process within the primary care setting was heavily patient-dependent. Now, employees have begun to utilize multiple software programs within their roles that improve the efficiency of and shortens the COC timeline. This has created a greater need for EHR and system education to be integrated into employee training (Berrouiguet et al., 2016; Devlin et al., 2008; Reynolds et al., 2015; Teo et al., 2017). Behavioral medicine schedulers can complete most of their job responsibilities, including make appointments and documents on patient charts within an EHR (Biringer et al., 2017; Boos et al., 2016; Teo et al., 2017). The COC model has transferred responsibility from patients to non-clinical staff, such as those who schedule appointments (Arora et al., 2010; Denneson, Cromer, Williams, Pisciotta, & Dobscha, 2017; Lamb et al., 2012).

Problems associated with the COC process in behavioral medicine outpatient environments include the following:

- Patients are having poor relationships with behavioral medicine staff.
- Experiencing frequent setbacks and anxiety due to breaks in poor provider-patient relationships.
- Poor timeliness of staff contacting patients.
- Long wait times at appointment check-ins.
- Not getting quality or appropriate help when needed.
- Having a single struggle with staff.
- Having an array of support options to choose from with little guidance (Arora et al., 2010; Denneson et al., 2017; Lamb et al., 2012)

Communication limitations continue to be an obstacle in behavioral medicine treatment (Batt-Rawden, Chisolm, Anton, & Flickinger, 2013; Neumann et al., 2011; O'Malley & Reschovsky, 2011). Communication between PCPs and specialist providers (SPs) about patient care has recently been examined by peer-reviewed studies (Batt-Rawden et al., 2013; Neumann et al., 2011; O'Malley & Reschovsky, 2011). Results collected from a survey gathered from the Health System Survey were analyzed in 2008. The study found contrasts in the perceptions of PCPs and SPs related to the referral process. Most PCPs (69.3%) had positive attitudes towards their actions conducted in the referral process (O'Malley & Reschovsky, 2011). PCPs stated that they routinely ordered referrals and created a comprehensive chart to transfer along to the SP. However, only 34.8% of SPs agreed that they regularly receive health documentation related to the patient from the PCP. Of the SPs surveyed, over 80% stated that they routinely provide feedback of the consult appointment to the PCP, but only 62.2% of PCPs agree that they routinely receive such feedback (O'Malley & Reschovsky, 2011). This evidence encapsulates another example where education is needed to improve process facilitation and to emphasize the negative aspects resulting from failed communication (Batt-Rawden et al., 2013; Neumann et al., 2011; O'Malley & Reschovsky, 2011).

A crucial piece of the COC scheduling process is the communication between the patient or patient's representative, and scheduling staff (Carnegie & Norris, 2015; Neumann et al., 2011; O'Malley & Reschovsky, 2011). It is important to remind patients days in advance of an upcoming appointment to eliminate possible absenteeism (Gabrielian et al., 2016; Miller & Ambrose, 2016; Reid et al., 2015). In addition to reminder timeliness, the volume of appointment reminders has shown to increase the likelihood of a patient arriving and presenting on time for

their appointment (Gabrielian et al., 2016; Miller & Ambrose, 2016; Reid et al., 2015). When a breakdown in communication occurs, a patient's treatment could be delayed or terminated (Avari & Meyers, 2018; Carnegie & Norris, 2015; Miller-Matero et al., 2015; Tomar et al., 2015).

Benefits to SBE

One key difference between medical and non-medical employee training in healthcare is the strategy of solving a specific problem. Providers and clinicians are often trained in programs using problem-based learning (PBL) as a tool in SBE (Clark, & Mayer, 2012; Higgs & Gates, 2013). Clinical staff uses PBL to diagnose and to treat a patient suffering from an ailment. During this course of learning, these subjects are exposed to related treatments, associated ailments, and protocols that occupy the periphery (Clark, & Mayer, 2012; Higgs & Gates, 2013). This type of learning is best for creating job experience and employee confidence as students are exposed to practical role-related problems (Clark & Mayer, 2012; Higgs & Gates, 2013).

Non-clinical healthcare employees, such as schedulers and registrars, may also take part in PBL or SBE. However, this training is often less financially supported by healthcare organizations than its clinical contrast (Higgins, Gallen, & Whiteman, 2005; Louis, Jones, Anderson, Blumenthal, & Campbell, 2001). This weak support can cause non-clinical staff to not have the same learning infrastructures, resources, or accessibility to organizational education as medical providers (Higgins et al., 2005; Louis et al., 2001).

The positive impacts of SBE can reach far beyond the individual student, with reverberations continuing throughout an organization (Clark, & Mayer, 2012; Higgs & Gates, 2013). However, immediate impressions are felt within the classroom on students. This form of

training can be as useful to schedulers as it is for clinicians. Some of the significant benefits to SBE include:

- Advancement of skills at a faster rate than traditional lecture-based education.
- Ability to manipulate the training environment to match a targeted context.
- The versatility of SBE to be tapered to various skill and experience levels.
- Avoiding potential harm to patients by eliminating staff-patient interactions during training (Clark, & Mayer, 2012; Higgs & Gates, 2013).

Evidence has displayed how SBE can improve one's confidence, expertise level, and knowledge in a workplace context (Clark, & Mayer, 2012; Higgs & Gates, 2013). These efficient and rapid results are supported by the theory of adult learning (Knowles, 1984; Merriam, 2001). This theory supports the proof that adults perform better overall in an SBE training context compared to lecture-based education due to the participation, stimulation, and engagement occurring within this situational learning (Clark, & Mayer, 2012; Higgs & Gates, 2013; Knowles, 1984; Merriam, 2001). Furthermore, this type of learning format has shown increased ability in students to teach others what they learned. This can create a ripple effect of learning (Clark, & Mayer, 2012; Higgs & Gates, 2013; Knowles, 1984; Merriam, 2001).

Conclusion

Several obstacles have been identified in the literature that negatively affects behavioral medicine treatment at the provider, clinical staff, non-clinical staff, patient, and organizational levels (Gallo et al., 2016; Mapelli et al., 2015; Reid et al., 2015; Reynolds et al., 2015). These themes tend to significantly affect patients within the behavioral medicine specialty due to the

variables displayed in patients suffering from psychiatric symptoms, including comorbidity and substance abuse (Gabrielian et al., 2016; Miller & Ambrose, 2016; Reid et al., 2015). Educating scheduling staff to have a greater emphasis on assimilating with patients while immersing them into the world of behavioral medicine has shown to provide a more-cohesive treatment environment and greater access to treatment (Corrigan et al., 2014; Gallo et al., 2016; Tomar et al., 2015).

The literature has shown a disconnect between patients and clinical and non-clinical staff due to a lack of transparent communication (Carnegie & Norris, 2015; Miller-Matero et al., 2015; O'Halloran, Worrall, & Hickson, 2015; Reynolds et al., 2015; Teo et al., 2017; van Eeghen et al., 2016). Poor communication between behavioral medicine staff and patients has shown to result in higher appointment absenteeism, creating a gap in patients receiving acute care (Gabrielian et al., 2016; Miller & Ambrose, 2016; Reid et al., 2015). Improving staff educational resources to help resolve these obstacles has shown to improve patient absenteeism rates (Gabrielian et al., 2016; Miller & Ambrose, 2016; Reid et al., 2015).

The literature also identified issues with new hire training for scheduling personnel (Bloomfield & Jones, 2013). Research has shown that new hires would benefit significantly from the implementation of SBE with specific exercises tapered to the department with which they will be associated (Garets & Davis, 2006; Leberman & McDonald, 2016; Wu, Kharrazi, Boulware, & Snyder, 2013). This may entail creating an SBE curriculum around specific role scenarios commonly displayed by scheduling staff in the target environments (Garets & Davis, 2006; Leberman & McDonald, 2016).

Per the literature, including examples of consistent obstacles pertaining to behavioral medicine into this SBE would improve the role of schedulers, the rate of No Show appointments, and the confidence of staff (Akhigbe et al., 2014; Dvorak & Rana, 2008; Goffman et al., 2017; O'Halloran et al., 2015; Paré et al., 2014; Santibáñez et al., 2012; Teo et al., 2017; Wu et al., 2013). Patients with behavioral medicine-associated symptoms can struggle to make a scheduled appointment with a psychiatrist, psychologist, social worker, or other behavioral medicine resources due to limited resources and staff, payer source complications, and adverse personality attributes commonly linked with these patients (Akhigbe et al., 2014; Dvorak & Rana, 2008; Goffman et al., 2017; Miller & Ambrose, 2016; O'Halloran et al., 2015; Paré et al., 2014; Santibáñez et al., 2012; Teo et al., 2017).

The industry of clinical healthcare training already displays an abundant amount of integrated education in simulation and scenario-based formats (Bruppacher et al., 2010; Chen, 2014; Hsu et al., 2015; Sorensen et al., 2015). Examples of this type of education include CPR training on artificial patients, trauma exercise simulation, and situ-simulation of medical staff in real-time environments (Rosen et al., 2012; Sanford, 2010; Weaver et al., 2010). While the evidence of positive outcomes with scenario-based training has been abundantly observed within clinical roles, it has yet to be expanded upon non-clinical positions to a substantive level (Devlin et al., 2008; Merriam, 2001; Nagle et al., 2009). Research questions one and two of this study dive deeper into this subject for answers. Identifiable abnormalities exist in behavioral medicine that could be improved through upgraded educational practices, but the various types of suitable education in the target context have not been examined in peer-reviewed studies. Research questions one, two, and three were created to discover more about this specialty.

Chapter III

Design and Methodology

The purpose of this study was to examine the current education, training, and feedback received from behavioral medicine scheduling staff associated with their position, and to collect their experiences, if any, associated with SBE (Davis & Khansa, 2016; Makam et al., 2013). Students who attend scenario-based training have shown a higher level of applied skills in real-time situations compared to those who receive lecture-only education (Rosen et al., 2012; Sanford, 2010; Weaver et al., 2010). This study chose two Greater Cincinnati healthcare organizations that specialize in behavioral medicine treatment services as locations to analyze. These organizations are ambulatory behavioral medicine healthcare institutions of various sizes based in Cincinnati, Ohio. This decision to choose to target these organizations was based on the access the researcher had to behavioral medicine departments and their established education curriculum for scheduling personnel. Additionally, these organizations were chosen based on their geographical size, diversity of the patient population, and a plethora of behavioral medicine treatment centers. The importance of selecting multiple organizations ensures a higher chance of capturing a parallel population sample of the Greater Cincinnati region (Andrulis & Brach, 2007; Behavioral Health, n.d.). The specialty of behavioral medicine encompasses a wide range of subcategories, including behavioral health, substance abuse, psychology, psychiatry, social work, and the treatment of various diagnoses (Andrulis & Brach, 2007; Behavioral Health, n.d.).

The selected institutions are non-profit organizations encompassing ambulatory offices offering resources such as child development, addiction counseling, medication management, developmental disability treatment, and a multitude of other resources (CDC Behavioral Health

Services, 2019; Greater Cincinnati's Academic Health System, 2018). These services treat a wide array of diagnoses, including anxiety, attention deficit disorder, and various learning disabilities (CDC Behavioral Health Services, 2019). The organizations' sprawl throughout Southwest Ohio, Northern Kentucky, and Southeastern Indiana. This grouping of three state corners is known as the Greater Cincinnati tri-state area (Greater Cincinnati's Academic Health System, 2018). The organizations are steeped in clinical, non-clinical, professional, and academic-based education. They range from large academic health institutions to mid-size outpatient offices (CDC Behavioral Health Services, 2019; Greater Cincinnati's Academic Health System, 2018).

This study designed a data collection method for obtaining qualitative descriptive information (Neergaard et al., 2009; Sandelowski, 2000). Semi-structured interviews with individual participants were used as the only data collection tool for this study. An eight-question interview template was used as a foundation for collecting responses from research subjects. The researcher chose to use semi-structured interviews for data collection to obtain information from the target audience pertaining to training to which they have been exposed. These semi-structured interview questions were tested using an expert panel of healthcare professionals who have experience with scheduler training and education creation (Creswell & Miller, 2000; Strauss & Corbin, 1998). The interview questions were pilot tested on past and present healthcare personnel who participated in behavioral medicine scheduling tasks (Creswell & Miller, 2000; Strauss & Corbin, 1998).

Research Questions

The obstacles surrounding behavior medicine patient-staff communication, education, training, and appointment attendance are becoming more apparent in healthcare (Carnegie &

Norris, 2015; Devlin et al., 2008; Wiznia et al., 2017). Furthermore, the researcher has identified vital problems between clinical and non-clinical roles (Miller & Ambrose, 2016; Nagle et al., 2009; Reid et al., 2015). To determine if the training methods for non-clinical roles could be attributed issues such as patient absenteeism, learner engagement, and COC, the following questions have been identified:

1. What types of education have behavioral medicine schedulers received prior to beginning their role?
2. How do behavioral medicine schedulers feel about the adequacy of their education to prepare them for their role?
3. How could behavioral medicine scheduling education be improved?

Research Design

Through the utilization of semi-structured interviews, the perceptions and experiences of behavioral medicine non-clinical education pertaining to schedulers were examined. Interviews were arranged with eight schedulers from two behavioral medicine healthcare organizations in Greater Cincinnati to perform the qualitative descriptive study. The purpose of interviewing the eight schedulers was to provide evidence from professionals who have experience with education and the obstacles associated with this role in behavioral medicine. This data provided a pinpoint location to the obstacles in education practices and materials (Creswell, 2014; Marshall & Rossman, 2016).

Approval was sought (see Appendix D) and acquired (see Appendix E) from the patient access director of each organization before the researcher received email addresses used for contacting individual schedulers. Approval to conduct the study was obtained from the human

resources department of the researcher's employer, a Greater Cincinnati healthcare company separate from the research sites. Letters explaining the purpose of the study and the NNU IRB approval (see Appendix F) were sent to the directors of each organization. Both directors responded with letters approving the study and data collection. The directors provided a combined 278 email addresses for staff designated with the role of a scheduler.

A qualitative descriptive approach is a process of creating the meaning of the lived experiences of individuals through semi-structured interviews of those who have experienced the event in question (Marshall & Rossman, 2016; Neergaard et al., 2009; Saldaña, 2015; Sandelowski, 2000). Data collected from eight participants allowed for a deeper understanding of the targeted phenomenon than a lower participant volume would have provided.

Participants were initially contacted (see Appendix B) to complete the interview. Follow-up communication (see Appendix C) was sent to all subjects two weeks after the first communication to collect additional participants. Volunteer subjects responded to the email with their name, contact information, and preference on contact days and times. Semi-structured interviews were scheduled with the participants who agreed to meet over the phone. The semi-structured interviews began with five questions about the person's demographics. The person's organization was not collected in hopes that subjects would feel more comfortable providing information about their experiences and perceptions. Participants were provided consent information (see Appendix G), and consent was obtained when subjects signed and returned the consent form via fax or electronic mail.

Questions asked in the semi-structured interviews were vetted using six healthcare education professionals versed in clinical and non-clinical training. Experts were used to review questions to test their trustworthiness (Creswell, 2014; Marshall & Rossman, 2016). The expert panel was asked to provide feedback pertaining to the questions' content and format, and verified the questions would likely provide adequate answers associated with the study's topic. Additionally, the experts were asked to provide feedback associated with biased, misleading, or improper questions that could hinder responses. Recommendations for improving questions were provided by experts, and modifications were made.

Participants

The population of possible subjects was defined as individuals who work as a behavioral medicine ambulatory scheduler at one of the two targeted healthcare organizations operating in Cincinnati, Ohio. Subjects had to be employed full-time, part-time, or on-call as of September 2019 at one of these locations. The researcher received a total of 278 email addresses from the two targeted sites of staff that met the participant criteria. Of the 278 email addresses which were contacted, nine individuals responded with interest in volunteering to complete an interview. Of the nine, eight subjects completed interviews and signed a consent form. One individual withdrew from the study due to time constraints.

All individuals within this population received an initial (see Appendix B) and follow-up (see Appendix C) electronic message from the researcher to participate in a one-on-one interview. A participant flyer (see Appendix H) was also dropped off at the organizations' physical sites to generate additional participation. Subjects were chosen based on the first eight participants who volunteered to complete the interview. Participants who volunteered to be

interviewed (n=8) provided their name, telephone number of best contacts, and preferred dates and times to be interviewed in a return email. If participants did not comply with all research requirements, such as providing signed consent, follow-up attempts were made, or a replacement was found.

Prior to semi-structured interviews being administered, participants were provided with an informed consent form, which included information about the purpose and background of the study, procedures, risks and discomforts, contact information of the researcher and supervisor, notification of volunteering to participate, information allowing subjects to stop the interview at any time, and a subject signature spot. The researcher answered any questions that arose, and subjects were told they could end their participation at any time. Remuneration was offered for those who completed an interview, signed, and returned their consent form. Each participant received an electronic $5.00 Starbucks gift card purchased and funded by the researcher.
In addition to participant remuneration, directors for the two sites were offered information about the study's findings while participant identities remained anonymous.

All records, including participant identities, site information, and interview notes, were stored on an encrypted and locked laptop only accessible by the researcher. Transcription was completed through Microsoft Word, which will be deleted within three years of the study's completion. Identities of participants, managers, directors, or companies were not included in the published results of this study. In compliance with the Federalwide Assurance (FWA) Code, data from this study were to be kept for three years, after which all data would be destroyed (45 CFR 46.117).

Data Collection

The data collection was used to study the perceptions that behavioral medicine schedulers have to pertain to the education and training received for their position. The qualitative descriptive semi-structured interview questions were approved by Northwest Nazarene University's (NNU) institutional review board (IRB). Interview questions were reviewed by a six-person expert panel (see Table 1) consisting of the following professionals:

Table 1

List of Expert Panel Participants

Subject Identifier	Experience	Education
Expert One	An inpatient nurse with over five years of clinical experience	• Bachelor of Science in Nursing degree • Certified in Epic Ambulatory
Expert Two	A healthcare Epic educator	• Master of Integrative Studies • Bachelor of Communication • Epic certification in Inpatient Orders
Expert Three	A healthcare educator and Registered Dietitian Nutritionist	• Master of Medical Science • Epic certified in Dorothy and Hospice Curriculum
Expert Four	An informatics analyst with over ten years of healthcare experience	• State of Ohio Nursing License • Master and Bachelor of Science in Nursing
Expert Five	A healthcare e-learning specialist with over twenty years of clinical education training experience	• Bachelor of Science in Nursing
Expert Six	A behavioral medicine scheduling and registration educator	• 10+ years of behavioral medicine scheduling experience

Expert panel subjects in the field of healthcare education were emailed interview questions along with a brief description of the requested review task. Written feedback was obtained from all six professionals who inquired to verify the objective of the questions, and to provide suggestions for question edits that would strengthen the validity of the data collection by ensuring questions were asked in specific, detailed terms that would generate the desired responses. Expert subjects also made suggested general strategies for conducting user interviews. Modifications were made to the original questions based on this expert feedback to improve the validity of the questions.

Pilot testing of the qualitative tool was conducted in August 2019 (Leberman & McDonald, 2016; Saldaña, 2015). The testing panel consisted of:

Table 2

List of Pilot Testing Participants

Subject Identifier	Role
Pilot Subject One	An outpatient pediatric behavioral medicine scheduler
Pilot Subject Two	An outpatient pediatric & adult behavioral medicine scheduler
Pilot Subject Three	An outpatient pediatric & adult behavioral medicine scheduler

The questions asked during the interviews were piloted using three participants who currently work or have worked in behavioral medicine outpatient scheduling. Subjects were each interviewed via the phone with questions edited from expert panel feedback. During the interviews, questions were further edited based on participant responses to allow for more

detailed and more significant quality answers. After all interviews were conducted, subject responses were compared to verify questions that triggered similar results (Creswell, 2014; Marshall & Rossman, 2016). Responses were verified to be analogous from all three subjects, which satisfied reliability.

Participants

The scheduling directors at each of the two behavioral medicine organizations in Cincinnati were contacted for research approval, which was obtained prior to data collection. Both healthcare organizations did not require the researcher to apply for study approval to their respective IRB. Both entities accepted the approval granted by the IRB at NNU. The electronic mail addresses of scheduling personnel were provided to the researcher by each manager. All individuals within this population received an initial and follow-up electronic message from the researcher to participate in a one-on-one interview. Contact information for the researcher and researcher's supervisor was included in both messages. Participants who volunteered to be interviewed (n=8) provided their name, telephone number of best contact, and preferred dates and times to be interviewed in a return email to the researcher.

Each semi-structured interview was conducted with individual participants over the phone by the researcher initiating the call. Each interview lasted between 30 and 50 minutes in length and was recorded using GoToMeeting (LogMeIn2020) and transcribed using Microsoft Word. The transcribed document of each interview was manually reviewed by the researcher for documentation errors. All data were housed in Microsoft Word 2016.

Participants were provided with a consent form to read in the initial contact message. Consent was obtained when a signed consent form was collected by the researcher from each

participant. Contact information for the researcher and researcher's supervisor was provided verbally to participants in case questions or concerns arose.

Semi-structured interviews were conducted with voluntary staff to collect qualitative descriptive data pertaining to education methods in behavioral medicine, and experiences with SBE in the same setting (Neergaard et al., 2009; Sandelowski, 2000). Initial and follow-up emails were sent to 278 schedulers of both organizations at the same time. The names and contact information of everyone who responded to the email were collected and sorted using Microsoft Excel 2016 from first to last response. If an interview with a subject were not able to be completed for any reason, the next volunteer in line would be contacted. This process would repeat until eight interviews were completed.

Interviews were scheduled based on the available time of subjects. Date and time arrangements were scheduled via email, and all interviews were completed over the phone with individual subjects. All interviews were recorded and transcribed using GoToMeeting (LogMeIn, 2020). Dictations were saved into Microsoft Word 2016. Initial verbal consent was obtained by participants prior to conducting interviews. An electronic Informed Consent Form was sent to subjects via email, was signed by each participant, and returned to the researcher.

Subjects being interviewed were asked to verify their name. Participants' employer identity was not collected in the study. Identifiable information collected in interviews was not shared with any individuals outside of this study's research group. All interviews and dictations were kept on a locked computer only accessible by the researcher.

Participants were given a pseudonym based on the number in which they completed their interview in association with the first United States senators based on sex. For example, the first

six female participants were given a pseudonym of Hattie, Rose, Dixie, Gladys, Vera, and Margaret (Senators of the United States, 2020). The two male participants were provided a pseudonym for Joseph and John (Senators of the United States, 2020). Additional participants were assigned aliases in the same pattern. Pseudonyms may or may not be identical or similar to subject names.

Each participant received a debriefing message (see Appendix I) via email shortly after completing the interview. This message was a form of gratitude for participating in the study, and it allowed for subjects to respond if questions arose. No subjects replied with questions, concerns, or issues.

Member checking (see Appendix J) was performed two months after each interview was completed (Creswell & Miller, 2000; Strauss & Corbin, 1998). This allowed the researcher to summarize the interview results and verify them with subjects. All participants were emailed the interview synopsis to verify the data reflected their ideas. Participants who did not respond to the initial email were sent the same message again. If no response were received by March 2020, the data would be included in this study with details on the lack of participant feedback. Detailed interview logs and reflexivity notes were taken by the researcher (Creswell & Miller, 2000; Strauss & Corbin, 1998).

Analytical Methods

In preparation for this study, the research completed the National Institutes of Health (NIH) certification, “Protecting Human Rights” (see Appendix K). Immersion of the data was performed over time by reviewing, analyzing, organizing, and coding the collected information (Creswell, 2014). These performed behaviors provided a thorough and personal analysis of the

data. Interview information was analyzed for emerging patterns and themes through a process of merging the transcribed conversations into manageable sections centered around the study's research questions (Marshall & Rossman, 2016). Color coding was performed on the collected data with a Microsoft Word 2016 document for the initial round of analysis. Different colors represented identifiable themes, and this allowed for the data to be categorized under each associated question. Some data correlated to more than one question and an association with each correlation was made.

Organizing the data into sections allowed the researcher to analyze the emerging themes and patterns, and to create a synopsis of the information. Responses with common phrases, keywords, and context were identified, highlighted, categorized, and tallied. This was followed by a second round of analysis were additional phrases, themes, and keywords were identified and highlighted. Each highlight was associated with its own research questions within the same Word document. The identified patterns were then reviewed and verified with the data collected. Letter codes were assigned to each color for categorizing, and this process continued until all themes were identified. Theoretical saturation of the collected data was achieved when no new patterns or themes could be identified (Bowen, 2008; Saldaña, 2015).

Roles of the Researcher

No researcher is without traits, experiences, values, and beliefs that have an influence on perceptions and decisions (Creswell, 2014). Contact with subjects, synthesizing qualitative descriptive data, and deriving conclusions are research factors that can be affected by these engrained attributes (Creswell, 2014; Neergaard et al., 2009; Polit & Beck, 2008; Saldaña, 2015; Sandelowski, 2000). It is imperative the researcher identify and bracket these personal beliefs

from influencing the research. To create this bracketing, the researcher should continuously self-identify what one knows, what one perceives, and what one has found throughout the research process (Marshall & Rossman, 2016).

Researcher bias may be present in this study due to the proximity of professions between subjects and the researcher (Creswell, 2014; Polit & Beck, 2008; Strauss & Corbin, 1998). This study's primary researcher was an employee at a direct competitor to the observed institutions at the time of this writing. This researcher was an EHR analyst and educator at the time of this study. Bias may exist due to the researcher's professional affiliations and expertise (Pannucci & Wilkins, 2010). This researcher attempted to eliminate possible biases by identifying himself as an independent researcher only. The researcher eliminated backyard bias by not conducting research at his employer. All communication with study participants occurred using an NNU electronic mail account.

Delimitations

This study was limited to a total of eight volunteer participants employed at one of two healthcare organizations located in Cincinnati, Ohio. This research was limited to this scope to individually examine the results associated with particular a medical specialty within a defined geographic area (Biringer et al., 2017; Boos et al., 2016; Teo et al., 2017). This study focused on examining healthcare institutions that provided diverse patient populations ranging from pediatric to geriatric ages throughout the Greater Cincinnati area. The roles of the participants were actively selected, and users were chosen based on their identification with the occupation of behavioral medicine scheduling, and their associated contact with role and system education. Within these parameters, the researcher sought to uncover and understand the association to

behaviors as expressed by the study participants (Creswell & Miller, 2000; Marshall & Rossman, 2016).

Limitations

The research acknowledges the presence of uncontrolled limitations in this study as contributing to bias by the researcher, participants, the study's qualitative design, the interview questions designed by the researcher, and the study's time limitations. The personal makeup of the research, including beliefs, values, experiences, and education, are considered limitations of the study (Marshall & Rossman, 2016). These attributes dictated the researcher's perspectives associated with designing, creating, performing, and analyzing of the study and its results. The beliefs, personality, and experiences of the participants in the study also contribute to the existing limitations (Marshall & Rossman, 2016).

The individual perspectives and experiences of the subjects provided the qualitative responses as the primary source of datum in this study. Subject responses were collected through semi-structured interviews, which were recorded, synthesized, and analyzed by the researcher. Although an expert panel and pilot initially reviewed the questions tested with a sample group, the rigor remains limited.

Chapter IV

Results

Introduction

This study examined the types of education received by behavioral medicine outpatient schedulers and the views of employees associated with this education. The study's objective was to collect the experiences and perceptions of schedulers based on the professional education they have received to determine its positive and negative attributes, and possible improvements. Most research in the area of behavioral medicine employee education has been performed with clinical occupations, such as nurses, psychologists, and physicians. However, very little research related to non-clinical occupations, such as schedulers and registrars, exists (Devlin et al., 2008; Ford et al., 2016; Wayne et al., 2008). With a growing need for higher quality medical treatment, and a prevalent resource crisis in behavioral medicine, the importance of improved staff training and continuing education is more significant than ever (Carnegie & Norris, 2015; McKinley & Ruppel, 2014; Miller & Ambrose, 2016; Wiznia et al., 2017). The research argues substantive, robust training can have positive effects on employee performance and overall job satisfaction (Davis & Khansa, 2016; Makam et al., 2013). Knowles' theory of andragogy (1984) provides a template for improving adult learner education, which could improve employee performance in this field. The questions guiding this dissertation study include:

1. What types of education do behavioral medicine schedulers receive prior to beginning their role?
2. What perceptions do behavioral medicine schedulers feel that current education received has prepared them for their role?

3. How could behavioral medicine scheduling education be improved?

Data from the semi-structured interviews were examined for emerging themes and patterns through the process of transcription and coding the results based on the associated research question(s) (Saldaña, 2015). The researcher first utilized color coding to identify themes, keywords, and patterns in the data by using a different color for each category. The highlighted sections were then coded with a number one, two, or three based on the particular research question(s) that responses fit best. Responses were transferred into another Microsoft Word document, each labeled with its respective number.

The interview questions were asked in a nearly identical manner and wording for each participant to collect the same type of information for each topic (Saldaña, 2015). This method of questioning allowed for a side-by-side comparison of the answers and a grouping of the qualitative descriptive data in a table displaying the responses about the patterns and topics associated with scheduling education and training (Neergaard et al., 2009; Sandelowski, 2000). The results signaled comprehension of the concepts of adult education, scenario-based training, and the implications of these tools in association with non-clinical patient interactions (Knowles, 1984).

The responses differed among participants, so the rate in which patterns were identified in the responses was not considered. For example, if one subject mentioned using email as an educational tool at the beginning of the interview, and another subject mentioned the same topic at the end, the time difference was not compared. However, as the analyzing and synthesizing of interview responses took place, four standardized themes began to appear.

The four principles of Malcolm Knowles' theory of andragogy were used by the researcher to determine the association between participant responses and the theory of adult education. The principles of andragogy used to examine the participant responses are:

1. Involving adults in designing and implementing their education.
2. Incorporating the past experiences of students into new education.
3. Designing education that is pertinent to students' personal and professional lives.
4. Creating problem-based curriculum (Knowles, 1984).

The confidentiality of the eight participants engaged in the study was supported by the use of pseudonyms (see Table 3). The initial contacts who provided site research permission, and the participating organizations, remained confidential throughout the study. The eight subjects who participated in the interviews were referred to by their associated pseudonym. The first female participant was assigned a pseudonym of Rose, followed by Hattie, Dixie, Gladys, Vera, and Margaret. The two male participants were assigned the pseudonyms, Joseph, and John. This pattern followed the first elected female and male senators of the United States (Senators of the United States, 2020).

The researcher collected demographic variables and professional experience information (see Table 3) during the early portion of the interviews. The data formed a snapshot of each subject and could provide further insight into the provided qualitative responses. The following table displays definite answers to questions one through five for each participant.

Table 3

Responses to Questions One Through Five

Pseudonym	Question 1 What is the highest level of education you have completed?	Question 2 What is your current age?	Question 3 What is your gender?	Question 4 Which ethnic group applies to you?	Question 5 How long have you been working for this organization?
Rose	Masters	55-64	Female	White (Caucasian)	15+ years
Hattie	Masters	25-34	Female	White (Caucasian)	1-5 years
Dixie	Bachelors	35-44	Female	Black (African American)	< 1 year
Gladys	Doctorate	45-54	Female	Hispanic (Latin American)	6-10 years
Vera	Masters	35-44	Female	White (Caucasian)	6-10 years
Margaret	High School	35-44	Female	Black (African American)	6-10 years
Joseph	Masters	25-34	Male	Black (African American)	< 1 year
John	Bachelors	35-44	Male	White (Caucasian)	1-5 years

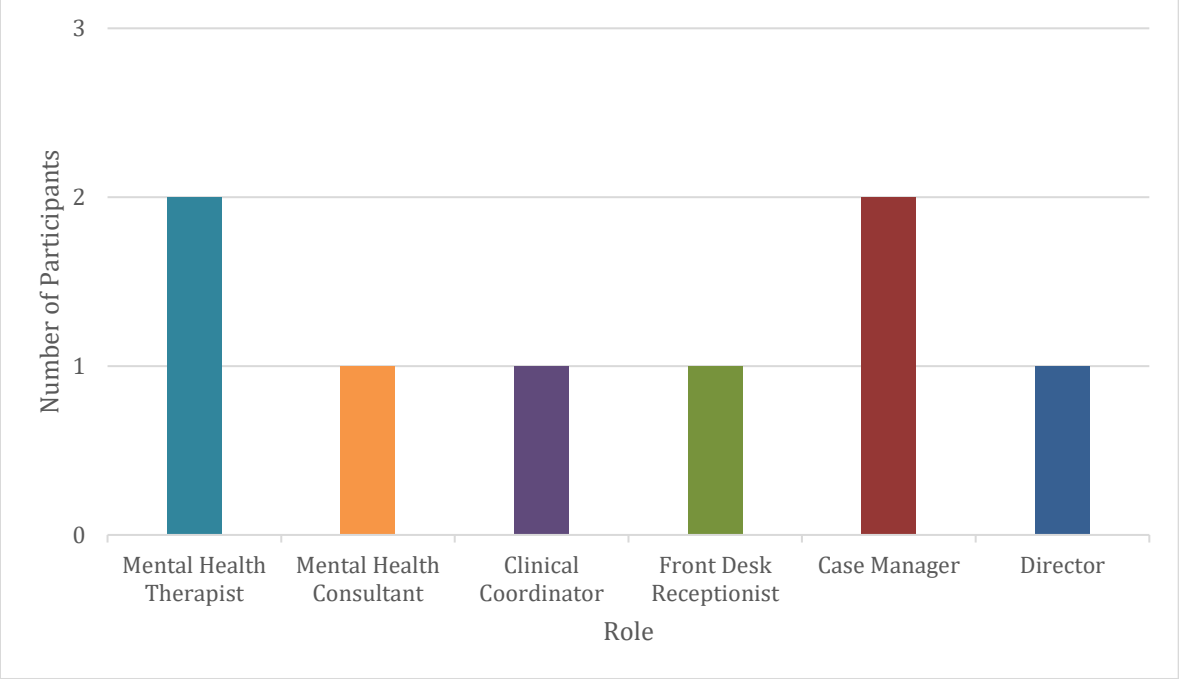
The highest education level for 87.5% of the participants was a four-year college degree or higher, and 62.5% had a graduate degree, including one participant with a philosophical doctorate. For ages, two subjects were between 25 and 34, four subjects were between 35 and 44, one subject was between 45 and 54, and one subject was between 55 and 64 years old. Ethnicity

differences in participants were 50% Caucasian, 37.5% African American, and 12.5% Hispanic. Half of the participants have been employed by their organization for greater than six years, two have been employed from one to five years, and two subjects employed for less than one year.

The study focused on the education received by behavioral medicine outpatient schedulers and therefore requested that all study subjects be in a role (see Figure 3) that performs appointment scheduling. However, scheduling tasks were not required to be their occupation's primary duties. Figure 3 displays the breakdown of participant occupations.

Figure 3

Participant Roles



Research Question #1

Data uncovered in the interviews displayed a strong presence of informal education and training for behavioral medicine schedulers. This evidence provided answers to the first research

question. The use of SBE or simulation-based training was slightly present, but most education strategies were unofficial, site-based, and not standardized across locations.

The interview responses did result in the observance of a consistent belief among the participants that SBE would be preferred over the current educational methods. This belief was observed in the participant interviews, which align with andragogical concepts (Knowles, 1984). Some subjects referenced exposure to these aspects during clinical role training, or from past employers.

Participants in this study referenced a wide variety of educational tools to which they have been exposed. Rose, Joseph, and Hattie explained most of their professional knowledge was built through academics or prior work experiences, and not from any training received by their current employer. When asked explicitly about education pertaining to scheduling, Rose and Hattie stated they had not seen any conducted at their facilities. John, Vera, and Gladys explained their scheduling workflows had been independently learned without any formal or informal education. Vera stated her training was "more self-taught," while Gladys had to “figure it out, and then troubleshoot if things weren't going well.”

The contrast between the education received for previous roles, and the participants' current occupations were remarkable. Margaret, a front desk receptionist whose primary objective is to handle office intake, stated she had received formal training with her previous role at the same organization but had not received any new training when she was hired into her current position. Dixie, a mental health provider who also makes appointments, stated she received sufficient training for her clinical duties, but not for scheduling. She indicated most of her education comes in the form of “staff meetings. Some information may be in a handout or in

an email. In terms of the training for scheduling, I don't think we have any. Nothing really comes to mind." An examination of training and educational programs offered to staff was neither requested nor conducted.

Participant responses were manually highlighted when they were found to be answering research questions one. The responses were then imported into an Excel spreadsheet for easy comparison. This data was then put into a visual form (see Table 4).

Table 4

Responses to Questions Pertaining to Andragogy Education Utilized by Participants

Types of Education Received	Subjects Who Have Utilized or Observed Feature
Job shadowing	Vera, Gladys, John
Roleplay	Joseph
SBE/training	Gladys
Electronic mail communication	Rose, Hattie, Margaret
Group presentations	Margaret
Lecture-based education (classroom training)	Gladys, Margaret
Handouts distributed ad-hoc	Rose, Gladys, John
Peer-to-peer question and answer	Rose, John
Supervisor-to-employee question and answer	Hattie, John
Reliance on employee past experiences and education	Rose, Dixie, Gladys, Vera, Margaret, John, Joseph

Of the 10 types of education received, "reliance on employee past experiences and education" was reported by seven of the subjects. This was followed by "handouts distributed ad-

hoc" and "electronic mail communication," reported by three subjects. The participant reporting the most types of education received was John (5) and Gladys (5), followed by Rose (4), Margaret (4), Joseph (2), Vera (2), Hattie (2), and Dixie (1).

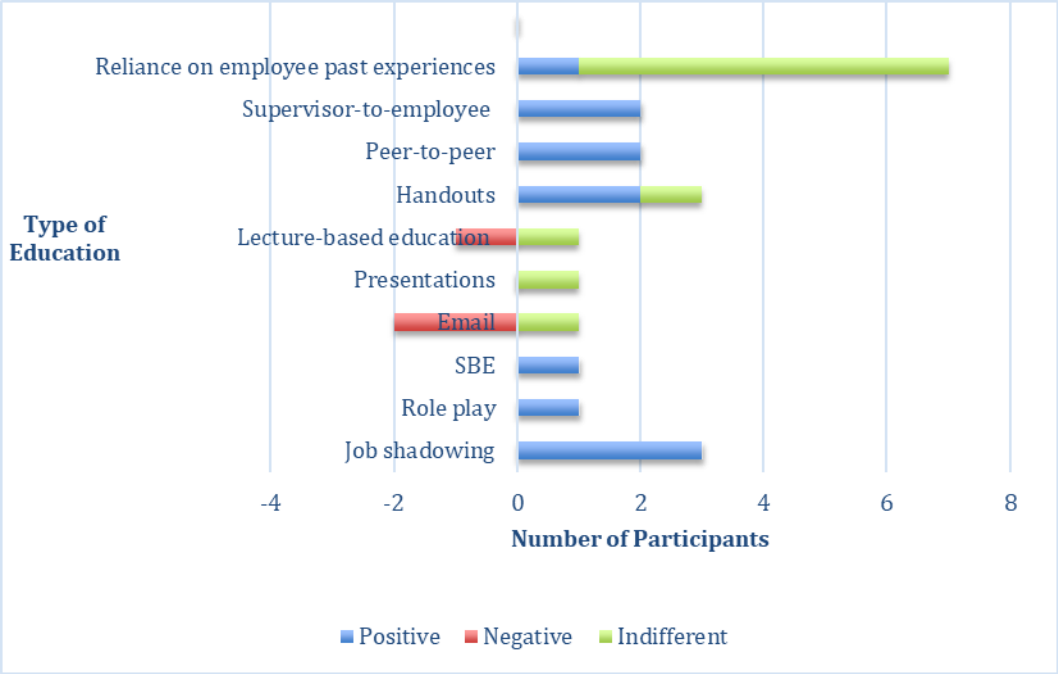
Research Question #2

The collected qualitative data displayed a pattern of participants who had not received formalized training or continuing education in new and established scheduling roles. Despite the participants' absence of formal knowledge and interaction with SBE and adult learning theories, subjects discussed behaviors and insights that strongly align with andragogy. Responses displayed negative feelings associated with traditional means of education and training, and with the absence of either, as was reported by some subjects. In contrast, positive responses were often associated with job shadowing, SBE, and simulation training.

Participant responses were highlighted when they provided answers pertaining to research question two. The responses were imported into an Excel spreadsheet, and each response was given a positive, negative, or indifferent value based on the response. This data was then put into a visual form (see Figure 4). The 10 types of education participants mentioned having experienced at their current position were rated with various positive and negative views. The following figure displays the perceptions of subjects towards the received education.

Figure 4

Perceptions Towards Received Education



The perceptions of participants towards the 10 types of received education, as shown in Figure 4, shows a predilection towards interpersonal training. Forms of education with the highest favorable rating were job shadowing, supervisor-to-employee, and employee-to-employee. Negative ratings were associated with email and lecture-based education.

Some participants mentioned how email is their primary form of receiving education from supervisors, but how other forms could provide more significant benefit. “(Email) is easier for (some) cases,” stated Rose. “But not for all cases.” She also stated, "the (current) process of the informal (training) is arduous to pick up as a new hire.” Margaret remarked, “emails are very beneficial, but maybe instead of emails, just have everybody that does it come together and get training. Everyone that does an intake get training.”

A majority of subjects referenced job shadowing as having been a beneficial tool for role acclimation. Gladys stated, “(What I found to be) beneficial was that I had an opportunity to job shadow other case managers." Vera mentioned, "(to train new hires), I think a lot of shadowing (is beneficial). Just put the phone on speaker and let you listen to the different types of phone calls.” Job shadowing was found to be beneficial when subjects shadowed their colleagues and supervisors. John referenced job shadowing as a way for him to meet with his supervisor for ongoing education. “This helps me get everything I need,” he said.

Participants also provided information on formalized education tools they felt were beneficial. Joseph stated he enjoys role play and simulation-based training as opposed to lecturing. He remarked, "I would kind of like to role play a lot of scenarios (for training)." John reiterated this sentiment by stating, "I think there needs to be a little bit more formalized training on how to do things for certain individuals."

Research Question #3

Close to the end of each interview, participants were asked a question pertaining to their perception of how to improve the appointment scheduling education at their organization. The topic of andragogy and its features were not mentioned to participants as to avoid confusion and contamination (Saldaña, 2015). Participant responses were manually highlighted when they provided answers to research question three. The responses were imported into an Excel spreadsheet, which was then put into a visual form (see Table 5).

Table 5

Participant Responses for Education Improvement Tools

Types of Education/Tool	Subjects Proposing Improvement
Job shadowing	Vera, John, Hattie
Roleplay	Joseph, Hattie, Vera
SBE/training	Gladys, Dixie, Vera, Joseph
Open communication with supervisor	Rose, Gladys, Vera, John
Education created with employee input	Hattie, Dixie, Gladys, Vera
Handouts	Gladys
PowerPoint presentations	Gladys
One-on-one/classroom training	Margaret, Joseph, John
Test/Assessment	Joseph

Overall, there was a perception that implementing andragogical-centered education features into behavioral medicine scheduling curriculum would improve the knowledge of end-users, possibly resulting in improved patient experience (Knowles, 1984; Merriam, 2001). Participant responses to this question were direct and concise. Rose stated, "being upfront with new hires that schedule with this population is just really hard at times. Verbal communication should be the primary source of that training, along with early access to a supervisor." This same emphasis on verbal communication with new hires was reiterated by fellow participants. Hattie suggested new staff be trained on how to handle irate or upset patients over the phone when scheduling issues arise. Dixie, Gladys, and Vera discussed the stress and sensitivity often

associated with behavioral medicine patients. Dixie stated employee education pertaining to communicating with patients who have experienced trauma could always be improved. "I think we have to (create education and training programs) that can be attuned to what struggles (the patient) has faced before they walk through the door."

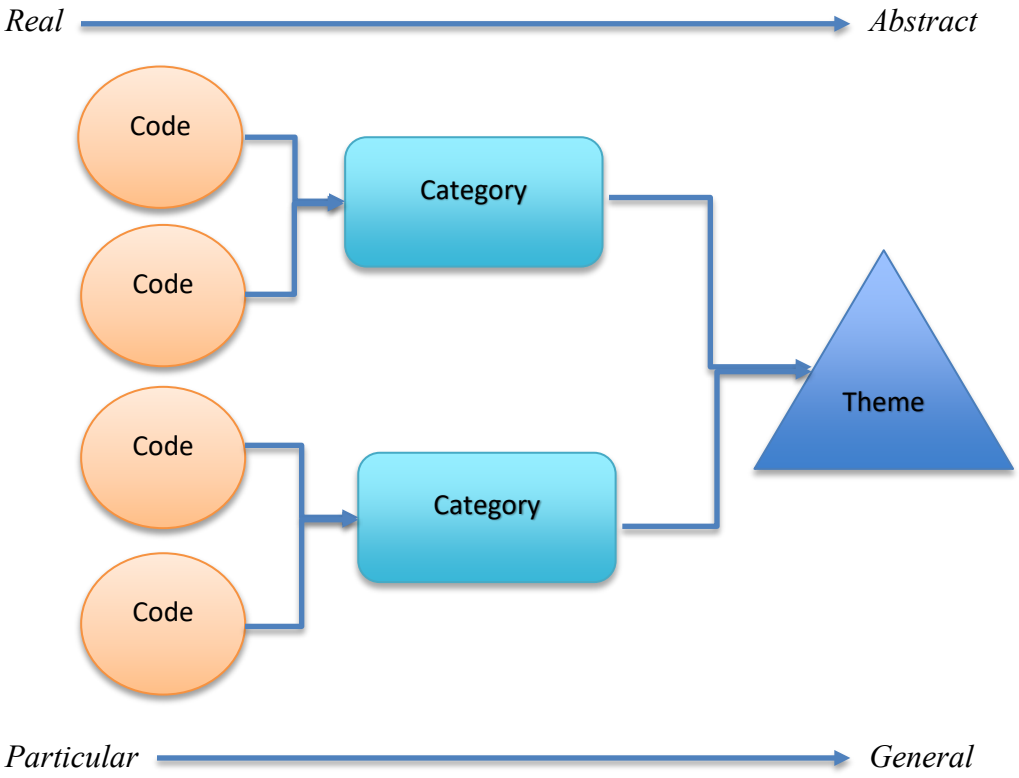
Participants offered many suggestions for possible improvements in scheduling education. The suggestions that routinely arose were SBE and job shadowing. Gladys and John recommended new hires shadow senior staff for a period to become acclimated to the types of patients and situations staff encounter and the processes for handling these. Joseph also recommended using SBE, but in a role-playing format using various situations staff may face. Vera, who has had experience with creating educational tools for staff, stated:

> "A big factor in training staff is experience. Training should be through exposure, kind of get them a seat on speakerphone where we're sitting. Let (new staff) sit with (senior staff) and let them hear us letting us hear them talking (with patients). We will guide them through it."

Themes are an outcome of coding, categorizing, and reflection (Saldaña, 2008, pg.13). All identified transcript codes were grouped into categories of best fit and not predetermined by the researcher. For this instance, the researcher used a streamlined codes-to-theory model (see Figure 5) to identify themes (Saldaña, 2008, pg.12).

Figure 5

Streamlined Codes-to-Theory Model



After seven months of research and analysis, including one interview with each participant, a total of 192 codes (see Appendix L) and five categories were identified in the interview transcripts. The process was completed as themes arose for the three research questions in a written format and in a visual display. Table six is a visual representation of the five categories and the code count. Codes included one or multiple-word answers.

Table 6

Five Categories and Code Counts from Interviews

Categories	Number of Code Responses
Scheduler workflows/making appointments (SWMA)	61
Patient/family interaction (PFI)	51
Informal training/adult learning (ITAL)	50
Past work experience (PWE)	17
Formal training (FT)	13

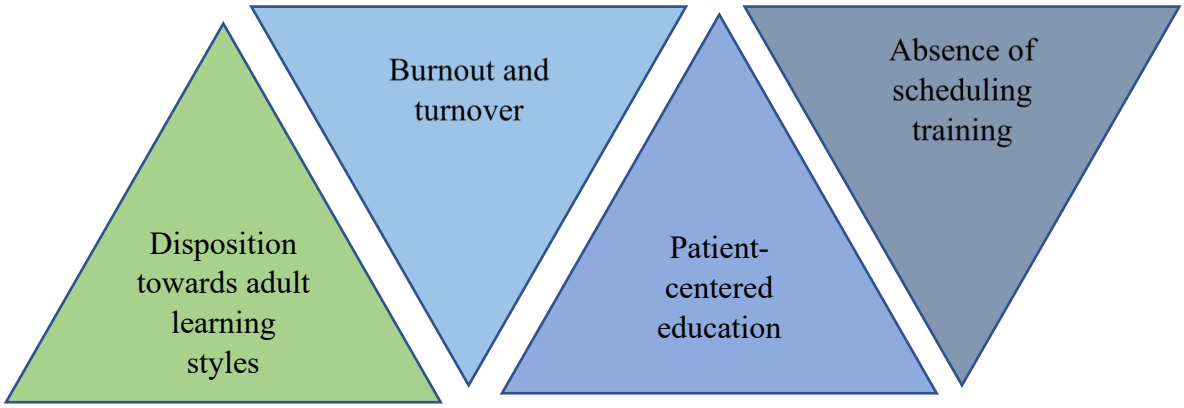
Based on the coded interview responses, roughly 31.7% of codes were pertaining to scheduling workflows, processes, and routine activities. Roughly 27% of codes reflected interactions with patients or their families, and roughly 26% fell into the informal training/adult learning category. This category encompassed responses related to SBE, SDL, job shadowing, and interpersonal communication with managers and coworkers. Codes pertaining to past work experience accounted for 9% of all codes, and formal training accounted for 7% of all codes.

Subjects reflected on experiences they had encountered with the training they had received for scheduling activities, and this was naturally compared to received training for other organizations and roles. Some subjects were dismayed by the lack of scheduling training, while others were optimistic about the possibilities for improving the curriculum. The perceptions and suggested improvements provided by participants ranged from company-wide to individual.

Figure 6 displays a diagram depicting the themes identified from this study's collected responses. The right-side-up triangles represent positive themes, while the upside-down triangles display negative themes. Together, they intermingle to represent the significant views of study subjects. It became apparent to the researcher the experiences associated with education and training were often distinct but coalesced into an individual's experience. The result is a visual representation of each theme.

Figure 6

Identified Themes



The themes are associated with the construction, implementation, and improvement of aspects presented in research question #3 were designed to offer beneficial and practical education to staff. They revealed a need for organizational leadership to create education structures for new and established employees, support staff with education resources, bolster knowledge with training opportunities, and create avenues for improving internal and external

communication. Without prompting, participants provided improvements associated with adult learning strategies (Knowles, 1984; Merriam, 2001).

Conclusion

Chapter IV produced a summarization of the results from the qualitative data collection methods in the study of behavioral medicine education. The semi-structured interviews found some critical themes with the current training received by employees at the targeted sites, including a lack of realistic training, standardized curriculum, and ongoing educational support. Ideas for improvements to the education were proposed that strongly associate with Malcolm Knowles' theory of andragogy, such as the use of SBE and simulation training. Resources should be more accessible to employees as new patient situations arise. The data displayed in Chapter IV will be expanded upon in Chapter V as the factors affecting behavioral medicine staff education, and training will be analyzed at higher levels.

Chapter V

Discussion

Introduction

Clinical education and training programs have experienced tremendous growth in efficiency and quality improvement through the late 20th and into the 21st century (McNeal, 2010; Paskins & Peile, 2010). As a result of the massive growth, healthcare organizations have begun to use the same education tools in non-clinical areas, such as scheduling and registration (Reed et al., 2014; Robinson & Dearmon, 2013). However, these occupations have continued to receive less funding for education and training than clinical roles, which has led to a lack of innovation and quality (Proudfoot & Kebritchi, 2017; Reeder & Turner, 2011). Furthermore, the specialty of behavioral medicine received even less funding than its physical medicine counterparts, which has led to further weakening of educational and training programs for these non-clinical positions (Bruppacher et al., 2010; Chen, 2014; Macaro, 2006).

In addition to a lack of funding, very little research was found in the field of behavioral medicine scheduling education. A lack of spotlighting the importance of this role, and the functions within, is glaring in this study's results. Of the eight participants who schedule patient appointments, only one subject was in a traditional front desk role (Margaret). The other seven were clinical providers who also made appointments. In some cases, the task of scheduling was forced upon them by organizational leadership due to a lack of staff and funding.

Research showed that behavioral medicine resources are underfunded and geographically limited compared to other specialties (Miller & Ambrose, 2016; Reid et al., 2015; Wiznia et al., 2017). This is due to many factors including limitation of behavioral medicine offices accepting

new patients, acceptance of certain types of insurances, and a high number of self-pay patients as compared to other medical specialties (Miller & Ambrose, 2016; Reid et al., 2015; Wiznia et al., 2017).

One of the most significant issues in scheduling, as supported by this study's findings and the literature, is a patient's limited availability for treatment due to personal obstacles, such as a lack of transportation (Carnegie & Norris, 2015; Miller & Ambrose, 2016; Reid et al., 2015; Wiznia et al., 2017). Subjects in this study stated their patients had trouble getting to appointments due to a lack of personal transportation, limited funds for public transportation, or the time needed to utilize public transportation.

Past evidence has shown that behavioral medicine has higher rates of no-show appointments than any other specialty (Akhigbe et al., 2014; Reynolds et al., 2015). Patients who feel the stress of not being able to access a behavioral health provider will sometimes stop seeking assistance. It has been documented that some patients who cannot access treatment, for whatever reason, may turn to self-medicating or go untreated (Berrouiguet et al., 2016; Miller & Ambrose, 2016; Reid et al., 2015).

It was important that this study examines the types of education provided, to analyze how the types of education combat the aforementioned issues, and how they possibly are improved. It was necessary for the researcher to collect the perspectives of behavioral medicine schedulers on the types of education they receive. This is particularly important because few studies have specifically addressed non-clinical education and training in the field of behavioral medicine (Gabrielian et al., 2016; Gallo et al., 2016; Mapelli et al., 2015). The research questions investigated in this qualitative case study included:

1. What types of education have behavioral medicine schedulers received prior to beginning their role?
2. How do behavioral medicine schedulers feel about the adequacy of their education to prepare them for their role?
3. How could behavioral medicine scheduling education be improved?

This chapter addresses the theoretical framework for this study, including a discussion of Knowles (1984) and the adult learning characteristics essential for employees to possess in a behavioral medicine scheduling environment. In addition, issues pertaining to retention are addressed and suggestions made for organizational leaders who are currently responsible for managing scheduling staff, or for those who develop education and training for this group.

Summary of Results

This study examined how schedulers in outpatient behavioral medicine view the adequacy of their education and training. A qualitative study was considered best for examining the in-depth thoughts and feelings of individuals and would provide a greater understanding of these matters than a quantitative assessment. Creswell (2014) discussed how qualitative research allows a researcher to find meaning to a specific problem or question from the participants' perspective, which is not based on the researcher's or literature's preconceived opinions. In this study, a set of semi-structured, audio-recorded, and transcribed interviews with individuals who conducted occupational scheduling tasks in behavioral medicine were constructed in order to collect their perceptions associated with the education they received for their scheduling tasks.

This study included interviews of healthcare professionals employed at one of two outpatient behavioral medicine organizations in the Greater Cincinnati, Ohio region. The organization names were left anonymous, and participants were provided pseudonyms. Eight participants, six women and two men, volunteered to provide feedback regarding their perceptions of the education they had received from their current employer. An electronic invitation to participate was sent to 276 individuals, of which eight completed an interview and returned a signed informed consent. All questions were vetted by a panel of industry experts and tested on a sample group. Qualitative data from the interviews were collected, analyzed, and coded for themes.

Qualitative Data

Qualitative descriptive methods allow for new ideas to enter the research as new evidence develops (Creswell, 2014; Neergaard et al., 2009; Sandelowski, 2000). This qualitative descriptive study coordinated a volunteer sample of behavioral medicine employees to participate in semi-structured interviews conducted over the telephone and recorded using GoToMeeting (LogMeIn, 2020). Eight semi-structured interviews ranging in time length from 30 to 50 minutes were transcribed using Microsoft Word 2016 dictation software. The transcriptions were reviewed for accuracy and manually coded for keywords, phrases, and patterns, and themes (Saldaña, 2015).

Collected data were manually coded for themes. Similar codes emerged from each subject, and patterns developed over the course interviews. Table 6 displays the five categories and number of codes for each. The researcher identified 192 codes that were grouped into five categories. Four main themes developed from these codes:

1. Disposition towards adult learning styles
2. Burnout and turnover
3. Patient-centered education
4. Absence of scheduling training

Research Question #1

The first research question asked: What types of education have behavioral medicine schedulers received prior to beginning their role? Participants mentioned ten educational tools they had been exposed to in their current role. The 10 forms of education discussed by participants include:

- Job shadowing
- Roleplay
- SBE/training
- Electronic mail communication
- Group presentations
- Lecture-based education (classroom training)
- Handouts distributed ad-hoc
- Peer-to-peer question and answer
- Supervisor-to-employee question and answer
- Reliance on employee past experiences and education

Of the 10 types of education received, “reliance on employee past experiences and education” was reported by seven of the subjects. The second-most-common received education

formats were “handouts distributed ad-hoc" and "electronic mail communication,” reported by three subjects. Five participants expressed being exposed to three educational tools or less.

Based on the analysis of the semi-structured interviews, subjects listed varying levels of exposure to educational methods and training. Internal employee training structures are affected by many factors such as funding, resource allocation, leadership, and culture (Dieckmann et al., 2012; Hermans et al., 2013; Sandlin et al., 2013). Participants referenced this culture by assimilating with the parameters set during their initial orientation period. The first subject interviewed, Rose, stated that she received lots of preliminary employee-manager shadowing, but it tapered off with no remaining guidance.

> “When I came in, I had much supervision, so it was kind of part of the supervision process. Kind of, I guess it wasn't anything I never had like specific ways to schedule. It was kind of figuring it out and then if things weren't going well troubleshoot.”

Gladys stated that she received crisis management training and continuing education opportunities as a case manager, but these same opportunities for scheduling have not been provided. She stated that case management training is formal, standardized, and always evolving. Her higher experience level (6-10 years) than other participants provided a more comprehensive picture of past education at the organization. These are similar attributes that create quality adult learning programs (Knowles, 1984). Gladys also stated that training is necessary for new employees in the behavioral medicine field. "Brand new (employees), I don't think they would pick up the process."

Some participants, including Rose, discussed the inconsistencies between their provider training as a mental health counselor, therapist, or consultant and the training received for scheduling. Hattie mentioned this point when asked what training and education she received for her role. Without hesitation, she stated:

> "We continually talk about (how) the system changed, and what we have to change in our processes, so we provide that kind of ongoing training for staff. We provide face-to-face training, handouts, a little bit of all of that. Staff meeting, so face-to-face, some things may be in a handout or in an email. Somebody from the compliance department will make a presentation to a combination of all of us."

When asked about scheduling-specific education, Hattie stated, "in terms of the training for scheduling, I don't think so. I haven't seen anything that really comes to me." Clinical occupations often receive more significant educational funding, resources, and organizational support as compared to nonclinical roles due to the impact on patient care (Proudfoot & Kebritchi, 2017; Reeder & Turner, 2011). However, this assumption was challenged by subjects who provided claims of supporting patient visits through scheduling practices. Many subjects felt this was extremely beneficial to a patient's overall treatment, and some identify as a primary contributor to a patient receiving care. Vera supported this in her interview.

> "(Scheduling) has created a more positive process. Yeah, because I know they are being appropriately scheduled, and they're not being scheduled with someone who doesn't do (the correct) evaluation. In the past, they

would sometimes get scheduled wrong. They would say, 'I'm coming in for this stuff' and would be scheduled with a therapist or counselor only for them to come in and learn they were scheduled wrong."

The importance of interpersonal communication between employees and supervisors was apparent in the interviews. Many participants mentioned utilizing some form of education that required communication between two or more individuals, such as email, job shadowing, or peer-to-peer questions and answers. However, some subjects received little to no interpersonal training. This evidence conflicted with studies that suggest standardized training is essential for providing quality and consistent education for all employees, especially in the same role (Dieckmann et al., 2012; Hermans et al., 2013; Sandlin et al., 2013).

Joseph was the only subject that mentioned exposure to roleplay, and Gladys was the single participant who discussed SBE/training. Gladys also received handouts and lecture-based education, which are often displayed as contrasts to SBE in the literature (Carnegie & Norris, 2015; Miller & Ambrose, 2016; Reid et al., 2015; Wiznia et al., 2017). Also noteworthy was that only Margaret received scheduling education group presentation.

Most participants stated they had either received very little or no training for scheduling role. Alternatively, their organizations relied heavily or exclusively on the persons' past academic and professional experiences. Dixie mentioned what has prepared her for scheduling "would have been in my schooling. Nothing that I have ever seen. At this clinic, I have never seen training. I would say just my experience." While adult education facilitates learning by leveraging past experience, it incorporates many additional variables

(Knowles, 1984; Merriam, 2001). Subject experiences conflicted with successful implementations of andragogy (Hewitt-Taylor, 2001; Knowles, 1984; Merriam, 2001; Pratt, 1988; Tamura-Lis, 2013).

Some participants fell into the scheduling role through necessity as problems arose with patients being scheduled to the wrong location, provider, or service. This problem highlights the complexity of scheduling and how a high level of knowledge is needed to conduct the job (Bruppacher et al., 2010; Chen, 2014). Vera substantiated this claim:

> "I didn't actually even want to do the scheduling. It was a group of us clinicians that were doing the evaluations, and we just kept saying this as this person got scheduled with me, and they shouldn't have been, or you know this person came on my schedule, and no one even tried to ask if they had an IEP. No one knew that they recently had a psych eval and they should have been scheduled again, or you know that no one asked the right questions and basically shouldn't be on my calendar, so we brought it up to our CEO during a staff meeting and he said okay well start doing your own scheduling, and we were like oh that's not really how we wanted that to go, but it turned out fine taking (scheduling) over."

Vera also stated, "experience, your informal education, and knowledge of the evaluation process has allowed us to just kind of be able to do the same calls and scheduling ourselves." When asked if she has created education for coworkers entering the same situation, she stated: "not at this time." From our discussion, it was apparent that Vera was very knowledgeable and comfortable with her scheduler role, but resources and time were limited. The lack of employee

resources and funding is a common issue plaguing behavioral medicine treatment centers (Miller & Ambrose, 2016; Reid et al., 2015).

In summation, participants in this study referenced the exposure of 10 types of education, with a majority of subjects being required to supplement organizational training individual experience. Three of the ten methods were observed by one subject each, highlighting the inconsistencies of scheduling education. The nonexistence of professional education is incongruent with past research that exhibited some form of training, mostly traditional, in nonclinical occupations (Leberman & McDonald, 2016; Liu et al., 2017; McNeal, 2010;). Some subjects received peer-to-peer training from senior staff and supervisors. This method of interpersonal training is also observed in clinical role training (Boos et al., 2016; Reid et al., 2015; Reynolds et al., 2015).

Research Questions #2

The second research question asked: How do behavioral medicine schedulers feel about the adequacy of their education to prepare them for their role? The primary reason for conducting semi-structured interviews instead of a survey was to amplify the possibility of collecting quality, lengthy responses (Creswell & Miller, 2000; Strauss & Corbin, 1998). The perceptions of education varied according to their role, experience, and education level. The education tool with the highest favorable rating (pg. 62) was job shadowing at 37.5%, followed by supervisor-to-employee, peer-to-peer, and handouts at 25% each. Education tools with the most indifferent perceptions were reliance on past experiences (75%), followed by handouts, lecture-based education, presentations, and emails (12.5% each). All but three tools (lecture-

based education, presentations, and email) received at least one positive rating. Two of those, email (25%) and lecture-based education (12.5%), received the most negative perceptions.

Research has shown higher levels of negative perceptions associated with lecture-based education and other traditional forms compared to adult learning tools (McNeal, 2010; Paskins & Peile, 2010). The adult learning theory prioritizes past learner experiences and involves students in the training build process (Knowles, 1984; Merriam, 2001). The following figures show the association between collected data and adult learning theory principles.

Figure 7

Principle One – Participant Involvement

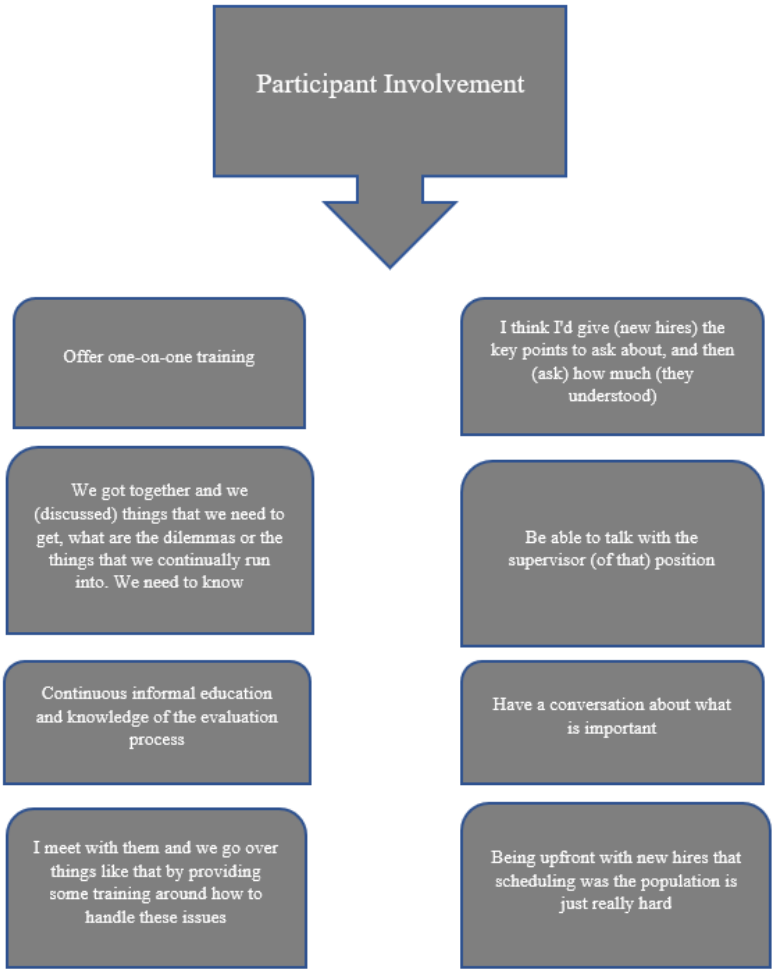


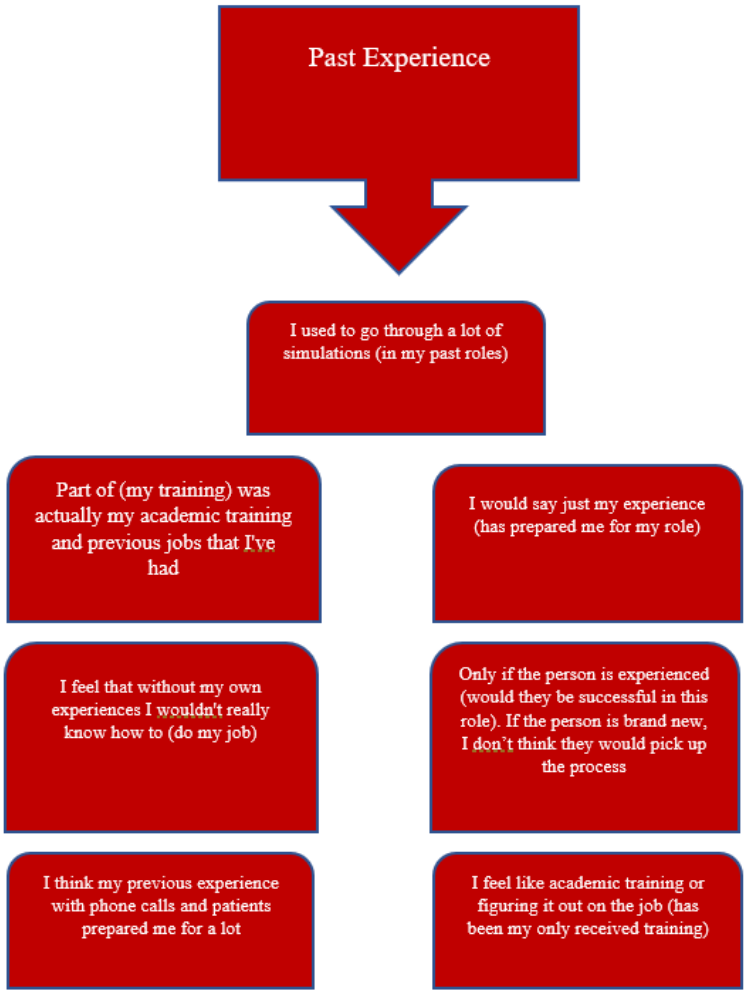
Figure 7 displays excerpts from participants associated with the andragogy principle of participant involvement (Knowles, 1984; Merriam, 2001). This topic recommends the involvement adult students in their own learning through various teaching forms (Merriam, 2001). Divergent from pedagogy, that has a one-directional teacher to student communication path, andragogy incorporates learner feedback to improve information being taught (Hase & Kenyon, 2000; Knowles, 1984; Merriam, 2001).

Study subjects discussed various ways of including employees in scheduling training. Rose recommended, “maybe giving some general parameters (during training) for how to handle people who are inconsistent”. She also stated, “you can get mixed messages on (how to handle patients)”, and “giving more concrete parameters (during training) is helpful.” Rose suggested that schedulers new to behavioral medicine should be taught to “know your limitations and your boundaries.”

Margaret, the front desk associate who felt that she had received sufficient training for her scheduling position, also believed that education could be improved through interpersonal tactics. “Maybe instead of emails just have everybody that does (scheduling) come together and get a training. Everyone that does an intake get a training. Maybe offer one-on-one training.” She referenced her positive experiences with interpersonal training. “If I don’t understand something, I call a person of the super user group who goes to all the trainings, and she will come up here and train me. Or, she’ll share her desktop with me.” These suggestions are supported by clinical education literature, but insufficient results have been reported for non-clinical healthcare occupations (Goffman et al., 2017; Kravitz et al., 2006; van Eeghen et al., 2016).

Figure 8

Principle Two – Past Experience



The concept map of study participant quotes pertaining to past experience (see Figure 8) is the second principle of andragogy. This pillar of adult learning asks educators to leverage past experiences of students to generate new learning by relating unfamiliar concepts with previously learned topics (Knowles, 1984; Merriam, 2001). An example of this topic is CPR training for nurses and clinical staff (see page 15).

Most participants in this study communicated their consistent utilization of past experiences to conduct scheduling in their current role (see Table 4). Joseph, one of two males in the study, discussed referencing his experiences in call centers to establish his current role.

> "My academics training and other previous jobs that I've had (helped prepare me for my role). I worked at a call center for most of my professional career, and I worked in the complaints department all the time, so most of the time, I'm used to escalating someone over the phone with them screaming at me."

Joseph was adept at handling sporadic issues that occur when scheduling patients, such as personal, financial, and emotional troubles (Miller & Ambrose, 2016; Taubman et al., 2014; Wiznia et al., 2017).

> "I used to go through a lot of simulations through my past, so not my current job but my fellowship, that forced us to be in a medical setting answering random questions that clients would provide us at the time of the office visit."

Preparing staff for these encounters through educational techniques, such as SBE, can better prepare adult learners for real-life exposure (Allan et al., 2010; Elliott-Kingston et al., 2014; Lévesque et al., 2013).

Figure 9

Principle Three - Relevance

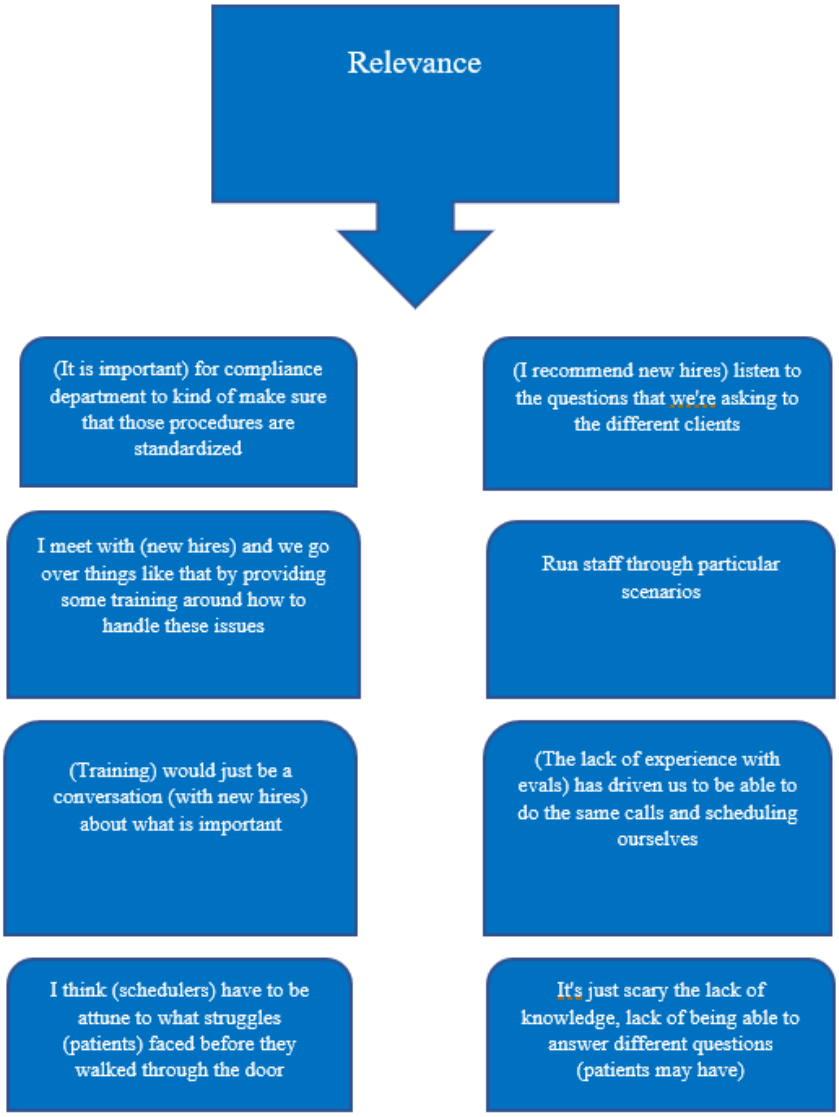


Figure 9 displays a concept map for andragogy's third principle, relevance, with associated quotes of subjects in this study. The subcategory of relevance applies to the theory that adults are interested in learning topics relevant to their personal and professional lives

(Knowles, 1984; Merriam, 2001). Study participants mentioned important themes pertinent to their role that could be beneficial to new and established employee education.

Vera discussed the benefit of asking patients particular questions to determine what behavioral medicine service(s) would be best to schedule them for. "(I recommend new hires) listen to the different things that were asking (patients). The different things that were trying to gather. Everything from demographics to, you know, medication." She stated:

> "(People learn best) through experience and through exposure. Kind of get them in the seat on speakerphone where we're sitting with them and they're sitting with us, and letting them hear us letting us hear them talking. We will guide them through it."

Dixie stressed identifying what is relevant to schedulers and patients, and suggested tapering education to meet those demands. "The (patient) knows what they are walking in with. Trauma and family (issues). (Teaching staff to) be sensitive to that. I think we have to be attuned to what struggles they faced before they walked through the door." Trust and adherence between patient and staff can be generated by providing transparency and compassion through quality communication (Gallo et al., 2016; Garets & Davis, 2006; Goffman et al., 2017).

Providing relevant continuing training to established employees is also important for organizational education quality (Avari & Meyers, 2018; Corrigan et al., 2014; Gallo et al., 2016). John discussed a variation of educational resources and techniques for targeting relevant information.

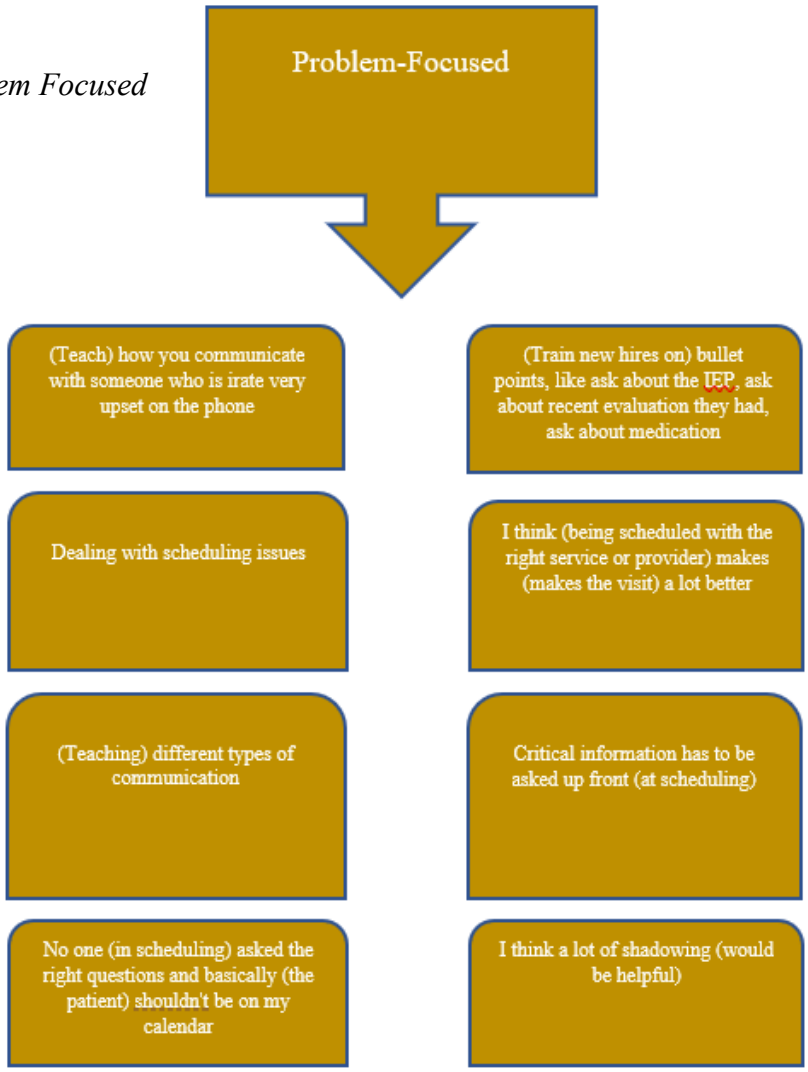
> "Training might be like days training, get used to central clinic. Where to put the paperwork and all that stuff is (in a) binder with some of that

information, but actually go over it in person I think would be a good idea. I continue with shadowing individuals. Like I said earlier, they might increase the shadowing. Extend it. Especially if you got someone coming in that's brand new to the mental health field and case management in particular, and they just need to feel like they're being supported."

Data collected from John's interview is congruent with tools identified in the literature review for decreasing patient absenteeism (Reid et al., 2015; Reynolds et al., 2015; Santibáñez et al., 2012). The data also corroborates findings associated with confidence building of new employees (Bruppacher et al., 2010; Chen, 2014; Macaro, 2006).

Figure 10

Principle Four – Problem Focused



The fourth principle of andragogy is adults being more adept at problem-focused learning as compared to other forms (Hase & Kenyon, 2000; Knowles, 1984; Merriam, 2001). Figure 10 displays excerpts from study participants related to problem-focused education, and how it can be utilized in behavioral medicine. This form of education is incongruent to pedagogy which tends to be content and lecture based (Hase & Kenyon, 2000; Knowles, 1984; Merriam, 2001).

Some participants expressed negative opinions towards new employee orientation training. These opinions were expressed in substantive responses based on their own past training experiences. One subject, Vera, mentioned:

> "I think that scripted type stuff sounds precisely what it sounds like, a script, and I think that it sounds so fake. It sounds like 'welcome, how can I help you' you know. 'How are you today?' I think it sounds very singsong and scripted."

Joseph also discussed the inadequacies of training to prepare new staff for situations they may encounter. "I think there's some training that they're lacking. Like, we deal with Social Security a lot, and I think it would be nice to have some more formal training." John acknowledged that his current role has a high amount of employee turnover, in part due to nonexistent continuing education for schedulers. However, Joseph felt that shadowing supervisors and senior employees helped him transition into the scheduling role. "I like to bounce ideas off others and see what works, what doesn't, and try different things." Margaret also emphasized this point by stating that "communication with my supervisor and others is really helpful."

Margaret mentioned that email was a beneficial source to receive education, but felt it was poor quality in comparison to one-on-one support from a senior employee. Many healthcare institutions have used some form of an email to successfully communicate with patients, but past research has not profoundly explored this tool to educate healthcare staff (Berrouiguet et al., 2016; Teo et al., 2017). Interestingly, email received the highest number of negative participant perceptions of the ten tools.

Research of healthcare clinical roles has exhibited positive student feedback from innovative adult learning formats such as interpersonal, small group training, simulations, and senior supervision (Chen, 2014; Hsu et al., 2015; Sorensen et al., 2015). This was also observed in this study's subjects as the most positive perceptions were associated with supervisor-to-employee, peer-to-peer, and job shadowing (see Figure 4). Handouts also received a high number of associated positive opinions by subjects. However, handouts were accompanied by another form of education and were not the sole form of exposure. The perceptions of participants in this study pertaining to the education they had received were disconnected from past research. While most subjects of past education and training studies have negative perceptions towards traditional techniques, individuals in this study mainly discussed feelings of indifference (Proudfoot & Kebritchi, 2017; Reed et al., 2014; Reeder & Turner, 2011).

The participants in this study expressed positive opinions associated with educational tools that tended to have an intimate format, such as job shadowing and employee-to-employee training. The educational tools that received the highest amount of associated negative opinions were less intimate, such as email and lecture-based training. Lecture-based training is a traditional form of teaching that has been found to have poor success with adults than children

(Bobrow et al., 2013; Creutzfeldt et al., 2010; Hase & Kenyon, 2000). What was most shocking was the high levels of indifference associated with non-existent training. Seven out of eight subjects discussed having to lean on past professional and academic experiences to complete role tasks. However, six participants felt indifferent, one felt positive, and none felt negative towards this phenomenon resulting from a lack of training.

Research Question #3

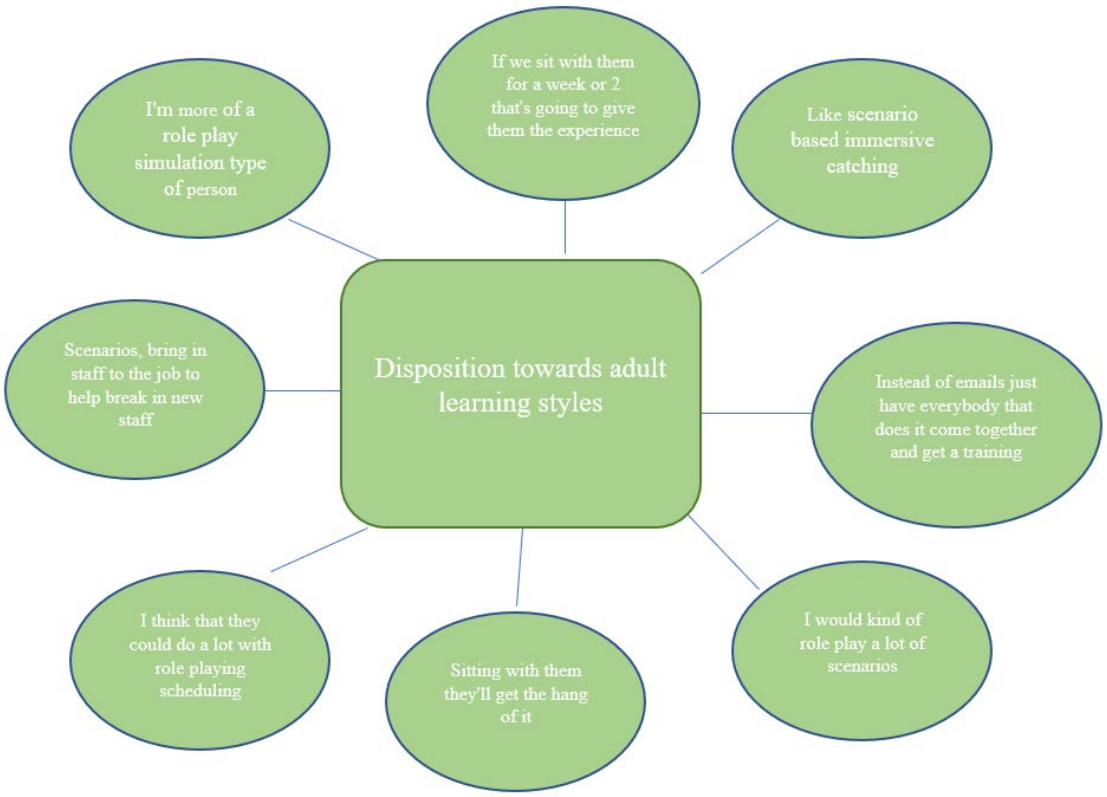
The third and final research question asks: How could behavioral medicine scheduling education be improved? Participants in this study discussed a variety of ideas for improving behavioral medicine scheduling education. Additionally, four themes arose from the interviews that support improvement recommendations. Each theme and its associated improvement(s) are discussed below.

Disposition Towards Adult Learning Style

Research in the field of healthcare education has shown a wealth of positive results associated with adult learning strategies (Gallo et al., 2016; Goffman et al., 2017; Kravitz et al., 2006; van Eeghen et al., 2016). However, these strategies were documented at minuscule levels from participant interviews in this study. While most subjects spoke about their lack of education and training received through their employer, some had been exposed to innovative adult learning styles at past employers or in college. Some subjects spoke of their associated opinions with adult learning styles, with a majority being positive. The following concept map (see Figure 11) displays data collected from participants on the subject of their disposition towards adult learning styles:

Figure 11

Theme One Concept Map



One response that highlights the beneficial results generated from adult learning while identifying the contrast between medical and non-medical education was when Gladys was asked what parts of training she found most beneficial. Gladys responded, “What was beneficial was that I had an opportunity to job shadow other case managers (when I first began my role).” When asked what improvements she would recommend, Gladys stated, “Improvement would be having a standard case management training program.” When specifically asked about her experiences

with new employees receiving scheduling education, she stated, “only if the person is experienced (would they do well in scheduling). If the person is brand new, I don’t think they would pick up the process.”

Additional individuals discussed interacting with adult learning styles by emphasizing they be utilized in scheduling training. Joseph stated, "I think there could be a lot of role-playing in scheduling (training). With a lot of scenarios, that might be a way people can be prepared (to start their job).” When asked what the most beneficial part of her training was, Rose responded, “When I came in (as a new case manager), I had a lot of supervision, so it was kind of part of the (orientation) process.” When asked this same question, Hattie’s response was, “(Anytime there are) systems changes and whatnot, we continually talk about having to make those changes with staff. (Leadership) provides that kind of ongoing training.” Hattie also emphasized the importance of standardized education across multiple locations.

> “(The) compliance department works to kind of make sure that (case management education practices) are standardized and to make sure that happen across our different locations. But I would also say that different locations provide different services, and so some things may be standardized but not all things.”

Another participant, Margaret, observed little standardization in her training experiences, and recommended a more standardized approach. “Just have everybody that does (scheduling) come together and get training. Maybe offer one-on-one training.” Joseph recommended combining adult learning techniques with traditional measures” (Batt-Rawden et al., 2013;

Neumann et al., 2011). “I think it would be easier for me to train someone by role-playing a lot of scenarios, along with a written test.”

Not mentioned in the literature pertaining to adult learning theory principles is the notion of standardizing education. However, the importance of normalizing training across medical offices was a frequent topic discussed by study subjects (Knowles, 1984; Merriam, 2001). However, the literature referencing adult learning practices in medical training was abundantly supported by this study’s participants who discussed education that had been received in clinical roles (Devlin et al., 2008; Ford et al., 2016; Nagle et al., 2009).

An additional recommendation heard from subjects in this study was the ability to have a senior team member available when questions arose. This could be a supervisor, colleague with more years of experience, or an educator. One participant who supported this form of education was John. "The job is just learning as you go, and to do the best you can. I try to bounce things off other case managers and supervisors when I run into issues.” John continued, “Fortunately, you need a supportive network where case managers can communicate with each other. I think that would be a good idea to have.” This recommendation was also supported by past research that showed students were likely to perform better on post-assessments when senior advisors were available during the intervention (Boos et al., 2016; Reid et al., 2015; Reynolds et al., 2015).

In contrast to other subjects, Margaret discussed having access to educational experts if questions arose. “If I don't understand something, I call a person or the superuser group who goes through all the pieces of training, and she will come up here and train me. Or, she'll share her desktop with me.” However, Margaret was dependent on this expert's knowledge and

availability. She felt that employees in her position, which mainly performed scheduling tasks, should receive a higher amount of consistent training (see page 96).

This researcher collected transcripts from eight subjects, most of whom had never received scheduling training or education from their current organization. However, the amount of interest in adult learning strategies compared to the limited exposure was noticeable in the transcripts. Unlike past studies where participants were exposed to various types of adult learning and then gauged on their perceptions, subjects in this study mentioned receiving little training, yet had a definite interest in innovative adult learning features (Boos et al., 2016; Reid et al., 2015; Reynolds et al., 2015). Coincidentally, taking the interests of students into account during curriculum and training development is a theory of adult learning principle (Knowles, 1984; Merriam, 2001).

Burnout and Turnover

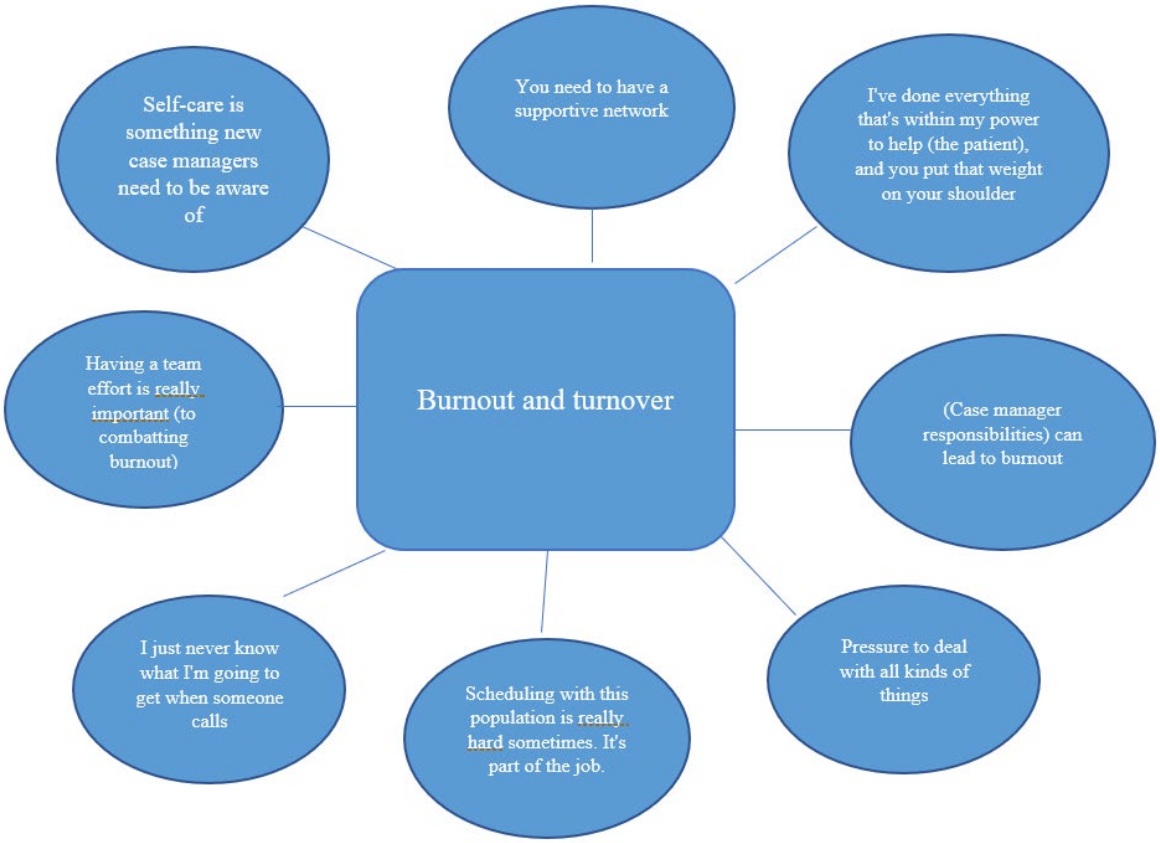
Employee stress has been noticeable within the research of behavioral medicine and healthcare occupations (Goffman et al., 2017; Leberman & McDonald, 2016). This is often related to roles with direct patient contact (Berrouiguet et al., 2016; Miller & Ambrose, 2016; Reid et al., 2015). Forms of stress can cause a person to feel exhausted, agitated, and overwhelmed (Goffman et al., 2017; Leberman & McDonald, 2016).

While this study did not specifically design questions pertaining to scheduler emotions, some participants mentioned the stressful nature surrounding the occupation. These prevalent discussions supported the theme of Burnout and Turnover. This theme's label was a quote from a study participant who discussed the feeling of "burnout" when a role becomes too stressful, and

the turnover of employees succumbing to this pressure. Figure 12 displays a concept map of subject excerpts associated with this theme.

Figure 12

Theme Two Concept Map



John emphasized the obstacles related to organization and role stressors that could lead to employee burnout.

> "One thing with case manager is that burnout happens a lot. You have clients that have (many) mental health (problems) and a lot of needs. Clients have gone homeless, or those who are currently homeless, and I've

> done everything that's within my power to help them. You get that weight on your shoulder, everybody in the mental health building. So, it can lead to burnout."

This type of mental and physical stress can lead to employees entering and leaving the organization in short periods of time, also known as turnover (Kravitz et al., 2006; van Eeghen et al., 2016). When John was asked if quality training would improve staff turnover, he stated: "yes, absolutely." He recommended that new employees receive job shadowing with a senior employee for a period before working alone. John also recommended that new and established employees be provided with a "supportive network" that can act as a resource for answering questions, assisting with tasks, or providing emotional support.

Joseph discussed how education he received in college and with previous employers prepared him for the associated unease in behavioral medicine.

> "My academics training and other previous jobs that I've had (helped prepare me for my role). I worked at a call center for most of my professional career, and I worked in the complaints department all the time, so most of the time, I'm used to escalating someone over the phone with them screaming at me. A whole bunch of things also within my actual academic career (have helped). I've taken motivational interviewing, which is the class that helps with a probing open-ended and close-ended questions. I used to go through a lot of simulations through my past, so not my current job but my fellowship, that forced us to be in a

> medical setting answering random questions that clients would provide us at the time of the office visit."

Margaret referenced the importance of schedulers keeping a calm disposition during patient interactions.

> "I think (scheduling) is a high impact (position) because they're the first person (patients) see when they get off the elevator. I think they want to feel warm and comfortable. They feed off my energy. If I'm not feeling good, then they may have a bad visit and may not want to come back. So, I try to stay upbeat."

Vera discussed how the poor quality and efficiency of scheduling in her department led to a breakdown in patient treatment. As previously mentioned on page 87, Vera incorporated scheduling duties into her role after discussing the scheduling issues with her organization's CEO. "I didn't actually even want to do the scheduling. It was a group of us clinicians that were doing the evaluations, and we just kept saying this like this person got scheduled with me, and they shouldn't have been." She added, "We constantly are having issues with (scheduling)."

Participants highlighted the types of cases observed in behavioral medicine as potential causes for occupational burnout. Dixie stated, "Some of (my cases) could be sexual abuse, mental abuse, physical abuse, neglect, absent parent." She added, "Yes, it is difficult to make an appointment with a patient who was referred instead of a county hold patient, foster care patient. Sometimes (patients are) referred by social services or daycare."

Hattie also emphasized concerns behavioral medicine staff face with patients who have absenteeism matters.

> "I would say that most (compliance issues) have to do with 99% of the families we serve live in poverty, and so there are lots of barriers to accessing services due to their poverty. So, barriers to coming to session could be lack of money to take the bus, not having transportation, or not having money to be able to get here. Or, it can be things like because we serve children, they don't want the child to miss school, or because of their work hours. If they're working a job that it's hard for them to get their children here after school, sometimes we have two choices where families are in need. They run out of their food stamps, they have to go down that day to get in line to get food for the family, or they have to request food stamps, or they're losing their housing. There's a lot of chaos that happens and so sometimes kind of getting those basic needs that is number one priority, and therapy then moves down their priority list."

Stress and anxiety felt by patients can cause postponement of care and exacerbate their health condition (Behavioral Health, n.d.; Gallo et al., 2016; Goffman et al., 2017). Dixie emphasized this topic when stating, "I talk to (patients) about what they were referred about and what they need to get here. It's a lot of validating how hard it is, and I'm adding one more stress to their life." Rose also mentioned the stress of handling patient behavioral issues that may be observed when healthcare resources are limited. "Mental health resources, you know, you may live in an area where there are not resources, and by the time they get to the intake person, you

can almost seem like they are angry at you." She continued to say, "I think as a scheduler, I'm thinking like this is your appointment, or how can I help you, but also like you want to be positive." Topics such as this were prevalent in previous behavioral medicine studies (Corrigan et al., 2014; Kravitz et al., 2006; Liddy et al., 2014).

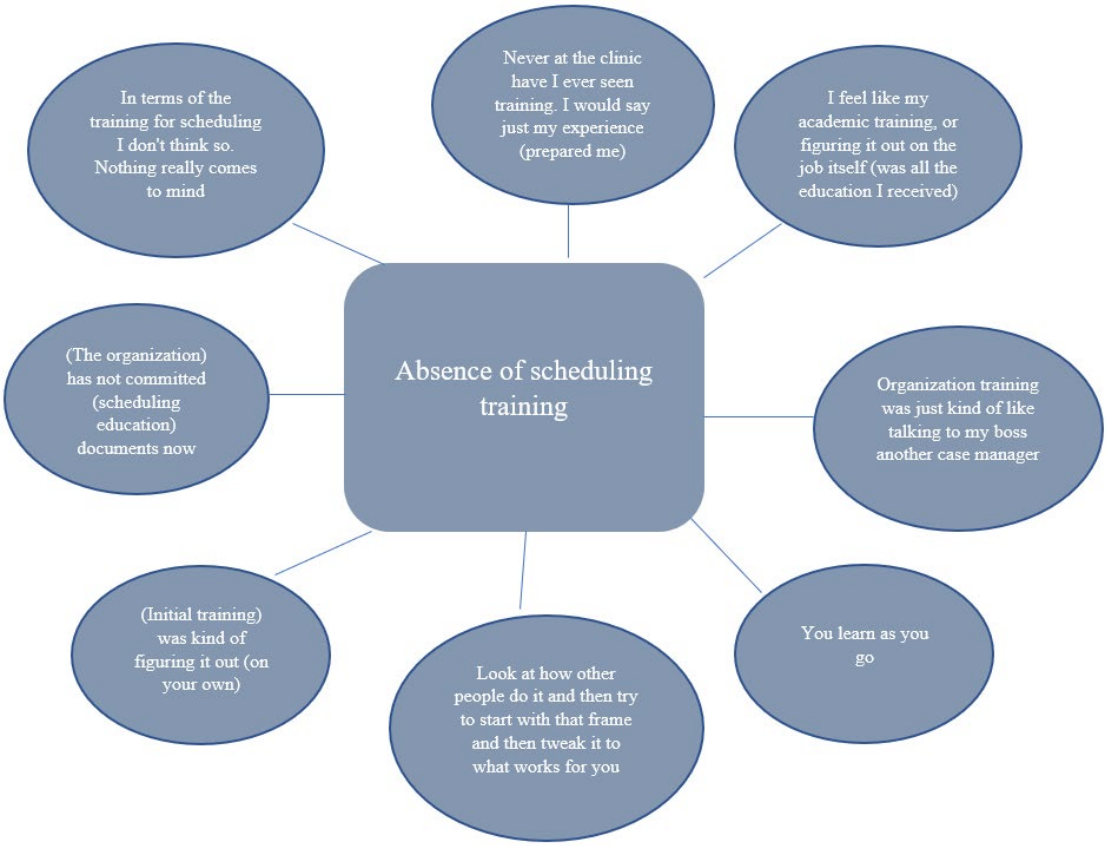
In conclusion, the literature review did not mention data associated with behavioral medicine employee emotions. However, many participants in this study discussed feelings of stress and anxiety (see Figure 12). A suggestion posed by subjects in this study for improving these adverse effects is to connect new employees with experienced, knowledgeable individuals that can ease role transitioning, opposite to a sink-or-swim mentality. Several subjects also recommended employees be provided with a supportive care network to help ease tensions from occupational stressors.

Absence of Scheduling Training

By a wide margin, the nonexistence of formal, standardized training for schedulers at both organizations was the most glaring result identified within this study. Furthermore, the lack of education support system features, as recommended by subjects, was disconcerting. Figure 13 displays a concept map displaying participant quotes associated with the absence of scheduling training. While many healthcare organizations have a standard education structure from which to improve, subjects in this study routinely mentioned having no, or a minuscule education structure (Proudfoot & Kebritchi, 2017; Reed et al., 2014; Reeder & Turner, 2011).

Figure 13

Theme Three Concept Map



Several participants detailed the absence of formal training for schedulers. Rose expressed this in contrast to clinical training.

> "When I came in (to case management), I had a lot of supervision, so it was kind of part of the supervision process. I never had like a specific way to schedule. It was kind of figuring it out, and then if things weren't going well, troubleshoot."

Hattie also discussed the divergences between clinical and scheduling education. When asked what forms of training new staff receive Hattie stated:

> "(We receive) a little bit of it all. Staff meetings, so face to face. Some things may be a handout or in an email. Somebody from compliance department will make a presentation, so a combination of all of us. In terms of the training for scheduling, I don't think so, no. Nothing really that comes to me."

She continued discussing how she provides training to schedulers who make appointments for her patients.

> "I meet with (the scheduler), and we go over things by providing some training around how to handle these issues, and a lot of times it may be that they just forward (the issue) to me and then I handle it depending on how that goes."

When asked what education her organization provided for scheduling, Hattie expressed reliance on academic training. "Um, that (training) would have been in my schooling. Nothing that I have ever seen at the clinic have I ever seen training. I would say just my experience." Vera, who previously expressed encountering "constant issues with (scheduling)," stated that her role with scheduling was "self-taught." Joseph's knowledge of scheduling practices also came from past roles, and not from his current organization. "My academics training and other previous jobs that I've had (helped prepare me for my role). I worked at a call center for most of my professional career." When Joseph was asked if he felt like his organization relies heavily on employees coming in with a base of knowledge, he stated:

> "Honestly, I feel like that academic training or figuring it out on the job, is it. I feel that without my own experiences, I wouldn't really know how to have a conversation over the phone or (how to) schedule things."

Not all subjects observed the absence of formal scheduler training. Margaret stated:

> "We get emails with all steps to follow with new changes, and we archive the emails to look back on. New hires would shadow the established hires step by step, and we would mock scenarios. I don't know what training occurs at the other locations. I'm guessing they do but not sure."

She recommended, "Instead of emails just have everybody that does it come together and get a training. Everyone that does an intake get a training. Maybe offer one-on-one training." Suggestions like this support previously mentioned adult learning principles (Knowles, 1984; Merriam, 2001).

Seven of the eight research participants discussed tapping into their past experiences and education to perform their current role (see Figure 4). While this method coincides with Knowles' theory of andragogy, the three other principles should be incorporated for optimal success (Knowles, 1984; Merriam, 2001). This evidence contradicted past studies in which a majority of subjects received some form of formal, standardized training (Croxton, 2014; Proudfoot & Kebritchi, 2017; Reed et al., 2014; Reeder & Turner, 2011).

In summary, study participants have relied on minute amounts of training and educational resources to perform their current role. The data is contrary to levels of occupational normalcy where most healthcare employees receive some form of standardized education during their orientation period, and continuing receiving education as processes change (Behavioral Health,

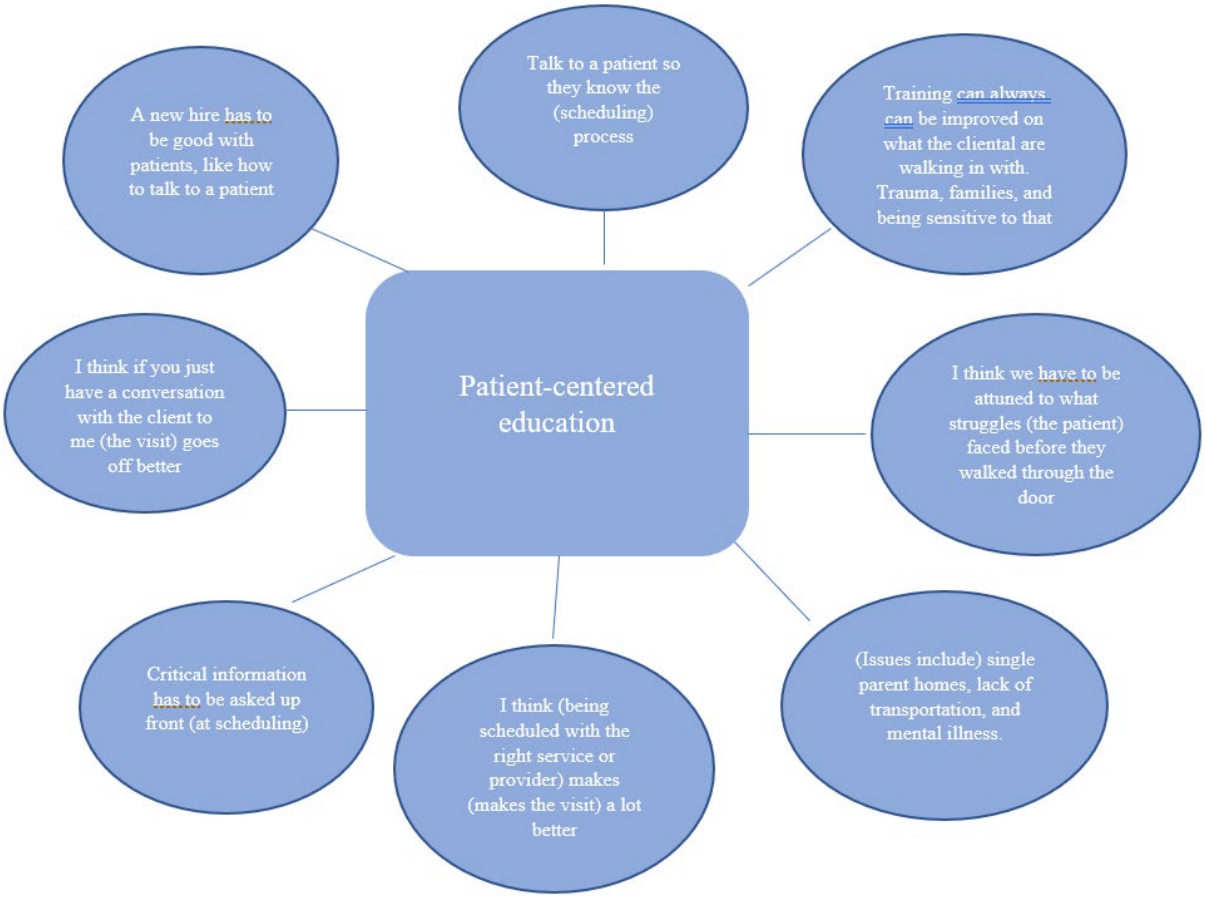
n.d.; Creutzfeldt et al., 2010; Miller & Ambrose, 2016; Reid et al., 2015; Wiznia et al., 2017). Surprisingly, many subjects do not feel negative towards this self-taught approach. However, not astonishing were the proposed improvements to scheduling education discussed in previous sections that subjects felt provided a higher quality of role preparedness.

Patient-Centered Education

Education for clinical and nonclinical roles in behavioral medicine has a history of focusing on improving patient care, which ultimately affects their experience (Carnegie & Norris, 2015; O'Halloran et al., 2015; Reynolds et al., 2015; Teo et al., 2017). Schedulers are often the first staff member to encounter a patient either through the phone or in-person (Avari & Meyers, 2018; Corrigan et al., 2014; Gallo et al., 2016; Maxfield et al., 1996; Tomar et al., 2015). While a majority of studies in clinical education have retained the focus of improved patient care as the end goal, research in nonclinical education is more aligned with improving efficiency rather than patient experience (Corrigan et al., 2014; Kravitz et al., 2006; van Eeghen et al., 2016). Interestingly, patient experience appeared to be an essential subject discussed by study individuals, a majority of whom were healthcare providers. Figure 14 is a concept map showing subject quotes supporting the theme of patient-centered education.

Figure 14

Theme Four Concept Map



Participants provided detailed excerpts supporting the importance of designing education that focused on patient experience. Rose discussed how her interactions with children and their families could be sensitive in relation to scheduling.

> "A big barrier with us in the child division is, of course, you know I keep a caseload and usually have 40 to 50 kids. Everybody thinks that their need (is important). I got maybe even one place where they can schedule. It's

> hard to find a time where (patients) got time to get the kids from wherever they are, get them to come see us, (and) get home."

To overcome these obstacles, Rose provided ideas for educating new staff who schedule patients.

> "Somebody coming in and going through the education process, maybe give some general parameters for how to handle people who are inconsistent. You can get mixed messages, so that is hard, to be honest. Giving more concrete parameters is helpful for that. Just being upfront with new hires that scheduling with this population is just really hard sometimes. It's part of the job. I'm kind of just giving permission to be frustrated with it."

These suggestions for improved education are similar to those documented in clinical studies on adult training methods (Batt-Rawden et al., 2013; Neumann et al., 2011; O'Malley & Reschovsky, 2011). Adult learners tend to have more success when supported by senior staff (Corrigan et al., 2014). Providing support and stability can increase confidence, improve subject knowledge, and decrease user mistakes (Corrigan et al., 2014; Kravitz et al., 2006; van Eeghen et al., 2016).

Some participants in this study discussed issues affecting patients they felt could be avoided through improved education (see Figure 11). Vera discussed how poor scheduling created havoc for behavioral providers in her organization. "We were running into so many issues with clients not being connected for the appropriate services." She later stated, "There was a breakdown in communication somewhere along the line of scheduling, so we kind of revamped the process." While internal communication issues were apparent with organizations in past

research, problems with patients being scheduled for the wrong services was not found in the literature (Gallo et al., 2016; Mapelli et al., 2015).

In addition to the importance of scheduling patients with the correct services, patient communication was also emphasized by individuals. One example was Vera, who stated:

> "I think if you just have a conversation with the client. To me, that goes off better and just talking to them. I think they respect that more, especially our clients because I don't think they often get a level of respect that they deserve with being under lower socioeconomic status. They are very low on resources, they have very little support, so if we come in there like with arms open and trying to support them and guide them and help them, I think they're going to respect that a lot more. I'd rather get that (as a patient) than get a super scripted phone call."

Patients in behavioral medicine have unique difficulties that can hinder the scheduling process (Corrigan et al., 2014; Kravitz et al., 2006). Joseph discussed encountering these issues and finding ways to overcome them.

> "I get a lot of transportation issues when I have to schedule. Not able to do in a specific moment and dealing with transportation. Some external family issue or illness, like a physical illness, so it could be anything. (I have been) verbally or mentally attacked, or physically attacked, and I just never know when I'm going to get (those) calls. I think my previous experience with phone calls prepared me. I think that (the organization)

could do a lot with role-playing scheduling with a client in a lot of scenarios that might come off so that way people can be prepared."

In summation, study participants discussed their observations of patient absenteeism as being closely associated with personal problems, such as lack of transportation of juggling work and children. Subjects tried to assist patients in overcoming these obstacles with scheduling flexibility, free bus passes, and encouraging communication. Schedulers reported feeling stressed and helpless from their inability to meet the needs of all patients fully.

Conclusions

This study investigated the perceptions of behavioral medicine staff who schedule patient appointments regarding the education and training they have received. Eight current employees who schedule appointments at two behavioral medicine organizations took part in this study. Each subject was required to have an appointment scheduling aspect in their role, but job titles varied. The participants ranged in education level from high school graduate to a doctorate, with a majority of subjects (50%) possessing a master's degree. Experience at their current organization ranged from less than one year to over 15 years. Occupation titles of the subjects were two mental health therapists, two case managers, one mental health consultant, one clinical coordinator, a front desk receptionist, and one director.

Subjects were currently employed at one of two targeted organizations at the time of data collection. After seven months of research and analysis, including one interview with each participant, several themes surfaced involving the experiences and perceptions of these subjects. Being alert to these themes will help healthcare administrators and curriculum designers better understand this specific population of employees, adult learning characteristics necessary to meet

challenges in the scheduling role, challenges of interacting with patients, and prospects for educational growth and development.

Andragogy aims to explore the characteristics of educating adult learners who are self-directed, autonomous, and have established experiences and knowledge pertaining to the new curriculum (Knowles, 1984). This is performed by following the four principles of the theory of adult learning, which are:

1. Adults should be involved in the planning and evaluation of their education.
2. Past experiences provide the foundation for learning activities.
3. Adults, unlike children, are most interested in building knowledge in topics that have pertinent relevance to their occupation, skills, or personal life.
4. Adult learning is problem-focused rather than based on content (Knowles, 1984).

Because there are no sustaining truths, and change is constant, we cannot always trust what we believe is right (Merriam, 2001). Therefore, it is critical that adults continue to judge these things around us in order to find the truth. Developing and using validated values and beliefs to make informed decisions is an essential key to adult learning (Merriam, 2001).

This prompts the question, as behavioral health organizations across the world are being held to higher standards to provide more quality treatment with excellent efficiency (Reed et al., 2014; Robinson & Dearmon, 2013), how does employee education help this process? The experience a patient has during their medical appointment is not only affected by a provider but also the support staff that interacts with the patient (Corrigan et al., 2014; Kravitz et al., 2006; van Eeghen et al., 2016). Each participant spoke of how important it is for a scheduler to communicate with a patient, and how this can be a significant factor in the overall success or

failure of an appointment. A patient's visit can be disastrous if they do not have their initial inquiry call returned in a timely manner, if they are scheduled with the wrong or service, or if they are treated insensitively (Behavioral Health, n.d.; Miller & Ambrose, 2016; Wiznia et al., 2017).

Consequently, the issue of quality staff education and training is specifically critical due to the importance of the scheduling role (Behavioral Health, n.d.; Miller & Ambrose, 2016; Wiznia et al., 2017). The ability of behavioral medicine organization administrators to understand the value of quality improvement at the scheduling occupation could enhance employee satisfaction (Davis & Khansa, 2016; Makam et al., 2013). Participants in this study mentioned the pervasiveness of employee burnout and recommended more improved training to prepare employees for difficult situations they may face with patients.

Table 4 outlines the ten education and training tools experienced by participants while employed at their current occupation. The tools listed by the subjects were: job shadowing, role play, SBE, emails, supervisor -to-employee, employee-to-employee, group presentations, lecture-based education, handouts, and reliance on employees' past experiences. Based on subjects' perceptions, education tools that were viewed with positive perceptions (see Figure 4) included: job shadowing, role play, SBE, supervisor-to-employee, employee-to-employee, handouts, and reliance on employees' past experiences. In contrast, tools expressed by participants that were negative of indifferent included: email, lecture-based education, and group presentations. These ten educational tools were discussed by subjects as ones they had received for their scheduling occupation. Some subjects stated they had not received any training for this role, and therefore, had to utilize other forms of learning, such as relying on past experiences or

informal employee-to-employee education. This lack of training affected the control, or lack thereof that employees had on their own professional learning. This tended to affect subjects intrapersonally through emotional or mental happiness. As previously stated, these stressors tended to play a significant role in job satisfaction and employee turnover.

Adult learners have a profound psychological desire to be autonomous, and that the sign of adulthood for many is when one achieves this level of self-independence (Knowles, 1984). Additionally, Pratt (1988) and Tamura-Lis (2013) discuss how adult learning factors can affect organizations that employ schedulers. Similar to Merriam (2001), Pratt (1988), and (2003), and Tamura-Lis (2013), the subjects in this study displayed the same interest in adult learning principles that is characteristic with andragogy. One participant in the study expressed discouragement with a lack of formal training provided to schedulers, and two subjects discussed not receiving any official training for how the scheduling should be performed.

Four significant themes arose from the data outlining the perceptions and discussions associated with behavioral medicine scheduling provided by participants. The subjects voluntarily and openly discussed what specific experiences they have with the education and training they have received. Table 5 displays eight suggestions participants had for educational tools that could improve their knowledge and the knowledge of other staff in scheduling. Two suggestions were methods that were not previously mentioned by subjects (test/assessment and education created with employee input), and one (one-on-one/classroom training) was an augmentation of a previously mentioned tool. Many studies have been conducted, and researchers agree adults learn differently than children, and therefore, have higher rates of success when taught using adult learning techniques (Knowles, 1984; Merriam, 2001; Pratt,

1988; Tamura-Lis, 2013). However, the conflict in this study is a lack of scheduling education received by participants.

Multiple studies have shown that adult learning tools such as simulations, SBE, and role-playing can be highly useful in the field of clinical education (Batt-Rawden et al., 2013; Neumann et al., 2011; O'Malley & Reschovsky, 2011). However, the field of clinical and nonclinical education is complicated due to a variety of roles, education levels, funding, resources, and other aspects. These variables can impact the quality of education provided to adults and can affect the quality of performance shown by each employee as a result. Some organizations can afford to devote a large amount of funding towards education and training, while others must deal with the constraints of limited resources. The financial figures of the two organizations in this study were not analyzed, but data provided by most participants displayed characteristics of institutions with budgetary constraints. The most significant evidence of this were providers having to make their own appointments and lacking a formal training curriculum for schedulers. Seven out of eight participants were in a role non-traditional scheduler role, and two individuals stated they had never received or observed any scheduling training be performed at their organization. Healthcare institutions can and should provide educational support to their non-clinical staff in demanding roles.

Subjects in this study discussed the importance of involving patients in their educational process. Some recommended involving certain patient situations into training, while others organically kept the patient’s needs in mind. Participants shared how it was crucial for training to meet the needs of patients. For several who had been working in behavioral medicine for multiple years, they were in positions where they trained new staff to handle these demands. The

patient experience was a critical aspect shared by each participant, and discussions were often thought-provoking on how the experience could be improved. Another experience for the subjects was the strain of working in a demanding occupation. Although working in the field of behavioral medicine was a distinction of pride, for some subjects, the stress could sometimes seem unbearable. One individual spoke about the high turnover rate at his organization and how they felt training could improve this.

The one commonality amongst adult educators is that irrespective of our field, industry, or occupation, the facilitation of learning is at the heart of what we do (Merriam, 2001). A variety of learners exist in the medical field today who have varying degrees of education, background, and professional aspirations (Gallo et al., 2016; Garets & Davis, 2006; Goffman et al., 2017). The importance of nonclinical occupations in this field has risen as the healthcare environment has become more rigid with a plethora of regulations and constraints (Avari & Meyers, 2018; Corrigan et al., 2014; Gallo et al., 2016; Tomar et al., 2015). The specialty of behavioral medicine has displayed tremendous growth as morbidities are diagnosed, and new treatments become available (Centers for Medicare & Medicaid Services, 2020). Healthcare administrators are seeking additional methods for improving the patient experience, sustaining high marks of quality care, and lowering costs (Reid et al., 2015; Wiznia et al., 2017). Nevertheless, while vast improvements have been made in clinical training, that same effort has not been matched for nonclinical healthcare occupations (Batt-Rawden et al., 2013; Neumann et al., 2011; O'Malley & Reschovsky, 2011).

This study examined perceptions of schedulers in behavioral medicine outpatient organizations on the occupational training and education they have received. By identifying the

emotions of subjects associated with specific educational tools, such as email, role-playing, and peer-to-peer training, administrators have the opportunity to improve their organization's education structures. Systematic construction of a patient-centered adult learning structure designed with employee input could be implemented to assist staff meets their role demands.

Perceptions are obtained when one can think independently, and through this, independence is born autonomy (Hewitt-Taylor, 2001). Knowles (1984) mentions the optimal performance of adults is created when self-direction is enabled, and past experiences are referenced as a tool for facilitating new learning. These statements are supported by subjects in this study who have predominantly relied on past experiences to conduct occupational tasks. Student involved learning comes in many forms; self-directed learning (SDL), situ-simulation, and SBE. Each form has shown higher quality learner outcomes than traditional lecture-based education (McNeal, 2010; Paskins & Peile, 2010). Unlike literature review findings, subjects in this study did not explicitly discuss these types of education. Some participants mentioned exposure to role-playing, supervisor to employee, and employee to employee training, but not with any significant positive or negative feelings. Most subjects were expressed indifferent feelings pertaining to exposed education and training. However, having a positive outlook on one's occupation or aspects within it has shown to decrease employee turnover (Davis & Khansa, 2016; Makam et al., 2013). The following is a menu of suggested improvements for behavioral medicine patient access education.

Organizational considerations. Professional and personal experiences are integral parts of adult learning (Knowles, 1984; Merriam, 2001). Quality education and training programs are designed within organizations to leverage these past experiences to create a robust learning

structure (Collet et al., 2018; Miller & Ambrose, 2016; Reid et al., 2015). Participants of this study noted multiple positive traits associated with perceived education experiences and improvements. Suggestions include:

- Managers and supervisors being responsive to employee questions and concerns
- Quality of organization training and continuing education
- Employees providing feedback to managers on how training can be improved
- Standardized training for all employees within the same role

Administration and policy. The utilization of SBE, SDL, and simulation-based training is directly linked to improved individual performance traits such as confidence, knowledge, and memorization (Corrigan et al., 2014; Kravitz et al., 2006; van Eeghen et al., 2016). Creating organizational training programs integrated with adult learning techniques could be beneficial to scheduling performance, employee satisfaction, and patient care (Hewitt-Taylor, 2001; Knowles, 1984; Merriam, 2001). Similar findings have been well documented in the educational structures of clinical roles (Carnegie & Norris, 2015; McKinley & Ruppel, 2014; Miller & Ambrose, 2016; Wiznia et al., 2017).

Subjects in this study supported organizational policy changes for standardizing training for all new schedulers. Forms of learning proposed by participants include increased job shadowing, SBE, staff able to have open communication with supervisors, and creating support networks around employees to decrease burnout and turnover. These suggested forms of learning address this study's third and final research question.

Recommendations for Future Research

Understanding and evaluating adult learning environments is paramount for determining what andragogy is and what it could be. We only need to see ourselves and the context in which we live to understand the importance and potential of expanding the vision of adult learning (Merriam, 2008). Further research is vital in the evolving field of non-clinical healthcare education, specifically in the specialty of behavioral medicine, in order to meet the needs of patients. Schedulers play an essential role in the field of behavioral medicine and are critical to the patient experience. The scheduling staff is often the first employee to come into contact with a patient, at which time they could be tasked to handle a wide range of issues that are outside of their control, such as no health insurance or the office not having available appointments (Miller & Ambrose, 2016; Taubman et al., 2014; Wiznia et al., 2017). When these situations arise, scheduling staff are left to utilize their training, experience, and educational resources provided by the organization. However, when training is inadequate or nonexistent, and education support is diminished due to funding constraints, the employee is left with few tools for handling these situations.

Research is needed to determine if a supportive educational system could decrease employee turnover in the field of behavioral medicine. Studies might consider examining the financial comparisons between constructing quality education structures and losses suffered from losing quality staff. Participants were not asked if they had thoughts of leaving their role due to the stress level, a topic outside the scope of this study. Additional research should also investigate how inequalities in a healthcare organization's financial and resource status may affect employee education and training quality.

Furthermore, future studies may consider examining the nonclinical education structure in association with patient experience to determine a relationship that exists. Future research should consider investigating other behavioral medicine institutions, a diverse population of geographic locations, or compare the perceptions of current and former schedulers. In addition, future studies may consider analyzing the patients' perspective while focusing on nonclinical staff performance. It is common knowledge in the field of medicine that the quality of clinical care received is directly associated with a patient's satisfaction, but very little research exists on nonclinical care (Carnegie & Norris, 2015; Miller-Matero et al., 2015; O'Halloran et al., 2015; Reynolds et al., 2015; Teo et al., 2017; van Eeghen et al., 2016).

Lastly, the importance of sensitive communication and patient engagement has been displayed in the literature (Goffman et al., 2017; Leberman & McDonald, 2016; Wiznia et al., 2017), and participants in this study by majority mentioned the same aspects of significance. Behavioral medicine is unique in that it does not handle physical ailments as a primary focus. Instead, patients are seen for a wide range of emotional, mental, psychological, and behavioral morbidities (Behavioral Health, n.d.; Gallo et al., 2016; Goffman et al., 2017). The sensitivity required for the role of a scheduler is paramount, and communication must be allowed for a patient-centered focus (Reid et al., 2015; Reynolds et al., 2015; Santibáñez et al., 2012). These details were emphasized by study participants, and some individuals believed these elements could be incorporated into scheduler training. There is a need to explore adult education in the field of behavioral medicine based on the literature gap.

Implications for Professional Practice

The results of this study have consequences for healthcare administrators of behavioral medicine treatment centers, adult educators, and healthcare employees. Specifically, behavioral medicine administrators may consider continuing to integrate adult learning techniques into employee education and training. The level of formalized training provided to scheduling staff was much lower than initially expected. Organizational leadership should work to increase educational opportunities for non-clinical staff. The findings show that all participants displayed a high level of reliance on past education and experience to replace the lack of scheduling training.

Possible implications indicate healthcare leadership might consider examining how training schedulers on communication, systems, and processes can impact a patient's medical visit, including no-show and return rates (Avari & Meyers, 2018; Kheirkhah et al., 2015; Olfson et al., 2014). Subjects in this study discussed patient limitations, such as lack of transportation, when asked about no-show correlations. This contradicts research that shows patient attributes and comorbidities are substantial factors associated with absenteeism (Akhigbe et al., 2014; Reynolds et al., 2015).

Additionally, administrators might consider investigating what role training has on employee satisfaction and turnover, as mentioned by participants. Many subjects discussed the stressors associated with their roles in behavioral medicine, and some spoke of the high turnover rates resulting from these anxieties. Leaders in behavioral medicine organizations should incorporate methods for handling these issues into employee training and continued education. These findings were not observed in the literature review, which tended to investigate employee

performance over emotional and mental feelings (Creutzfeldt et al., 2010; Miller & Ambrose, 2016; Reid et al., 2015; Wiznia et al., 2017).

Advocating for the implementation of adult learning education and formalized training programs for schedulers creates a support system for employees and enforces continuing improvement. Contrary to the literature review, which did not discuss support systems, subjects in this study emphasized the importance of these measures. Additionally, behavioral medicine administrators may consider the findings of how schedulers and other staff view the lack of formalized training. Based on the subject responses, administrators should collect ideas from their employees on how best to improve training, along with examining the educational success or failures of similar organizations. The degree of unstandardized training discussed by participants contradicted the literature review's portrayal of healthcare education (Paré et al., 2014; Reid et al., 2015; Santibáñez et al., 2012).

In this same vein, behavioral medicine leadership may consider standardizing their education models to increase homogeny among locations and allow staff to transition from site to site comfortably. Subjects discussed exposure to varying types of education depending on many factors, including office location. As observed in the literature, training curriculum in healthcare must be standardized to meet occupation expectations. The observed training inequities in this study were incongruent with past literature (Dieckmann et al., 2012; Hermans et al., 2013; Sandlin et al., 2013).

Scheduling educators and supervisors may consider integrating communication strategies into mandatory education for new employees. They could also provide equal amounts of educational opportunities for clinical and non-clinical roles within the same organization.

Additionally, knowing behavioral medicine and health care continues to evolve, administrators should continue to reassess staff education needs on a consistent basis (Miller & Ambrose, 2016; Reid et al., 2015; Wiznia et al., 2017).

Finally, this study has repercussions for local, state, and federal policymakers. In an industry where government funding can consistently shift, legislatures should understand the negative ramifications that come from behavioral medicine resources being cut (Proudfoot & Kebritchi, 2017; Reeder & Turner, 2011). Therefore, this study recommends policymakers take note of the positive perceptions and effects of quality adult education, and the constructive patient outcomes stemming from non-clinical training (Gallo et al., 2016; Goffman et al., 2017).

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Appendix A

Interview Questions

1. What is the highest level of education you have completed?

   ( ) High school

   ( ) College – diploma / certificate

   ( ) Bachelor's degree

   ( ) Master's degree

   ( ) Doctoral degree

   ( ) None of the above

2. What is your current age?

   ( ) 18-24

   ( ) 25-34

   ( ) 35-44

   ( ) 45-54

   ( ) 55-64

   ( ) 65 or older

3. What is your gender?

   ( ) Male

( ) Female

4. Which ethnic group applies to you?

   ( ) White (Caucasian)

   ( ) Hispanic (Latin American)

   ( ) Black (African American)

   ( ) Asian / Pacific Islander

   ( ) Native or First Nation

5. How long have you been working for this organization?

   ( ) Less than 1 year

   ( ) 1 to 5 years

   ( ) 6 to 10 years

   ( ) 11 to 15 years

   ( ) Over 15 years

6. What role do you perform for the company?
7. What are the duties of your current role?
8. How often do you interact with patients?
9. How does your role affect the patient experience?

10. Tell me about the types of patients you often encounter, and the appointment attendance of these patients.
11. How often do you handle incoming referrals? What are the challenges with referrals?
12. How well did the education provided by the organization prepare or not prepare you for your role?
13. What parts of the education or training did you find most helpful, and what could have been improved?

Appendix B

Initial Email to Subjects

(sent via email)

Hello

You are being asked to complete an interview about your education and training experiences related to your current job. Please respond to this email with the best date(s) and time(s) that you wish to be contacted. Completing an interview is not required. All conversations will be kept confidential.

If you have questions or concerns, please contact Jacob Rounds by replying to this email. If you require additional assistance, please contact research supervisor Heidi Curtis at hlcurtis@nnu.edu.

Thank you,

Jacob Rounds

Northwest Nazarene University

jrounds@nnu.edu

Appendix C

Follow-Up Email to Subjects

(sent via email)

Hello,

You previosuly received an email asking to complete an interview based on your education and training experiences related to your job. If you have not done so already, please reply to this email with date(s) and time(s) that you would like to be contacted by a researcher. Completing an interview is not required. All information gathered will be kept confidential.

If you have questions or concerns, please contact Jacob Rounds by replying to this email. If you require additional assistance, please contact research supervisor Heidi Curtis at hlcurtis@nnu.edu

Thank you,

Jacob Rounds

Northwest Nazarene University

jrounds@nnu.edu

Appendix D

Site Request Letter

(sent via email)

[redacted]
Director of Patient Access
[redacted]
[redacted]

Hello [redacted],

My name is Jacob Rounds and I am a doctoral student at Northwest Nazarene University (NNU). I am completing a research study on the effects of Epic and occupation training on ambulatory behavioral health scheduling staff.

I would like to send a brief survey to [redacted] personnel who schedule patient appointments for any outpatient behavioral health departments at [redacted]. This includes psychiatry, psychology, and social work. Would you mind sending me the email addresses for these individuals so that I may email them a survey link?

Please see my attached Institutional Review Board (IRB) approval documentation. Feel free to contact me or my institution if you have questions.

Best regards,

Jacob Rounds

Jacob Rounds
Phone: 513-491-4355
jrounds@nnu.edu
Doctor of Philosophy Student
Department of Education
Northwest Nazarene University

Appendix E

Site Permission Letters

(received via email)

Northwest Nazarene University
Attention: Jacob Rounds
Helstrom Business Center 1st Floor
623 S. University Boulevard
Nampa, ID 83686

RE: Research Proposal Site Access for Mr. Jacob Rounds

Dear Mr. Rounds

This letter is to inform you that the [redacted] has reviewed the proposed dissertation research plan including subjects, assessment procedures, proposed data and collection procedures, data analysis, and purpose of the study. You have permission to conduct your research study at the ambulatory offices of [redacted]. The authorization dates for this research study are May 1, 2019 to May 1, 2020.

Respectfully,

[redacted]

July 11, 2019

Northwest Nazarene University
Attention: Jacob Rounds
Helstrom Business Center 1st Floor
623 S. University Boulevard
Nampa, ID 83686

RE: Research Proposal Site Access for Mr. Jacob Rounds

Dear Mr. Rounds

This letter is to inform you that the [redacted] has reviewed the proposed dissertation research plan including subjects, assessment procedures, proposed data and collection procedures, data analysis, and purpose of the study. You have permission to conduct your research study at the ambulatory offices of [redacted] and its affiliated offices. The authorization dates for this research study are July 1, 2019 to May 1, 2020.

Respectfully,

[redacted]

Appendix F

IRB Approval

Submittable

Dear Jacob,

The IRB has reviewed your protocol: 4012019 - REFINING ADULT EDUCATION OF BEHAVIORAL MEDICINE PATIENT ACCESS OCCUPATIONS. You received "Full Approval". Congratulations, you may begin your research. If you have any questions, let me know.

Northwest Nazarene University
Bethani Studebaker
IRB Member
623 S University Blvd
Nampa, ID 83686

Appendix G

Informed Consent Form

A. PURPOSE AND BACKGROUND

Jacob A. Rounds, in the Department of Graduate Education at Northwest Nazarene University is conducting a research study related to behavioral medicine scheduler learning and education.

You are being asked to participate in this study because you are member of a healthcare behavioral medicine department. You are either a full-time, part-time, or PRN scheduler, and are over the age of 18.

B. PROCEDURES

If you agree to be in the study, the following will occur:

1. You will be asked to sign an Informed Consent Form, thereby volunteering to participate in the study.
2. You will be asked to answer interview questions that will be audio-recorded and is expected to last 45 minutes in length.
3. You will answer a set of demographic questions at the beginning of the interview. The expected time for this process is five minutes in length.
4. You will be asked to listen to a debriefing statement at the conclusion of the interview.
5. You will be asked to respond to communication asking you to verify the interview's synopsis.

These procedures will be completed over the phone at a date and time mutually decided upon by the participant and principal investigator, and will take a total time of about one hour.

C. RISKS/DISCOMFORTS

1. Some of the discussion questions may make you uncomfortable or upset, but you are free to decline to answer any questions you do not wish to answer or to stop participation at any time.

2. For this research project, the researcher is requesting demographic information. Due to the make-up of your organization's population, the combined answers to these questions may make an individual person identifiable. The researcher will make every effort to protect your confidentiality. However, if you are uncomfortable answering any of these questions, you may leave them blank.

3. Confidentiality: Participation in research may involve a loss of privacy; however, your records will be handled as confidentially as possible. No individual identities will be used in any reports or publications that may result from this study. All data from notes, recordings, and spreadsheets will be kept on a password protected computer or in password protected files. In compliance with the Federal-wide Assurance Code, data from this study will be kept for three years, after which all data from the study will be destroyed (45 CFR 46.117).

4. Only the primary researcher and the research supervisor will be privy to data from this study. As a researcher, both parties are bound to keep data as secure and confidential as possible.

D. BENEFITS

There will be no direct benefit to you from participating in this study. However, the information you provide may help educators to better understand the factors that enhance the environment to be a place of positive patient-staff interactions.

E. PAYMENTS

Each participant in the study will receive a $5.00 Starbucks gift card after completing the interview and returning the signed and dated consent form.

F. QUESTIONS

If you have questions or concerns about participation in this study, you should first talk with the investigator. Jacob Rounds can be contacted via email at jrounds@nnu.edu, via telephone at 513-491-4355. If for some reason you do not wish to do this you may contact Dr. Heidi Curtis, Professor at Northwest Nazarene University, via email at hlcurtis@nnu.edu via telephone at (208) 250-6341 or by writing 623 S. University Blvd, Nampa, Idaho 83686.

Should you feel distressed due to participation in this, you should contact your own health care provider.

G. CONSENT

You may print this consent at any time for your own records.

PARTICIPATION IN RESEARCH IS VOLUNTARY. You are free to decline to be in this study, or to withdraw from it at any point. Your decision as to whether or not to participate in this study will have no influence on your present or future status as a student at Northwest Nazarene University (if applicable).

I give my consent to participate in this study:

Signature of Study Participant **Date**

I give my consent for the interview and discussion to be audio taped in this study:

Signature of Study Participant **Date**

I give my consent for direct quotes to be used in this study:

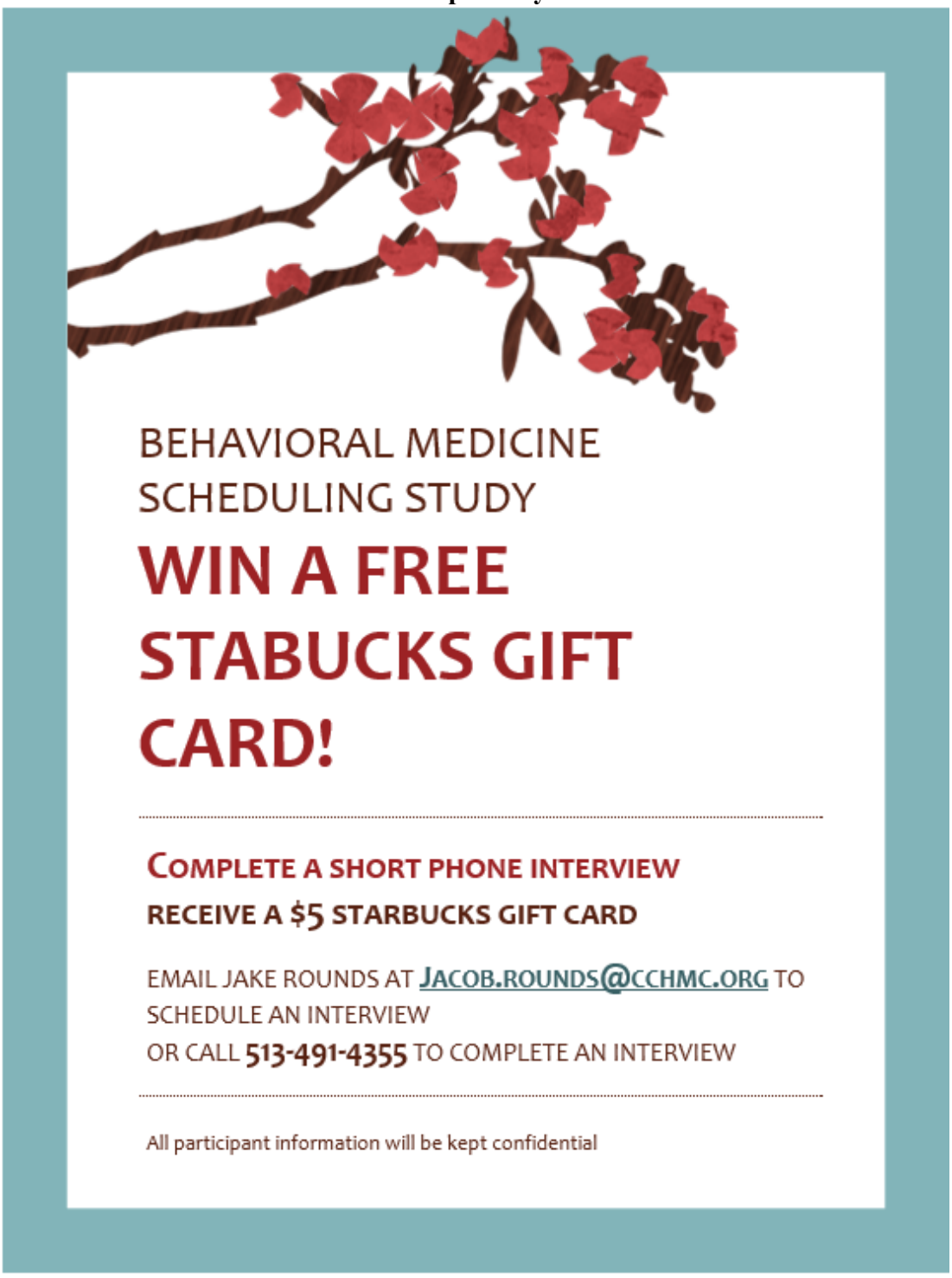
Signature of Study Participant **Date**

Signature of Person Obtaining Consent **Date**

THE NORTHWEST NAZARENE UNIVERSITY HUMAN RESEARCH REVIEW COMMITTEE HAS REVIEWED THIS PROJECT FOR THE PROTECTION OF HUMAN PARTICIPANTS IN RESEARCH.

Appendix H

Participant Flyer



Appendix I

Debriefing Statement

(sent via email)

Thank you for your participation in this study. My hope is that the results of this study will help us gain an understanding of the experiences of students who were enrolled in an online program. The results of this study may help program administrators and faculty at universities around the country who plan to develop an online undergraduate program.

After I have a chance to analyze the data, I will email you the results and ask for feedback. Mainly I want to ensure that I captured the essence of our discussion, accurately portraying our discussion and your thoughts. This study will conclude by February 1, 2020.

In the meantime, if you have questions or concerns, please contact:
Loredana Werth at Jrounds@nnu.edu, via telephone at 513.491.4355
or by writing: Jacob Rounds, 3333 Burnet Avenue, Cincinnati, Ohio 45229.
You may also contact the faculty sponsor for this study. Dr. Heidi Curtis can be contacted via email at hlcurtis@nnu.edu.

Thank you for your participation!

Jacob Rounds, MS, MBA
Doctoral Student
Department of Education
Northwest Nazarene University

Appendix J

Member Checking Message

(sent via email)

Dear participant,

Thank you for taking part in my study during the Fall of 2019. I have included the themes that were present in the data collected from our interview. Please let me know if these themes accurately depict our conversations together and if you have additions or modifications.

(List of themes)

Thank you again for your participation, and please contact me if you have questions or concerns.

Sincerely,

Jacob Rounds

Appendix K

National Institutes of Certificate

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Jacob Rounds** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 01/08/2018.

Certification Number: 2589810.

Approval from Northwest Nazarene University's Human Research Review Committee to begin conducting research was received on April 18, 2019. Protocol Number: 4012019.

Appendix L

Sample Data Analysis Process and Categories

Category	Description	Question #
ITAL	When I came in, I had a lot of supervision, so it was kind of part of the supervision process kind of I guess	1
PWE	I never had like a specific way to schedule	2
PWE	It was kind of figuring it out and then if things weren't going well troubleshoot	1
ITAL	Informal training on scheduling	2
SWMA	It was easier for those cases but then other clinical cases typically four cases or whatever it is no kind of spread it around	2
ITAL	Email	3
SWMA	Constant issues	2
ITAL	The informal this that really is hard to pick up as a new hire	2
ITAL	I started off with only my way in I'm sure somebody that got hired right off the bat	2
FT	Giving some general parameters for how to handle people who are inconsistent	1
SWMA	Can get mixed messages on that	1
FT	I think a script sounds very singsong, scripted	2
SWMA	It’s so hard, to be honest	2
FT	As a new hire giving more concrete parameters is helpful	1
ITAL	Being upfront with new hires that scheduling was the population is just really hard time sometimes it's part of the job I'm kind of just giving permission to be frustrated with it	1
SWMA	Universal verbal communication going to be the primary source of that sort of training	1
ITAL	Be able to talk with the supervisor position	1
FT/ITAL	System changes, ongoing training	1
FT/ITAL	Face-to-face	1
FT/ITAL	Handouts	1

ITAL	Email	1
PWE	Nothing comes to mind	1
SWMA	There's some variation in terms of the types of appointments that people schedule	2
SWMA	Some things may be standardized but not all things because of the different services that are offered	1
SWMA	You communicate with someone who is irate very upset on the phone and dealing with scheduling issues	2
FT	I don't think our compliance department has a formal training around that	1
SWMA	The cliental knows what they are walking in with, trauma and families, be sensitive to that. I think we have to be attuned to what struggles they faced before they walked through the door.	3
FT/ITAL	PowerPoint	3
FT	Handouts	3
ITAL	Bring in staff to the job to help break in new staff	3
ITAL	Run staff through scenarios	3
PWE	More self-taught	1
SWMA	I didn't actually even want to do the scheduling	1
PWE	Self-taught	1
SWMA	We constantly are having issues	2
ITAL	Job shadowing	3
PWE/ITAL	I think some of the best ways to learn is like learning by doing	3
FT/ITAL	Sit with you just kind of jump in like bullet points	3
ITAL/SWMA	Should be though exposure	3
SWMA	Just go do it	1