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Use of Standardized Patient Scenarios to Train Medical Assistants in an Ambulatory Rehabilitation Medicine Clinic


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Background

The American with Disabilities Act of 1990 (ADA) and Section 504 of the Rehabilitation Act of 1973 prohibit discrimination against individuals with disabilities in every day activities, including medical services, and require healthcare providers to make their services available for all patients in an accessible manner.¹ Nonetheless, due to inadequate facilities and equipment and untrained staff, many practices cannot accommodate patients with mobility impairment.² Subspecialist clinics often cite the inability of practice staff to transfer the patient from a wheelchair to an examination table due to lack of equipment and knowledge of the safest method for transferring as the most common reasons for practice's inability to accommodate a patient in a wheelchair.³ As a result, adults with functional physical impairments are frequently denied specialty care and are less likely to get routine preventative care.¹

Furthermore, longer ambulatory clinical wait times have been found to be negatively associated with clinical provider scores of patient satisfaction.^{4,5} More importantly, they are negatively associated with patients' confidence in providers and perceived quality of care.⁶ Increased wait times can also impact the productivity of patients, incurring substantial opportunity costs.⁷ Patients with limited mobility and difficult access to transportation are even more vulnerable to negative effects from longer wait times than the general population.

Introduction

At our ambulatory Rehabilitation Medicine clinic, we serve a diverse patient population with a variety of unique needs. As a result of cognitive and physical impairments, many patients have difficulty transferring to exam tables, removing clothing and positioning properly in preparation for their exam. Despite adequate facilities, equipment and staff, this often adds to the time it takes for a patient to be ready to see the provider following initial check-in. As a result, individual patient visits are prolonged and there is a tendency for providers to fall behind in their schedules, contributing to longer patient wait times as the day goes on.

It is thus necessary that the clinic support staff possess a high level of comfort and knowledge in working with patients with disabilities. In our clinic, the Medical Assistant (MA) is responsible for the patient rooming process, which includes the time from which the patient has completed the registration process at the front desk to the time that the patient is ready to be seen by the physician. There are several tasks that the MA is expected to complete in a short period of time (Fig. 1). The MA's competence and ability to perform these tasks in a timely manner without compromising quality patient care is imperative. With the assistance of University Clinical Skills and Simulation Center, staff and providers in our clinic designed an intervention that was hoped to contribute to MA efficiency and comfort in the rooming process, knowledge in caring for our patient population, as well as potentially lead to shortened patient wait times and overall improved patient satisfaction.

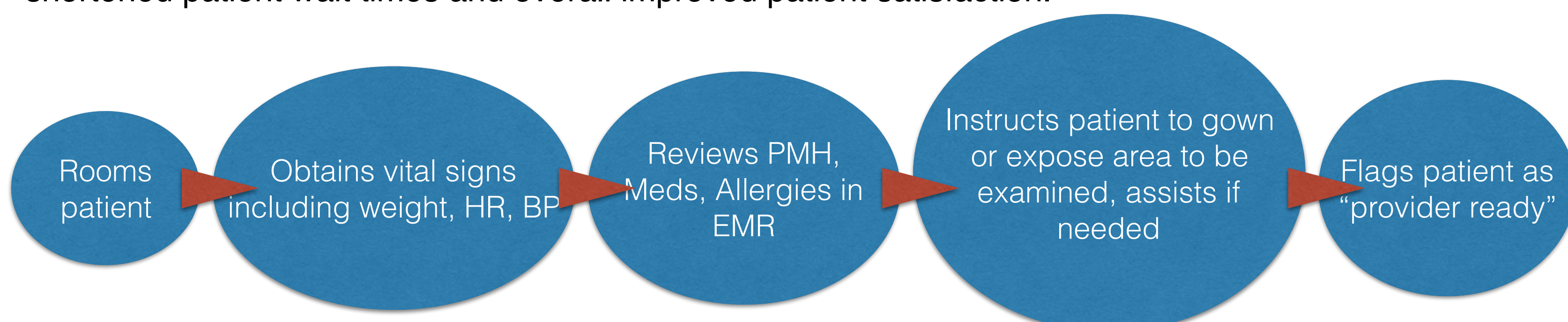


Figure 1. Patient rooming process, responsibilities of Medical Assistant

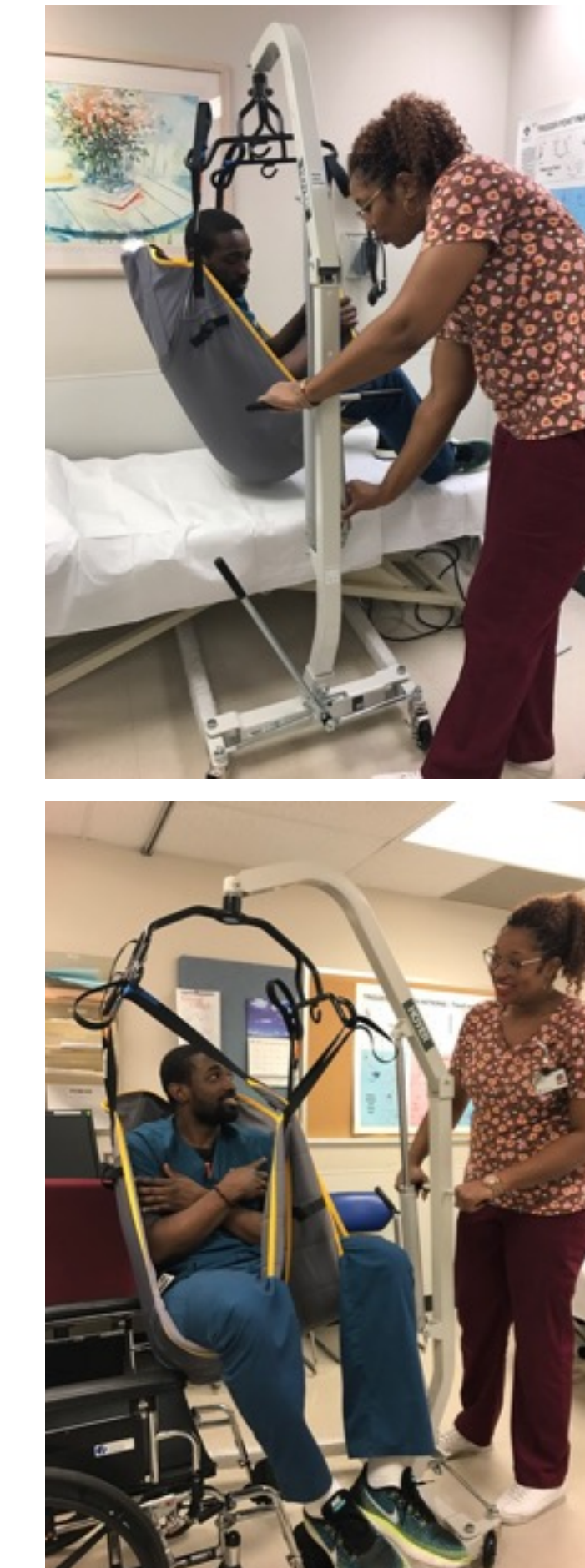
Objectives

- To improve the efficiency of our outpatient Rehabilitation Medicine clinic without sacrificing high value/quality patient care.
- To clarify the responsibilities of the MA and identify areas of redundancy in the rooming process.
- To demonstrate the utility of in-situ simulation for MA training.
- To reduce the time it takes for MAs to complete all assigned tasks to 10 minutes or less per encounter in at least 50% of patient encounters within two months from the time of intervention.
- To potentially highlight other areas in which to improve clinic efficiency and overall patient satisfaction (e.g. front desk registration process, resident and attending physician encounters, clinic and exam room accessibility).

Methods

- Jefferson outpatient services implemented a new Electronic Medical Record (EMR) in the fall of 2016. We allowed one month for the staff and providers to become accustomed to this new EMR prior to collecting rooming data.
- The clinic's three MAs each participated in four mock rooming scenarios using standardized patients (SPs) in the ambulatory clinical setting. This in-situ simulation was arranged with the assistance of the Jefferson Clinical Skills and Simulation Center.
- On March 31, 2017, the clinic's three MAs participated in an in situ training involving four mock rooming scenarios using SPs with a selection of chief complaints believed representative of our clinic patient population. These included one patient with incomplete paraplegia presenting for post-acute care follow-up, one patient with lower extremity amputation presenting for prosthesis fitting, one wheelchair dependent patient presenting for baclofen pump refill, and one patient with cerebral palsy, spastic diplegia and developmental delay presenting for routine health maintenance.
- The average time it took to complete the rooming process (time from completed front desk registration to "provider ready") was determined by extracting data from the EMR for three months prior and one month following this intervention.

Figure 2. Using a portable overhead lift for wheelchair to exam table transfer



Results

Time to complete the rooming process was extracted from the EMR for January 1, 2017 through March 31, 2017. Excluding Telehealth visits, a total number of 597 patient encounters occurred during this time period. Visits in which the rooming process took less than one minute or greater than 45 minutes were also later excluded, as these were considered to be outliers and the times recorded were believed to be results of users signing in and out of the EMR at times that did not accurately reflect the rooming process. After excluding outliers, a total of 531 patient encounters were included in the final analysis. The mean rooming time before the intervention was 15 min 11 sec (SD 10 min 21 sec).

Following the SP intervention, rooming times were again extracted from the EMR for April 1, 2017 through May 2, 2017 from a total of 231 patient encounters. After excluding Telehealth visits and outliers (rooming times <1 minute or >45 minutes), 205 patient encounters were included in the final analysis. The mean rooming time after the intervention was 15 min 3 sec (SD 10 min 24 sec). The MA workflow did not change following the intervention.

	Jan 1-Mar 31	Apr 1-May 2
Number of visits	531	205
Mean rooming time (std dev)	15 min 11 sec (10 min 21 sec)	15 min 3 sec (10 min 24 sec)

Table 1. Mean rooming times before and after standardized patient training

Conclusions

This initial data reveals no significant difference in rooming time before versus after the MA training intervention with SPs. Further data collection is ongoing.

The clinic MAs reported increased comfort with the rooming process overall, as well as increased confidence in their ability to transfer patients with mobility impairment to and from the examination tables.

Discussion and Sustained Improvement

Despite there being no change in wait time before and after the MAs participated in the SP scenarios, our mean patient wait time falls below the national average of 21 minute for general Physiatry practices.⁸ Thus, the lack of difference before and after the intervention may be of less significance than originally believed. As our clinic staff and providers continue to familiarize themselves with the intricacies of our relatively new EMR, we suspect that clinic efficiency will continue to improve and overall patient wait times may decrease.

While MAs reported improved confidence and understanding of their clinical responsibilities following the SP training, we have no means of determining whether this or clinic wait times correspond with patient satisfaction in our particular clinic. Potential future investigations include surveying patients for satisfaction and likelihood to recommend the practice, as well as soliciting suggestions for improvement in clinic and exam room accessibility.

Acknowledgements

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