Colorado: Using Patient Agendas

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Hello, everyone. My name is Nicole Banister from TMF Health Quality Institute, and I want to welcome you to this regional webinar entitled Patient Agendas. I have a few announcements. First, today's program is being recorded and will be posted along with all slides and materials to the Collaboration site. However, you can also download the slides directly from the WebEx environment during today's event, by going to the top toolbar and selecting File, and Save As, and then Document. You can do this both for the slides that are on display right now, as well as two tools that are uploaded into WebEx today; one that is labeled patient agenda, and one that is labeled patient visit, which are tabs across the top toolbar right next to the slide tab. We do like our sessions to remain interactive. Although your lines will remain muted, we do encourage you to submit questions and comments. You can do this by using the Q and A tab on the right-hand side of your screen. Feel free, also, to use the Chat box. It may not be visible right now, but if you go to the top right and click on the Chat icon, it looks like a conversation bubble, this will open your Chat screen and you can see both a chat from myself, as well as chats from others during today's webinar. You may also raise your hand if you'd like to verbally ask a question, and you can do this by selecting the hand icon in the participant panel, and then I can unmute your line for you to ask your question out loud. Keep in mind that we will ask you to complete a survey at the end of the event in order to track your participation. With that, I want to recognize the presenters' time and effort in preparing for and sharing their valuable knowledge today. Any statements about the quality or utility of any product or vendor made in this presentation is an expression of opinion of the person making the statement only and is not an opinion or endorsement of the Center for Medicare and Medicaid Innovation, TMF Health Quality Institute, or the host of this presentation. Now, before I turn it over to Emilie, from HealthTeamWorks, who's going to get us started, I did also just want to make a quick announcement about some of the programming that we anticipate in the region and nationally for CPC in the summer and moving into the fall. You can anticipate that we will continue with the EHR Affinity Groups, with 13 different EHR vendors. We will also continue with national webinars throughout this next year. And then our action groups are going to move from a group and cycle of webinars and forum activity that last over the course of 12 months, to shorter cycles of activity where there may be courses with a number of live webinars over a 3-month period. So we're changing a little bit of the cycle and timing for those action groups. And those are national groups that allow for cross-regional sharing on specific milestones, particularly those related to Milestone 2. You can also anticipate that we will have fewer regional webinars. And we're going to have more targeted formal activities, both in the regional webinars, as well as in the one-on-one coaching that you receive, really working to make sure you get the resources that you need now to continue your transformation. And where the activities

might not be as frequent, it will give opportunity for measurement and for you to see, sort of, a progress or trend in measurement data over time. So those are some of the things that we are anticipating at TMF, and with HealthTeamWorks and Rocky Mountain Health Plans, starting in the summer and really launching in earnest in the fall. And I wanted you all to have a heads up. So, with that, I'm going to turn it over to Emilie, who's going to get us started with Sterling Primary Care and the Family Physicians of Greeley reps. Thanks so much.

Thanks, Nicole. Welcome to the presentation today on patient agendas. My name is Emilie Buscaj. I am the recognition manager and a quality improvement coach with HealthTeamWorks and Colorado Regional faculty for the Comprehensive Primary Care Initiative. I will be facilitating the presentation. Joining me from Sterling Primary Care is Diane Calvert and from Family Physicians of Greeley, Lane Mattox, to discuss their experience using patient agendas in practice. Our shared purpose today is to recognize the value of integrating patient agendas into a patient appointment; choose or create your own patient agenda for use in your practice; identify a workflow for how to use a patient agenda, and how that can be incorporated at the practice. And to do this, we will identify the benefits of using patient agendas to better prepare and set expectations with patients at the beginning of their visit. The Agency for Health Care Research and Quality recommends that patient engagement takes place at three levels: the individual, the institution and in the development of policy and research. From the individual care perspective, primary care practices can better engage their patients, families and caregivers by communicating with them about engagement benefits, and by defining the roles of patients and their care delivery team, supporting patients in self-care, which includes the development of goals, care plans, and reduction of risk factors. Partnering with patients in informal and formal decision making, including the use of tools such as shared decision making tools, and giving patients access to their own medical records to improve patient safety. Additionally, the Center for Advancing Health defines patient engagement as actions individuals must take to obtain the greatest benefit from the health care services available to them. In order for patient engagement to truly take hold, it must be a collaborative effort of focusing not only on health professionals and how they can support patients, but how the patient can be activated in their own care and take ownership and responsibility for the information that they provide. Engagement is not the same as compliance. I often hear in health care settings that patients are noncompliant with their medications or treatment recommendations after being told exactly what to do. This is a directive that the patient is expected to obey. Instead, we are here to explain that this focus can be switched towards engagement instead, involving patients in the process by defining care plans, treatment goals, and those that realistically fit in with their lifestyle, potential barriers and desires. Now for the question we'll help to answer today: How do you know when a patient is truly engaged in their own care? To start, the patient comes prepared for the visit with their own agenda and discussion topics. It may be related to an acute issue that is clearly defined, or it may be an underlying condition that needs more investigation by the care team. Regardless of the condition, a patient can be expected to describe their purpose for being seen and what is a priority to them. This engaged patient will also ask follow-up questions seeking to understand their condition and participates in producing a treatment plan that also addresses shared decisions developed through collaboration between the patient and the care team. To start, patients need to understand the expectation. They will be asked to develop an agenda before the visit to present to the care team that fits within the time allocated for that visit.

Setting this expectation upfront will help the patient prioritize their needs and help the care team to identify agenda items that may be related that can be addressed together, discrepancies in the care the patient has received, and the care documented in their chart and identify any gaps or concerns. Setting an agenda with the patient can help prepare the care team for an efficient visit and build a relationship of mutual understanding and support. Now I would like to introduce Diane Calvert to speak about Sterling Primary Care's experience using patient agendas.

Hello, everyone. My name is Diane Calvert, and I am the manager of clinic operations in Sterling, Colorado. And I'm really excited to be able to share how we've used patient agendas setting in our clinic. And I'm going to go ahead and forward to the slide that gives you a glimpse of what we use as our patient agenda setting sheet. This form, as it is today, is actually in its third revision. We started about a year ago and over time have realized that there are more and more things that we'd like to include on the visit sheet that's not only meaningful to the patient, but it's also meaningful to the provider, as well as the nursing staff. So, the primary focus of our visit, our agenda setting sheet, was to create a patient-centered visit. And we actually have four focal points that include the patient expectation at the top, the physician expectation in the middle. We have included a PHQ to depression screening in our form, and then we also have listed our shared decision making tool data verification at the bottom, so that when we're sharing shared decision making tools with our patients we have a way of capturing that so that we can enter it into our EMR at a later time. So the first part of the form is actually the patient expectation portion. And what this part of the form has taught us is that the schedule isn't always the most pressing patient issue. We found out many times that we believe that we know why the patient's coming in, but the patient comes in, they begin to share with us what it is that they really want to visit with the doctor today, and a lot of times it is completely different then where we were going with the visit. And we really believe that this is resulting in more streamlined patient visits. This, excuse me, this is the bottom portion of the form. It's our physician expectation portion. We actually have our nurses complete this, either our LBN or our MAs, prior to the patient visit. So what she does, is she goes back to the previous visit for the patient, looks to see what's in store for the patient at this visit, checks that off as either one month, three months, six months, and so on, and then goes on to mark the things below that really she believes that, based on the physician’s previous office note, will be discussed at that visit. If it's not listed, she'll write the other medical problems. And then when we present this to the patient at the front desk, we show them that and we let them know that this is the physician's expectation for the visit. But what's driving us, is we really want to know why they're here. Tell us why you — what you need to discuss with the doctor today. So, the cool thing about this is that the patient understands that the physician, too, has an expectation for the visit, but we want them to know that they're the driver behind everything that's going to happen in their office visit that day. So one of the things that we recognized early on is that we really wanted to screen for depression in our clinic. Behavioral health is one of the things that we're working to integrate. So tying the PHQ to a screening tool into our patient agenda sheet was — has been really helpful. It's kind of streamlined how much paper is going through our office. And one of the things that we found out, surprisingly, is how many positive PHQ-2s happen when the patient's not even coming for that reason. They'll come in for a completely different reason, all of the sudden have a positive PHQ-2, which then triggers a PHQ-9, and then the visit tends to go a completely different direction than either the patient or the provider anticipated, and it's been a real

positive thing for patients. Sometimes it's that tool that they just need to open up and be able to share that, you know what, there's some things going on that I really need to talk about. And so we're really — so it's been a really good thing for that warm handoff then to behavioral health so that behavioral health can help that patient. Normally, we assess at 3, 6 and 12 month visits only, we don't give this to every patient at every visit. Or when there was a previous PHQ-9 that was positive at their last visit, we'll ask them to complete that. If the patient's coming in for an acute visit, or this just simply does not apply to them, the nurses actually mark this section completely out so that the patient doesn't answer it if they don't need to. The section at the bottom of the form is just something that we added in. The purpose of this section, for us, is to capture when shared decision making tools are given to the patient. We found out that we're really doing the work with the shared decision making tools, we just weren't capturing the data in our EMR. And so, because we're using kind of a one tool for all of these purposes, it aids us to be able to track that information, get it entered, and so that when it comes to reporting we're able to actually give some solid data. Also, we've added another line. We figured out that there are times when we're not capturing charges for things that are billed, and this also helps us to capture charges so that we're not missing billing for items. So, how we got here, we actually had a request from our Patient and Family Advisory Council, that they — we went to them as an office and discussed their ideas around making a patient more — or making a visit more patient centered. And they actually really loved the idea of the form, and actually helped put a lot of information — gave us a lot of direction on what information we should put into that form and what would be meaningful to them. We also discussed it at our QIT meetings of a focus on really making those patients — patient visits more centered around the patient. I know when we first started using the tool, many patients have come in and just look at us and say, well, what do you mean? I'm here because the doctor wants me to be here. I don't know what we're going to discuss, because, you know, the doctor told me to come back so I'm here and I'm doing what he told me to. But, the cool thing over the last year is we've really seen that change. We've seen patients really know and understand that this is part of their visit. They expect it. If we don't give them one, they'll ask us. And that's been cool, and it's also been very — it's been really great to see patients really start to own why they're here. They're not just here because the doctor told them to be here. They're here because, you know, they can have a say in what they're being seen for, and it's just been awesome to see that turn around in patients. And I can tell you, at the beginning the physicians were originally concerned that visits would become lengthy and detailed. And what we've done with that is we've used the tool when we have a patient who has a lot going on, and then the patient has listed several items at the top, the nurses will then talk to that patient and let them know that, you know, what we're going to do is really address their concerns first, that we may need to break their visit into another visit so that they come back at a time, at a later time. But it's helped the physicians streamline those visits. It's also helped the nurses be more communicative to the patients, and it's really helped set that agenda for the patient so that they truly understand that we're here for them, they're driving the visit, and they have, you know, they have some control on what's being done. They're not leaving the visit that day feeling like they weren't listened to and they weren't heard. And that's really been important for us. Our early results, the cool thing is our physicians have owned it, and they like it, and it's helping them in their day-to-day operations of the clinic. So that's cool. Early we — we've had some early identification of at-risk patients for significant depression that required immediate treatment, and I don't think that was something that we weren't necessarily anticipating. We put the

PHQ-2 screening on the sheet so that we didn't have multiple papers going to the patient, but that was something that we found that was completely surprising. We are a practice that's about 71 percent Medicare, so we weren't expecting the numbers to come back as high as they have, but that's definitely an area of need that we're looking more closely at. We know that our visits now are more patient centered, because the patients, the input that they're putting on to that sheet has been very valuable. We're doing a better job of tracking those shared decision making tools, and we know that this is a living document that just continues to evolve for our clinic. We have made three revisions to it, and each time we meet we come back with something else that we want to use it for, and feel like it's valuable to the patient, the physician, and the entire team. Thank you for this opportunity to present. I have — it's very exciting for me to be able to share what we're going. And I'm excited to pass the baton on to Lane, so that he can share with you what he's doing in his clinic. Thank you.

Thank you, Diane. Next we have Lane Mattox to speak about Family Physicians of Greeley's experience using patient agendas. Welcome, Lane.

Hi, everyone. So we — we are much newer at this than Diane and the Sterling Clinic. We've only got about a, probably, less than a month of experience on it. So I thought I'd share more how we were able to implement this, because that seemed to be the biggest hurdle, is convincing our physicians that this was a good idea. That's why entail the first part of it how our doctor's learned how to stop worrying and love patient agendas. We actually had talked about this more than, maybe, six to nine months ago, and it was shot down at first. But like with Diane's clinic, the patient council brought it up independently, brought up wanting a tool to improve physician/patient interaction in the office visit. But this really was kryptonite to some of our doctors. It made them very sad to think about a patient agenda at first, because there was this fear that if you let the patient set the agenda, that it creates an expectation that we're going to be able to talk about all these things that you've listed. Where some of our doctors have done a very good job of training their patients that we can cover one, maybe two things, and then they'll have to come back next time. And that's still the case. We — what I need to convince the doctors was this was actually going to be a time saver. Not to slander doctors, but with meaningful use and bad EMRs, and coding problems and all the things that we're throwing at doctors these days working with care management, we can't — we can't tell them that, oh, this is — patients are really going to love this and it's going to improve engagement and patient satisfaction scores. We need to convince them that this is actually going to improve their flow. Like at Sterling Primary Care, they've experienced that this is a time saver and helps with their flow. So how did we convince them of that? One thing is that doctors actually prefer when patients come in with a list of things, because at least they can grab that list and read everything they want to talk about. Instead of letting the patient talk, they can read faster than the patients can tell them what they're in there for. There is the ability, when you can — when you see everything all at once, to see connections between multiple concerns. One example of this is one doctor told me that he had a patient that filled in right-arm weakness, confusion, and difficulty speaking as the three things on her agenda, which are classic signs, I understand, of a stroke. And he was able to see that right away instead of waiting for each of these symptoms to come out. That's kind of a too clean of an example, but that's the kind of thing that you can see just at a glance when you have everything listed out at once. And then the big thing is fewer visits extending surprises. There's some things that

doctors consider important that patients may not consider important, like chest pain or a breast lump, those things come out right away instead of at the end. Embarrassing or personal concerns, these are things that maybe the patient is working up the nerve to bring up. Those things can be out on the table right away. And then, sometimes the patient will come in and the doctor will confirm that they are sick and be giving them all this advice, but really what they're in for is just a work excuse. They aren't interested in the advice. So it's nice to get that thing out on the table first as well. And the doctors know how to — doctors already have their own scripts of how to cut a visit off. They can say, it looks like you have a lot of things to talk about today, let's go through some of the things that are most important to you and to me, and then we'll create another appointment for the ones that we can put off. So they know how to say that, and it just helps them to have this all out up front. And it was also very helpful that we did a small test of change. We got three of our doctors at three different clinics to use the form for, I guess, it was probably about a month that they tested it out. And they reported back to the group as a whole that the patient agendas were benign. They didn't — it wasn't Armageddon, and it was slightly helpful to their workflow. So once all of our doctors heard that these three had a positive experience with it, they agreed to try it practice wide, all patients, all visits. So this is what our form looks like right now. It's a half sheet. And we're actually playing with, I'll get to this later, we're playing with removing that comments/note section at the bottom. So we've actually got that removed right now. But we have: List all concerns you wish to discuss. And we added an emphasis on the word all, and then we also added the emphasis on the: Remember, there may not be time to discuss them all at this visit. We have one — we've got five slots there. One of them is labeled as the main concern. And then the section on the right, these are things that maybe a patient wouldn't list as a concern or problem, but it's possibly what they're really in there for. They want a form. They want a new med. They want a referral. Some thoughts here, I've seen forms, like at Sterling, where there's just two slots. But our perspective was to put as many — put ten on there, put twenty on there, because it will — getting everything out on the table is what's going to save you time and prevent people from throwing in one extra thing at the end, as long as the doctor has the script to be able to cut things off with their patients. So we put five slots there. It wasn't a lot of space. Some people said two, some people said seven, and we ended up with five. Like I said, this is a half sheet, white paper. We got these little mini clipboards that they fit on nicely, and these are given to patients when they check in at the front desk on a little clipboard. They fill it out while they're waiting or while they're in the exam room waiting for the doctor to come in, and they hand it to the MA or the provider. And we decided not to keep these, but to just shred them, use them as a tool, a one-time-use tool, and then not make it part of the medical record. So very early results, like I said, we've only been doing this about a month with practice wide. Nobody's reported any problems with it, it hasn't ruined their practices, and we have had several, now, anecdotal successes of patients who put chest pain number five, or — number four or number five on their list, and a few times where the patient wasn't given the form or didn't fill it out, and the provider saying, you know, asking the patient why they didn't fill out the form because they really want this form filled out. So the doctors like it, and certainly, it's not causing a problem for them. We have seen some patients not wanting to fill out the form. Our practice is a little bit weird in that we don't have patients fill out a lot of forms, usually none. So it was - it was — we got a little bit of grumbling, and maybe for a few older patients who it was stressful to have to fill it out. That was why we are playing with removing the comments section at the end, because it just makes the form look a lot simpler, less overwhelming for

some patients, but we may put that back. And we will keep looking at it. And I'm going to continue to solicit feedback from patients, and front desk, and medical assistants, and doctors on the process. Thanks.

Thank you so much, Lane. Before we take any questions, I'd like to share a few additional examples to consider using in your practice. Hey, Nicole, can you give me — thank you. So patients can be asked to set agendas in a variety of ways as you can see from Diane and Lane's examples, and this is another example. This one's called the yellow sheet. And it's called the yellow sheet not just because of the highlights, but because the practice actually prints it on yellow paper. So that's also something that patients have identified when they're working with providers, as Lane spoke about, if the patient realizes they haven't completed the yellow sheet they ask for the yellow sheet now. And also providers, it's an easy cue for them to see if the patient has completed it if that yellow sheet is in the patient's hand when they come in the room. This addresses a number of things to prepare the patient for the visit, fairly wordy. I really liked Lane's simple form, but some practices like to use these longer forms as well. It starts by setting the expectation for a patient that they can discuss one priority item to start the visit, and if the time allows they can discuss other items to choose, or choose to set up a follow-up visit. This is the first and most important thing on the yellow sheet, and by placing it first the patient will also see if it is a priority and fill it out, even if they don't fill out anything else. This is also used as an opportunity for the care team to start the discussion with the patient about their overall health, and to set goals to achieve better health by setting self-management support goals prior to meeting with the provider, so the patient has time to think about what those self-management support goals might be. And this sheet also uses — is used to assess how confident the patient is in their ability to meet their goals. Just like Diane's, it has questions related to tobacco use, depression, and the PHQ-2 and PHQ-9 are both on this form. Here's another example of a form that patients are asked to fill out. On this one, they're asked to choose just one goal. So this form is specific to self-management support goals, not necessarily to the condition that the patient has. So setting an expectation that part of the agenda will be to talk about self-management support goals. It also addresses barriers of self-management support, and this is really an opportunity to discuss these barriers in the context of self-management support, but also identify if those barriers are inhibiting the patients in other ways. For instance, for taking their medication or working on treatment goals that were developed in collaboration with their care team. Instead of using a paper form, this practice that I've worked with has placed dry-erase boards in all of their exam rooms. Patients are asked to write their agenda and goals for the visit on this board. There are three spaces for medical symptoms or conditions and one additional space for the patient to write in a self-management support goal as well. This provides a visual reminder and cue for the patient and provider with the expectation that each of these items will be addressed, or an additional appointment will be set for anything that is missed. A couple additional references that I'd like you to consider are the Right Question Institute, and the Ask Me 3 National Safety Foundation. The Right Question Institute provides effective strategies to integrate into conversation with patients and to better engage them to partner with their health care team through teaching, encouragement, support and promoting the use of tools to develop shared decisions. And I've included the link to this website in the resources section. The Ask Me 3 National Patient Safety Foundation focuses on the patient's expectations for a visit, and how they can interact with the health care team to address their concerns and develop their own

strategies to improve their health. These three questions are: What is my main problem? Which helps the patient to address the prioritization of their visit. What do I need to do? Which addresses the patient's own overall understanding of the visit in action steps that need to be taken. And why is it important for me to do this? Which helps the patient take ownership of the decisions that are collaboratively made during that visit. Now I'd like to turn it back over to Diane and Lane for your questions.

Hi there, it's Nicole Banister. I'm just going to remind you, if you'd like to use your hand I can unmute your line, or if you'd like to type in a question you can use the Chat or the Q and A, and they can be addressed to any of our panelist this afternoon.

Emilie and Nicole, while we're waiting for questions [inaudible], and I had checked with my care manager while Lane was presenting, and I had kind of a cool story to share if that's okay. Just wanted to share with you one of the things that has come out of us using the patient agenda setting sheet was a situation where we had a patient come in, and Dr. Lamb had cared for this patient for a long time and did not have a diagnosis of depression on her — on her — as a diagnosis. And when she listed what she wanted to speak with the doctor about, she didn't mention anything about, you know, having some struggles or anything to that affect, but when she answered the PHQ-2 questions, it was obvious that there was something going on. And so, the nurse gave her the PHQ-9 questions and she really — that completely changed the focus of that visit. That visit became an urgent visit with a referral to a behavioral health specialist for significant depression. And I really believe with all my heart that if we wouldn't have been using that form, and we wouldn't have been asking patients to give us a direction of where they wanted to go with that visit, we might have missed that completely. And that patient, you know, was in a suicidal situation, and she wouldn't have probably shared that with us as openly as she did. So, I wanted to tell you that; that that's a very positive thing that's come from us engaging patients more on what they want to discuss.

Thanks, Diane, for sharing that. I also really appreciated some of the examples that Lane shared about fewer, I think he called them, visit extending surprises. Things that people might not want to say out loud, but they'll write down on a form when they have five or ten minutes alone in an exam room to think about things. Whether it's because it's embarrassing, or they just don't think anybody thinks it's a problem except them. I love that some of these issues are coming out when patients are prompted to write it down and to raise that concern. So thank you both for those examples and stories.

You bet. So in the Q and A there is a question from one of our participants asking if we record, if Sterling records the PHQ-2 questions and their answers into the EHR? And the question to that is yes. The sheets, at the end of the day, actually go back to our care manager, and the care manager actually enters that data into the EMR. In a situation where there was a positive PHQ-2, the LPN or the MA that was rooming the patient would have identified the positive PHQ-2, and then they would have given the patient the PHQ-9 so that the LPN or the MA then would then have recorded the results. But the answer to that is yes. We are recoding those results into the EHR.

And on those same lines, Diane —

I have a question. Oh, I'm sorry.

— it’s Nicole and then we'll go to the other question. Lane and the Family Physicians of Greeley talked about their approach with this — the patient agenda sheet at the end is to shred it or to let the patient take it home. What do you do with your form at the end of the visit?

Was that for me? I'm sorry.

Yes. Yes, ma'am.

We actually — the physicians have a — they basically have an out basket that they put it in, and then those forms are given back to our care manager who then takes the data that's on there and records it into — she keeps spreadsheets, and so she'll record it into her spreadsheet. We also capture the information into our EMR. And then after that the sheets are just shredded.

Great. Thank you.

You’re welcome.

And Emilie, did you have a question?

I did. I was interested to hear from Diane and Lane about how they address literacy or health literacy by using these types of forms.

That's a great question. There are times when we have patients that come in where we do get a little bit of push back. And one of the things — we are a reach out and read site, so definitely understand that there are times that patients, by pushing back, are only pushing back because that's a challenge for them. And so, a lot of times we'll either take that patient — we'll just give the patient the form and let them know that the nurse will discuss it with them in the back. You know, if somebody gives us a lot of push back at the front and they just simply do not want to answer those questions, we don't push them. Just try to be sensitive to that situation so that we don't offend the patient.

Yeah, and our answer is: Right now, the form being so simple, has got a very narrow scope, so I don't think we've been trying to address that with what we have right now.

I've also seen on some additional forms, especially those that are relating to self-management support using pictures instead of words to describe what the practice is asking about. So somebody running, if it's for physical activity; or if someone's smoking, if it's for tobacco use. It's another way to potentially address literacy issues.

And Emilie, this is Nicole. Along those same lines, there was a question from the audience about how our two panelists might address language barriers. Is the form in English and Spanish, or other versions? Do you — Lane or Diane, can you address, maybe, translation or what you're using for patients that don't have English as their primary language?

This is Lane. We haven't gotten there yet. We just have the English language version.

And my answer would be the exact same. That isn't — that doesn't come up a lot in Sterling, but definitely something that we should be looking into and having a version for the patients in other languages.

Yeah, I would say that that's a great idea.

Yeah.

And I'm sure we'll be there soon.

Great, thanks. I also want to point out that Melody posted a link to some patient education materials assessment tools that you can use as produced by AHRQ, an online tool that you might all in your practices, consider in terms of assessment of some of the tools that you have in your offices in dealing with patient education. So thanks for posting that resource.

Any other questions for Emilie or Diane or Lane related to patient agendas?

Nicole, I had another question.

Great.

Diane and Lane, who hands out the agenda form at the start of the visit? Is it something the MA gives them as their walking back, or is it given by the front desk? I know there's a variety of ways that an agenda form can get into the patient's hands.

I would — in our office, we actually have our front desk girls do that. The nurses prepare the form prior to the visit, during the time that they do chart prep, and then those sheets are left at the front desk. When the patient comes in and checks in, the nurse — or the girls at the front desk do the normal things that they need to do with the patient at the front desk, but then what we do is we have some scripting that we share the visit sheet with them. We let them know that this is their patient agenda setting sheet, and that we really want to hear why they want to see — why they're here to see the doctor today. So we'll give them that form at the front desk, and they're actually working on that in the waiting room before the MA or the LPN come out to get them to take them back for their visit. And then we instruct them to give the form to the LPN or the MA on their way back.

Yeah, ours is a similar process. The front desk will hand it to them with a little clipboard when they check in, and ask them to — first of all, say this is something that the doctor — this is information that the doctor is wanting from them, and — but of course, it is optional. And we ask them to go sit down to fill it out. We don't want them to be up at the front desk filling it out, because they're probably less likely to write down everything that they're actually there for in front of the person at the front desk. And of course, that will hold up the line. So we have them go sit down, and they'll often continue to, if they get called back right away, they'll often continue to fill it out in the exam room.

Great. Thank you both for that response. Emilie, I see a raised hand from Lisa. Lisa, do you have a question you want to ask out loud to our panelist?

Yes, hi. I was interested in how you are able to assess how this is impacting either outcomes or patient satisfaction, or physician satisfaction? I know you both have mentioned patient advisory council, so I was wondering if you were planning on bringing this back to them, as well as if there's any way that you can think about measuring whether or not this truly is a timesaver, and some of the other things you had mentioned as potential benefits.

So I would say in our clinic, we do meet with our Patient and Family Advisory Council quarterly. And I know that the girls that facilitate that, our care manager and our coordinator in our clinic, have taken that information into that panel and talked to them and asked them what their thoughts were on it. Is it helpful? Is it — does it bog you down? You know, how do you really feel about that? And they have a good group of people that have shared openly with them. So, we feel like that's a part way of gauging, you know, whether it's helpful or not. The other thing that we do is we do survey our patients, and there are questions, maybe not specific to the patient agenda setting sheet, but there are questions specific sent to the patient asking them, you know, about their patient experience, and were they listened to, and were they taken care of? And you know we really gauge those scores. We really rely heavily on the scores of those surveys to gauge, you know, how we're doing. Are we improving the patient experience or not?

I've struggled with how to measure this, because we know that having the patient fill out something is a negative thing, but — and then for us, it's maybe kind of a shock to a lot of patients that have to fill out this new form. But I wonder if, like, after we've had a year of experience like Sterling has, if that period will be over and people will embrace it more. And I'm not sure if this would — we might just have to continue to collect anecdotal information; ask patients as they're leaving what they thought about it. I have been asking a lot of MAs what reactions they get, and doctors of course, what reactions they get from patients filling it out. And so it's mostly anecdotal, no data at this point. And the timesaving question has also been anecdotal, but I think the doctors would tell me if they thought it was bogging them down.

Thank you both for that response to Lisa's question. I also see a question in the Q and A box from Frances asking how patients like having the white board set up in the exam room and how exactly is it set up. This is probably a question for Emilie. I think this is the practice that she coaches.

Yes. So here's a picture of the white board set up in the exam room. So it's right there by where the patient sits. We've actually talked about different locations within the exam room. If it's better if it's closer to the chair so that they can do it while sitting down. Or up above, some patients have a hard time reaching up that high to fill it out, or if someone's a little bit shorter. I'm pretty tall so it's a little bit easier for me. So we talked about that quite a bit. But I've also seen practices instead of printing out the paper for each of the patients; that they actually put it as a laminated copy into the patient and they give them a dry erase marker, and then they fill it out that way. And then later on, the MA or front desk person, or whoever is assigned, will erase it. So the information is captured on that piece of paper, but it's not necessarily something that they're going to put into the EHR. But that's been, at least, a paper saving idea for those practices. And that could be done with the white board as well, if you had those

resources or the patients given the white board, or the white board comes off of the wall to be used by the patient.

Frances, did that answer your question?

Frances might not be able to answer verbally, but if you want to send us a chat you could let us know yep, sounds like that was a good insight. Thanks, Emilie.

Great.

Any other questions from the audience about using patient agendas or some of these similar tools to help to guide visits, and to avoid that, oh, no, one last thing I forgot to tell you about after you've been in the office with the patient for 30 minutes? Frances posted a comment that she likes the idea about using lamination. And I think that's maybe inline of maybe not going through as much paper, but having some reusable resources. So thanks for that comment.

Any other questions for our panelists related to patient agendas today? All right. Emilie, do you have any closing comments before I do a couple wrap-up remarks?

I don't. I'd like to thank everyone for participating today. Lane and Diane, we really enjoyed hearing what you had to say about patient agendas.

[Overlapping speech]

Yes, I think it was a great session.

Thank you.

With that, I'm going to remind you that as WebEx closes, you will be automatically directed to a survey, and we appreciate your feedback on the survey so that we can continue to improve our learning sessions. In addition, please remember that it's important to accurately collect information on each individual and each organization that is in attendance. So please complete the exit survey as you leave, as well. Thanks so much for your participation, and I will see you again in the June Colorado webinar. Thanks, and have a great day.