Agenda Setting in the Outpatient Visit

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In preparing for battle I have always found that plans are useless, but planning is indispensable.

―Dwight D. Eisenhower

Learning Objectives:
1. Explain the importance of effective agenda-setting for an outpatient visit
2. Identify potential barriers to effective agenda-setting
3. Demonstrate effective agenda-setting using the exhaustive “What else?” and negotiation of priorities at the outset of the encounter
4. Discuss core elements of visit closure

Primary Reference:

Included Resource:

Author’s Note to Moderators: For the questions that follow, the moderator should consider “playing the role” of an imaginary patient/parent for the learners to demonstrate their techniques, or delegate this role to a willing and able learner. The purpose is to encourage participants to try out and share different words or phrases for inviting and negotiating an agenda, and to prompt the group to problem-solve obstacles drawing on their own (and your!) experiences. Consider challenging a more senior learner with the scenario of a parent who has several significant concerns but tends to digress with a story about each concern as it is first introduced.

CASE ONE:

You see a 12-year-old girl, Justa Minit, for stomach aches. Her mother brings up two other issues during the visit, and you don’t feel that you have time to address the stomach aches fully, so you ask the family to return in a month. You secretly hope to address weight-related issues at the follow-up. When you enter the room for the second visit, though, the patient’s mother pulls out a list of concerns and says she hopes you will have time to take care of everything this time since you were so rushed at the last visit.

1. How many concerns does a typical pediatric patient or parent bring to an outpatient visit, and why?

Most studies of patient agendas have focused on internal medicine or family practice settings, with an average of 2 to 3 concerns per visit, ranging up to 5 or more. Anecdotal experience suggests comparable agendas for pediatric patient/parent visits. Sometimes, a patient comes in to address several issues which arose in a short period of time. More often, though, one issue prompts a visit, and the patient or parents see the encounter as an opportunity to address other ‘saved-up’ issues.

Parents may ‘save-up’ issues for a variety of reasons. They may defer a separate visit because of the cost or the time required to come in. They may worry that a relatively small issue in isolation would be unworthy of the clinician’s time. There may also be issues that were previously unaddressed because of privacy concerns (e.g., another person in the exam room). Sometimes, an issue arises which a patient or parent had not quite realized needed to be addressed until they were at the appointment; sitting in
a waiting room can focus the mind on medical issues.

It is important to remember that the agenda for a visit often also includes, or needs to include, items that the provider deems important (e.g., growth abnormalities, overdue immunizations, directly-observed parenting issues), so that the “menu” of potential agenda items can be even longer.

2. Why do some providers try to address all the concerns in multi-issue visits, and what problems can this cause?

Providers’ motivations for addressing the entire list of patient and provider concerns in a given visit may include:

- the desire to address issues while the patient is present (i.e., fear of future “no shows” or limited open appointment slots)
- concern about penalizing the child because of a parent’s inability to structure the visit time together
- recognition of the difficulty involved in some patients making it to the office (due to transportation difficulties, disabilities, or having to miss work/school)
- guilt over the provider already running behind schedule creating a reluctance to limit the scope of the current visit

While provision of comprehensive care is our ultimate goal, it is simply not practical to aim to do this at every visit. First, doing so may overload the patient and family, and cause them to leave feeling stressed and confused. Patients may leave with confusion about multiple separately-formed plans (which prescription is for which problem?); recall of physician instructions drops precipitously after two separate lines of instruction. The actual handling of each issue may be compromised as the clinician may not have time to investigate problems thoroughly or may rush to make a plan which will help end the visit on time. Shortcuts on information gathering to save time can lead to unnecessary testing, over-prescribing, or inadequate discussion or explanation about treatment options. Inadequate handling of multiple issues by the provider can lead to patients feeling ignored, dismissed, or blamed for seeking help. Ironically, this can lead to more saving-up in the future.

There are also potential negative consequences for the provider. Trying to accomplish too much in a given visit may set us far behind, thus frustrating the patients who come afterwards on our schedules. Clinicians often leave over-packed visits feeling annoyed at the patient, frustrated because they just delivered suboptimal care, and stressed because they are heading into their next visit late. On a chronic basis, the impact can be broader, leading to frustration among clinic staff, colleagues, and our friends/loved ones. Lastly, a provider running behind schedule on a frequent or regular basis is simply not sustainable from the standpoint of healthcare resources (e.g., provider and clinic staff time) and patient tolerance.

Good agenda setting can help make sure that you address the most important issues. It also creates a partnership between patients, families, and providers in managing the time available to best address healthcare needs. Done properly, agenda setting can help a patient understand how time will be spent, and why it is preferable to not take care of everything they might have wanted to talk about.

3. What are some perceived barriers to negotiating a visit agenda? What are some useful agenda-setting techniques?

Some participants may cite the perception that it is too time-consuming to do detailed agenda-setting; point out that in a study by Marvel and colleagues, patients who were allowed to complete their opening “statement of concerns” took only 6 seconds longer than those who were prematurely redirected away from this; and that the substantial reduction in “doorknob complaints” (see more below) saves time at the tail end.

Some participants may cite the fear that patients/parents may just “keep on going” with a “positive review of systems.” Point out that a large number of separate concerns is statistically less common, and when it does occur may have some diagnostic meaning in itself (e.g., may indicate parental anxiety/depression or a breakdown in coping).

Some participants may fear that negotiating a subset of the concerns to address at a single visit may be taken as offensive. But patients rarely protest the need to postpone some items in a busy agenda to a
subsequent visit if (1) the importance of the patient/parent’s concerns are validated (using explicit language to do so); (2) an honest attempt is made to deal expeditiously with the most pressing ones; and (3) this is all dealt with up-front, early in the visit.

**Invite learners to share their experiences and strategies for building agendas, including specific language that they use with patients.** A well-described strategy advocated in Smith’s Patient-Centered Interviewing involves:

- an explicit request for the “list” (e.g., “I’d like to get a “LIST” of all the things you were hoping we could focus on today”)
- respectful interruption when patients digress during creation of the list, with explicit intent to return to earlier complaints (e.g., “That sounds important, and we’ll get back to it very soon, but before we do, what else did you want us to work on today?”)
- relentless inquiry into other concerns - the exhaustive ‘what else?’ until the “towel’s wrung dry.”
- mention and possible addition of any provider-driven topics that are on your mind
- negotiation of the agenda to a manageable number of topics for the visit.

Mentioning the allotted visit duration can also be very powerful; we know how much time that is, why not share that important information with the parent/patient? (Moderators should consider that it is usually fruitful to explore learners’ apprehensions about doing this, and discussing ways it can be done that would not be perceived as “rushing” or offensive to patients).

When it is medically appropriate to do so (i.e., when no concern is emergent), invite the patient to prioritize. For example, “Stomachaches can be complicated to sort out at this age. I want to make sure we don’t rush that conversation. In the 20 minutes we have together, should we focus all our attention on the stomachaches, or the two other things you brought up?”

Some providers encourage patients to bring a written list of their concerns to the visit. As pointed out by Olson, while these can appear intimidating at first, they can be helpful in organizing the visit and streamlining the agenda-setting process.

An initial list can be made by a nurse or medical assistant or using a questionnaire, but it is still important for the provider to double-check since sensitive concerns may not have been articulated through these methods.

Finally, keep in mind that many problems may not need to be solved. Families may be informing you of things as a trusted confidant or just to be heard, in which case an expression of empathy would be appropriate. Additional issues may be raised simply to keep you informed, for example if a child is seeing another provider for that issue already.

4. What is the “doorknob complaint”? Why do doorknob complaints happen, and what can be done to minimize them and address them when they do occur?

A doorknob complaint (DKC), also known as the “late visit concern,” is a significant or potentially serious concern brought up by the patient at the close of the visit. The concern may be too major to postpone to a subsequent visit. **Invite a few learners to share particularly illustrative anecdotes (supplement with your own if necessary).**

DKCs can happen when a patient/parent has (unbeknownst to the provider) used up the visit time on minor/less important issues or simply forgotten one issue until the end. In some situations, a patient/parent may be nervous or embarrassed about bringing up a concern, and only when time is suddenly out, or enough comfort has been built with the provider, do they find the courage to bring it up. DKCs can be minimized (although not entirely eliminated) by: (a) careful agenda setting, generating and negotiating a mutual list of concerns at the visit outset (using provider-driven redirection to this task until completed) and (b) use of a patient-centered approach early in the interview, along with explicit empathy, in an effort to “jump-start” the provider-patient relationship and create a safer environment for discussing sensitive issues.

Despite a provider’s best efforts, in rare situations, a patient may intentionally set up a situation where you have to address a question quickly in hopes that you will give them something specific that they want (e.g., nebulizer that a colleague had previously advised against in favor of a metered-dose-
inhaler).  

When faced with a DKC, pause to be sure you understand the nature of the issue. What sounds like a new problem may actually just be an update or a simple request. If the problem seems complicated but not urgent, validate the concern and arrange for a future visit. This conversation may also involve teaching the patient to more effectively advocate for their own needs in the future: “That’s an important issue, and I’m glad you’ve told me. Let’s make that the focus of your next visit, and please add important things like that to the top of your list down the road so I make sure we cover the issues most important to you when we are together.”

5. **What if there are simply too many important agenda items, or a serious “doorknob complaint,” that cannot be deferred to a subsequent visit?**

Encourage participants to brainstorm “solutions” (e.g., asking a patient/parent if they can return at the end of the afternoon to continue the visit, fixing a time later to speak by phone). None of the options or chosen courses of action will be entirely satisfactory. Ultimately, we each develop our own style or approach in our practices. In developing this style, we must recognize the resource costs and/or disadvantages inherent in each and every one of the options.

CASE continued:

You employ agenda setting strategies over your next few visits with Justa and her mother. You manage to address their pressing issues and even prioritize a motivational interview related to her obesity. You are pleased with the progress you’ve made with the content and structure of your visits. Justa’s father brings her to the next visit. Twenty-five minutes into the visit, you’ve covered everything you had agreed to discuss but the father is still talking and does not seem ready to end the visit anytime soon.

6. **What strategies can you use to end the visit smoothly?**

There are three fundamental elements to visit closure:

- **What the patient will do next** (“You had some great ideas about how to improve your health through healthier eating. You’ll put those in place and get the blood tests done like we discussed.”)

- **What will the provider do next** (“I’m going to find those recipes for healthy pancakes that we talked about and the medical assistant will bring them to you in a few minutes.”)

- **When is the next point of contact** (“I’ll send you an email message in the EMR patient portal in a week to see how you’re doing, and then I’ll see you back in the office in 1 month.”)

One must allot time for these tasks and to make sure the patient and family are clear about the plan, ideally using a strategy such as the teach-back method (refer to the module on Health Literacy for a more detailed discussion).

The transition to a discussion of these end-of-visit elements can be challenging at times. A recap of the agreed upon agenda with a framing statement (e.g., “We got a lot done today.”) can be helpful. A reflection back on the time allotted for the visit is also useful (“I learned a lot about you these past 20 minutes!”), and is another reason for informing the patient about the time available for the visit during agenda setting. Ultimately, if subtle strategies are ineffective, a more direct statement may be necessary (“Your job sounds fascinating, and I’d love to hear more, but we’ve got to wrap up now. I want to use the last 2 minutes to be sure we are all on the same page about the next steps for Justa’s health.”).

**ASSIGNMENT for learners:** During your next patient care session begin each presentation to your preceptor with a 20-second description of the agenda you developed for the visit, and which concerns you deferred (if any).

**Example 1:** “Ms. Jones was concerned about Johnny’s recent respiratory symptoms, a recurrent rash, and toilet-training. We agreed to focus on the first 2 concerns today and the other in 2 weeks”

**Example 2:** “Mr. Smith was concerned with his daughter’s chronic earaches, but then also mentioned
that he thought she’d been fondled at school. We agreed to tackle the latter and save the earaches for a follow-up that’s already scheduled next week.

Example 3: “Ronnie was brought for his 5-year well-child check today. There have been some concerns with his behavior at preschool. We agreed to complete his vaccinations and routine screenings today, and his mother is going to come back in 3 weeks when she has a babysitter for the other kids. Meanwhile, I asked her to sign permission for me to phone his teacher next week.”

Additional References:

Resource:
1. Institute for Family Centered Care. http://www.familycenteredcare.org/