

Patient Overview Process

A Human Factors Intervention to Reduce Risk in Primary Care of the Elderly

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Introduction

Our research has shown that many of the problems in the care of elderly patients are due to physicians having inadequate or confusing information during the visit. The purpose of this toolkit is to provide care teams with the information they need at the time that they need it. The use of the Patient Overview Document (POD) and a team huddle can make visits more efficient, effective, and safer for patients, and more satisfying for everybody.

The Patient Overview Process

Goals of the Patient Overview process:

1. To provide the care team with information about the purpose of the patient's visit,
2. To bring to the care team's attention to the things that they need to address during the visit
3. To ensure that the care team has all the necessary information on these issues.

We think the Patient Overview process will:

1. Allow the care team to plan for the visit and address the patient's issues more efficiently at the visit rather than scrambling during and after the visit to obtain needed information.
2. Allow the physician and the patient to set the agenda for the visit, and to address the patient's immediate needs as well as the patient's ongoing medical status, for example, managing his/her chronic medical problems and addressing preventive health needs.

The Patient Overview process: 3 Components

1. Pre-visit care coordination using the POD. This includes:
 - a. Reviewing the patient record to understand the patient's care needs and documenting this using the POD as a guide,
 - b. Calling the patient 4 to 5 days in advance of his/her appointment to complete the POD, and
 - c. Obtaining additional information relevant to the patient visit that is not already available.
2. Team huddle between the nurse/MA and physician. You will discuss the completed POD with the physician on the day of the patient visit and obtain any additional information needed by the physician for the visit.
3. Physician uses the POD and any additional information collected during patient visit.

Detailed Instructions: Information to Collect for the Patient Overview using the POD

There are 10 sections on the POD that provide the physician with information needed to address the patient's reasons for the visit and issues important to the patient's ongoing care.

The purpose is to help the doctor focus on what is most important. You will need to provide enough information to guide the doctor's attention and understanding of what you and s/he needs to know and do. If there is no information or no new information write "none". If a topic is not applicable to a particular patient, put a line through the section or write "n/a".

You should focus on the information that is new since the last visit with this provider.

The Patient Overview process is **NOT** meant to replace the medical record or the patient/doctor interaction during the appointment although you and your physician may use it to document the patient visit. Its purpose is to help guide the patient/doctor interaction to make it easier for the doctor to focus on the most important things and to assure that all needed information is readily available at the time of the visit.

The following items are considered **the most critical sections of the POD** and should **be filled out for all patients: Reasons for Visit, Follow-up Items, Visits with Clinicians, Lab/Test Results, Medication Changes / Problems**. Note that these items have asterisks (*) around them on the POD.

Header

Fill in patient name, patient age, Nurse/MA name, date of last appointment, date of phone call, and role of person spoken to, e.g., patient, spouse, family member, or other caregiver. Most of the time you will obtain the information for the POD directly from the patient, however, the patient may authorize you to speak to someone else to obtain the information or the patient may not be able to give you the information, e.g., the patient has dementia or is not feeling well. If the patient's chart indicates that the patient has an activated healthcare power of attorney, then speak to this person if available. If the person who has the healthcare power of attorney is not available, you may still be able to complete much of the form by questioning a spouse, family member, or other caregiver, but if that person is not a medical professional, you will need to keep in mind HIPAA rules when sharing information with that person.

Reasons for Visit

The purpose of this section is to let the physician know what problems/issues the patient wants to discuss at the appointment. The reason recorded on the schedule for the patient's visit may not always be clear, or may not have enough detail.

- Ask the patient, "What are the things you want to talk to the doctor about?" and list these items here.
- Also note if the patient needs any forms filled out (e.g., for truck driver license renewal).
- If the patient tells you that s/he has a personal item to discuss, and only wants to talk to the doctor about it, include this so the physician knows there is an additional issue requiring attention.
- End this section by asking, "Is there something else you'd like to talk to the doctor about?" until the patient says, "No". Saying "something else" rather than "anything else" is a more inviting way of asking the patient to tell you more.

Patient Questions

The purpose of this section is to let the physician know if the patient has specific questions or requests that need to be addressed during the visit.

- Ask the patient, “What questions do you have for the doctor?” and list these questions here.

Ongoing/Chronic Problems

The purpose of this section is to obtain updated information on the patient’s ongoing and chronic problems. There may be medical problems that need ongoing care yet the patient does not make specific appointments to get this care, leaving it up to the nurse/MA and physician to recognize these problems and what needs to be done.

- Review the last clinic note, history and physical note, or problem list in the chart for a list of the patient’s ongoing medical problems.
- If there is a problem list or a past medical history list in the chart, ask, “Have there been any changes in your health problems?” Focus on his/her ongoing and chronic problems (e.g., asthma, diabetes, hypertension, heart disease, etc.) that haven’t been already discussed in the Reasons for Visit.
- If a current problem list or past medical history list doesn’t exist in the chart, ask the patient what health problems they have and list them here.

Follow-Up Items

The purpose of this section is to review the previous clinic notes to see what the doctor recommended that the patient should do, and follow up with the patient to see if the recommendations were followed.

Doctor’s Recommendations

- Review the last clinic note(s) to see if the physician made any recommendations to the patient (e.g., walk 3 times a week) and document these.
- Ask the patient, “Is there something else the physician told you to do or that you were supposed to be working on?”

Actions Taken by Patient

- Ask the patient what his/her progress has been with regard to the recommended actions and document this.
- If the recommendation was to get labs/tests done or to consult with another clinician, you may write “see below” and fill in the information under the relevant section on the POD.

Lab/Test Results

The purpose of this section is to ensure that labs and tests ordered at or since the last visit were completed and that the results are available.

Labs/Tests/Date

- Review the last clinic note and other relevant sources to see if there were any labs, tests, or imaging studies ordered or completed since the last physician visit. These could have been done at the clinic or outside the clinic.
- Record the name of the test (e.g., CBC or mammogram) and the date on which it was done.
- Ask the patient if s/he has had any other tests since the last visit, especially outside the clinic, and record these here. Obtain the results if not already available.
- If the lab hasn’t been done yet and it is supposed to be done before the appointment, make a note of this and remind the patient that it needs to be done before the visit.
- If the lab or test needs to be scheduled, assist the patient or refer him/her to someone who can schedule it and note this.

Results

This section can be used in multiple ways, e.g., you may indicate if test results are available or where to look for them.

- If the results are not easily accessible for the physician, or if the physician prefers it, print the results and attach them to the POD. You do not need to write down exact lab values unless specifically requested by the physician.

Visits with Other Clinicians

The purpose of this section is to gather information about any appointments or test results that were done with another clinician or at an outside facility. Asking the patient about this ahead of time will give you the chance to locate reports or results that are not readily available.

Clinicians/Date

- Review the last clinic note and other relevant sources to see if the patient had any visits with other physicians or health care professionals since his/her last visit and record these.
 - This could include visits with specialist physicians, with another physician or clinician in the clinic, with an allied health professional such as a physical therapist, a trip to urgent care, or a trip to the emergency department.
- Relay this information to the patient and ask the patient if there were any other visits with outside clinicians since his/her last appointment with his/her physician.
 - Example: "I see in your record that you saw the Cardiologist last week. Is there anyone else you've seen since your last visit here?"
- If the last clinic note indicates that the patient was supposed to see another physician or health care professional but you do not have documentation of that visit, ask the patient about it. If the patient did not complete the appointment, ask the patient why and attempt to overcome any barrier to scheduling the appointment. Example: "Was there a problem with scheduling or making the appointment? Would you like help with this?"

Descriptions of Visits

- Review relevant paper/electronic information from the visit to see what the main outcome(s) or recommendation(s) from the visit were and record it.
- If there is no record of the visit or results, ask the patient if h/she knows what the results were. Example: "I see Dr. Smith referred you to a Cardiologist for your heart problems at your last appointment. How did this visit go? Did the cardiologist recommend anything to you such as a change in medication dose?"
- Obtain documentation of the visit. If your doctor routinely receives documentation from visits with other clinicians, you may wish to first ask your doctor if s/he has already received this documentation.
- If the patient has not yet been informed of the results, but the results will be discussed at the visit, indicate this for the physician and check it as an item that will require the physician's attention.

Home Readings

The purpose of this section is to gather some information about blood pressure or blood sugar measurements that the patient may take at home. Asking about these readings before the visit can help the physician quickly assess how the patient is doing.

- If you know or suspect that the patient takes either blood pressure or blood sugar readings at home, ask the patient what the readings are and document the readings here. You do not need to record all the readings the patient has taken. Instead, record where values are normally at and if there have been any abnormally high or low measures.
- Ask the patient to bring the detailed information to their appointment.

Health Overview Changes/Problems

The purpose of this section is to allow the nurse/MA and patient to review aspects of an elderly patient's health that may not be routinely discussed but that can affect their health.

- Ask the patient, "Have you had any changes in ____?" If the answer is yes, ask for more specific information.
- Use your judgment regarding whether or not to skip a question. For instance, if you know the patient hasn't consumed alcohol or smoked in 20 years, you don't have to ask about his/her alcohol or tobacco usage. Another example: if you know the patient is in a nursing home, you don't need to ask the patient where s/he is living. However, you should still make a note on the POD. For instance, write "none" for smoking and alcohol usage and "nursing home" for living arrangements.
- If there have been no changes, but the patient tells you the current status of the issue, record the current status.
- If one of the topics was already covered in a different category, it does not need to be asked again. For example, if the patient discussed problems sleeping as one of his/her chronic problems, you do not need ask again about sleep.

Health Maintenance

The purpose of this section is to review preventive care, or health maintenance, which is often not addressed when a physician and patient are dealing with multiple active medical problems at each visit.

- Review the patient's chart for information about health maintenance.
- Record the results and/or year from the last time the patient had health maintenance procedures, tests, or immunizations.
 - For immunizations, look for immunizations that the physician normally wants to keep updated (e.g., tetanus, influenza, pneumonia, shingles).
 - Based on your knowledge of the patient and the accuracy of your records, you may ask the patient when something was last done. Otherwise, you do not need to ask the patient to confirm this information.
 - If it has been a while since the last recorded test result, you may wish to ask the patient if there is a more recent result available. For example, if the last eye exam in the record is from 5 years ago, ask the patient if there is updated information.
 - If the patient indicates that he does not want to have the test or vaccination, document that on the form as well.
- Note that bone density screenings are not routinely applicable for men.
- If you already have a system worked out with your physician for recording information about health maintenance, you may continue to follow that system. For example, you routinely use "UTD" to indicate the test is up-to-date based on recommendations that you and your physician/clinic follow.

Medications: Changes/Problems

The purpose of this section is to learn if the patient has had any changes or problems with his/her medications and if s/he needs any refills. **This is NOT meant to be a medication reconciliation process.** If there is additional medication information you need to document you may do so on a blank page.

- Ask the patient if s/he has had any changes, problems, or concerns with any medications since the last visit.
 - Changes may include taking extra medication, not taking the prescribed amount, or discontinuing the medication.
 - Problems/concerns may be side effects or adverse reactions from the medication or not being able to afford the medications.

- If s/he needs medication refills, indicate it here and start/complete the process for the physician if that is the normal clinic procedure.
- Remind the patient to be sure to bring all his/her medications to the next the visit “so we can be sure that our records are correct”. This can be an opportunity to clear up any confusion about what medications the patient is taking as s/he can review his/her medication bottles with you.

“Attention”, “Information Available”, and “Notes”

The “Attention” and “Information Available” boxes are tools that will help you track information that you think will be important to relay to the doctor during the huddle and that will help you make sure all the information that is needed for the visit is readily available.

Attention Box:

- Mark this box, if in your judgment, the physician should address or be aware of or take action on this information during the visit.
- For example, if the patient mentions he went to the emergency department for chest pain while vacationing in another state when you ask him/her about **Visits with other Clinicians**, mark the Attention Box next to **Visits with Other Clinicians**. Or, if you believe a vaccination or mammogram is not up to date and may need to be ordered, check the Attention Box next to **Health Maintenance**.

Information available:

- Mark this box to indicate that there is NEW information since the last visit that is available in the place that the physician would expect to find it. For example, if a patient saw a cardiologist and the cardiologist’s note is available in the chart, check the **Information Available?** box next to **Visits with other Clinicians**.
- If something is missing, use the 4 to 5 days before the appointment to locate that information.
- Once the information is located, check the **Information Available?** box.

Example: The patient says that she went to an Emergency Department a month ago for dizziness, but there is no record of the Emergency Department visit in the paper chart where it should be. Before the patient comes in for her appointment, the nurse/MA should communicate with the Emergency Department to obtain information about the visit, place it in the proper part of the chart, and then check the **“Information Available?”** box. If your clinic has electronic health records and outside records are faxed to the clinic, consider keeping a copy of the fax with the POD for the physician to view during the visit.

Notes:

This section can be used by the nurse/MA or physician to take notes on something s/he wants to remember regarding the information on the POD. For example, the nurse might write a question that she wants to remember to ask the physician during the huddle or jot a reminder to get information from an outside hospital. During the huddle, the physician might use this section to record reminders to him or herself to ask about certain things during the visit or to help him or her prioritize problems for the visit.

Tips for Interviewing Patients and Completing the POD

- Use the “cheat sheet” as a guide when asking questions to the patients.
- Go through the POD section by section
- It’s okay if you need to pause to look something up or to check on something, just let the patient know this is what you are doing.
- If the patient tells you something, there is an expectation that this information will be relayed to the physician, so write it down.
- If you don’t feel comfortable asking a patient about a sensitive topic on the phone, but still feel it may be important for the visit, make a note of it on the POD for the doctor. For example, if the physician addressed erectile dysfunction at the last visit and prescribed a medication for it, but you are not comfortable asking the patient how the medication has worked, note “erectile dysfunction” under the **Ongoing/Chronic Problems** and the prescribed medication under **Follow-up Items** and leave the **Actions Taken by Patient** blank.

Timetable for Completing the Patient Overview Process

4-5 Business Days before the intervention patient's scheduled visit...

Before you call the patient...

1. **Review** the last clinic note. You may print the note and attach it to the POD if that is what your physician would prefer. If the last clinic visit was for an urgent care issue or procedure, also print and review the previous clinic note. The goal is to have a clinic note available for the physician that provides context for the upcoming visit (e.g., the patient's ongoing medical issues, what the patient was previously instructed to do and follow-up on.)
2. Review the patient's chart and other relevant sources of medical information to gather information about things that occurred since the last patient visit, including
 - Clinic notes
 - Lab results
 - Radiology/imaging results
 - Procedure reports (surgery, colonoscopy, biopsy, etc.)
 - Notes from visits with other clinicians
 - Health maintenance/ preventive health care
 -
3. Fill-in the following relevant sections of the POD: POD Header, **Ongoing/Chronic Problems, Follow-up Items, Lab/test results, Visits with Other Clinicians, Health Maintenance.**

Calling the Patient...

1. Set aside at least 15 minutes to complete the POD phone call.
2. Use the following script during the phone call
 - Introduce yourself
 - Identify where you are calling from
 - Explain that you are calling to collect some information for the doctor before the patient comes in for his/her scheduled appointment and that you'll be asking some questions that should take about 5 to 10 minutes.
 - Confirm that the patient is still coming in for their scheduled appointment.
 - If the patient asks why you are collecting this information, state:
 - "Your doctor would like me to collect information about your needs for the visit ahead of time which will help us take better care of you during your visit."

What if the patient cancelled or rescheduled the appointment?

- Ask the patient the date and time of the rescheduled appointment and who it is with. If the rescheduled appointment is **within 5 business days of the original appointment** (sooner or later), **continue** the process of completing the POD with the patient. Then, note on the POD the date and time of the rescheduled appointment.
- If the appointment **has not been rescheduled**, has been **rescheduled more than 5 business days after** their previous appointment, thank the patient and hang up.

What if you reach an answering machine?

- If you reach an answering machine, leave a message saying you will try reaching him/her again or that the patient may call you back at a specified phone number.

What if the patient does not have the mental or physical capacity to participate in the interview or wants you to talk to someone else?

- If in your review of the chart or your assessment of the patient when they answer the phone, you determine that the patient does not have the mental or physical capacity to participate in the interview (for example, if the patient has dementia or is hard-of-hearing), you may ask to speak to a spouse, family member or caregiver to complete the POD. (Examples of caregivers include a relative, sibling or child of the patient, a friend who lives with the patient or who will be attending the visit with the patient, or a home health aide or nurse who knows the patient.)
- If the patient wants you to talk to someone else to complete the POD, consider this permission to talk to that person. Do the best you can to complete the POD with them.

What if the patient does not want to talk to you?

- Don't feel bad. If the patient objects, find out the reason for the objection. It may be that the timing of the call is inconvenient or s/he would rather that you talk to a spouse, family member or caregiver. Be accommodating. Encourage the patient to spend a few minutes with you on the phone to at least complete the starred items on the POD.
- If the patient absolutely refuses to then you will say, "No problem. We'll see you in clinic."
Complete as much of the POD as you can from the chart and use this for the physician huddle.

How often should I try to call the patient?

- The POD phone call can occur up until the day before the scheduled patient visit. Please try a reasonable number of times to reach the patient before the visit – at least 10. That is, attempt to call the patient at least twice a day, changing the time of day when calling to maximize your chance of reaching the patient at home. If the patient has a work number available, you may also try to reach him/her at work, and if necessary, arrange another time to discuss the POD.

Before the patient's scheduled visit...

1. Obtain any missing or needed information for the visit (missing lab reports, consultant notes, hospital discharge summaries, etc.).
2. Complete the "Attention" and "Information Available" boxes on the POD.
3. It is OK to discuss the patient visit with the physician prior to the huddle on the day of the visit if there is an item that needs attention, for example, to obtain approval to order a test or lab ahead of time, medication refill, to discuss concerning symptoms the patient is having, or if you are unsure about what information physician would like obtained prior to the visit, etc.

On the day of the patient's visit...

1. Huddle with Physician to provide him/her with a patient overview using the POD.
 - It is critically important that the information in the **POD** be discussed with the physician shortly before the patient's visit. Most often it will be easiest to do this at the beginning of the

physician's clinic session during which the patient's appointment is scheduled (i.e., the morning or the afternoon session), but it could be done immediately prior to the individual patient's visit if that works better.

- Review the information on the POD with the physician. Talk the physician through the information you gathered and use your clinical judgment and the notes you made to identify what you think is important and which patient questions you think need to be dealt with. These items should have the "Attention" box marked.
2. After the huddle, put the **POD** on the top of the patient's chart so that it will be available during the patient's appointment and obvious to the doctor.

What to do if....

1. The phone call is taking too long?
 - Some patients have the gift of gab, but you may not have the gift of time. Other patients may have a lot of information to share since the last visit, e.g., they were hospitalized or have seen multiple specialist physicians. The goal is to "streamline" patient questioning to cover and record the "big things". If the patient is unsure of something, note that and move on. Plan for at least 15 minutes on the phone. If the 15 minutes is nearing an end, complete at least the starred areas of the POD. The starred areas of the POD are the areas that should always be completed with the patient when possible.
2. The patient is really sick and you think s/he needs to be seen by the doctor or someone else sooner?
 - Follow your normal clinic procedures for triaging patient problems. If the patient intends to keep the scheduled appointment with the doctor, finish completing the POD.
3. The patient refuses to give you permission to obtain records that you need?
 - Note on the POD that the patient refused to give permission to obtain outside records.
4. What if the patient or caregiver cannot stay on the phone to complete the POD?
 - Schedule a time with the patient to call the patient back to complete the POD. Make as many phone calls as are needed to complete the POD and obtain needed information before the patient visit (obviously one call is preferred for efficiency sake).
5. What if the patient is currently in the hospital when the POD call is made?
 - Ask if the patient will be discharged soon and plans to come to the scheduled appointment. If yes, complete as much of the POD with the caregiver or family member as possible and obtain the hospital records when available.
6. What if the nurse/MA who called the patient and filled out the POD is sick on the day of the POD visit?
 - The covering nurse/MA should review the POD and do her best to review the document in the huddle with the physician before the visit, highlighting the reasons for the visit and any sections with extra information available or needing attention. At a minimum, ensure that the physician gets the POD for the visit. Example huddle, "Dr. White, Carol filled out the patient overview document for this patient. My review shows that she is here to discuss three things, 1) ear pain, 2) diabetes, and 3) back pain. It looks like she was at Memorial hospital last week and a discharge summary is attached. She is also having problems affording her medications."

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Patient Overview Process Patient Checklist for Nurse/MA

Date of Patient Visit: _____

Date to Call Patient (4-5 days before Visit): _____

- Review Patient Chart
 - Review Last Clinic Note and attach to POD if desired
 - Review patient chart and complete applicable POD sections

- Call Patient and Complete POD (4-5 days before Appt)
- Obtain Additional Information as needed and complete Attention and Information Available boxes
- Day of Appointment:
 - HUDDLE with physician using POD
 - Put POD the front of the patient's chart