

**Evaluation of AGenda mapping
skill - Instrument
(EAGL-I v1.5.1)**

Coding manual

Gobat N.H., Kinnersley P., Gregory J.W & Robling M.

Evaluation of AGenda mapping skill – Instrument (EAGL-I)

“Agenda setting”, “mapping” and “navigation”

The term “agenda setting” has been used across the healthcare literature to mean different things. In essence “agenda setting” describes a process through which healthcare clinicians and patients establish the conversational focus of the clinical encounter. The origins of agenda setting lie in the patient centered clinical method and in Motivational Interviewing. As a result agenda setting is understood to be a shared process with mutual engagement and collaboration at its heart.

Agenda setting may occur as an implicit process in which the conversational focus is established by the first topic that is raised. This focus then shifts at a number of junctures as new topics are raised. Someone observing the conversation may notice that the topic has shifted for example but not have heard someone “signpost” that shift e.g. by saying something like “Could we also talk about xyz?”

Agenda setting has also been described as an explicit process – a structured conversation in which a number of discussion topics are identified before a conversational focus is agreed. Where agenda setting is described in this way, it is a separate from the phase of the clinical encounter where one particular subject is discussed in detail. For teaching a research purposes there are some advantages to thinking about agenda setting in this way as it can be isolated and clearly defined as distinct from other activities or process that occur in a clinical interview. There are also a number of evidence based advantages to this approach. Firstly it allows for a collaborative process of identifying the focus of the conversation. Secondly it avoids a premature focus on the first topic raised when this may not in fact be the most important. Thirdly it enhances the efficiency of the clinical encounter.

Nautical metaphors are used here to distinguish between these two types of agenda setting. “Agenda mapping” describes the explicit process of establishing – or re-establishing – the conversational focus. “Agenda navigation” describes the implicit process of moving flexibly across a number of conversational foci. Both agenda mapping and agenda navigation can occur with different degrees of skill.

This measure is designed to help learners acquire skill in explicitly agreeing the focus of the clinical encounter i.e. when agenda mapping.

A note on terminology

This measure has been developed in the healthcare context. As a result the term “patient” is used throughout the manual to refer to the person receiving a clinical service. It can be read as a synonym for “client” or “service user”. Likewise the term “clinician” that is used here can be read as a synonym for “practitioner” and refers to the person providing a clinical service.

Aim of EAGL-I

The aim of EAGL-I, is to help clinicians and/ or students acquire skillfulness in agenda *mapping* in clinical encounters.

It was initially developed for talking with patients about the management or prevention of long term conditions. These encounters are characterized by two features: (a) there are frequently multiple interrelated priorities to talk about, and (b) talk about a variety of lifestyle choices is common.

Aim of the coding manual

The aim of this coding manual is to explain the inner workings of EAGL-I. It is designed primarily for raters i.e. people who will be listening to segments of clinical interaction and using this measure to rate them.

It includes

- background on how agenda mapping has been conceptualized
- information about how the rating scale has been developed
- information on identifying the segment to be rated
- components of the rating scale and how to rate these
- guidance on how to score learner or clinician competence in each of the individual aspects of the rating scale

A scoring sheet is included at the end this manual.

EAGL-I is designed for:

Audio-recordings

- Coding is done directly from audio recordings or in vivo.
- It is not recommended to code from transcripts as no assessment of tonal quality can be made using only the written word.
- The scale may also be used with video recordings; however it is recommended that this is considered when comparing clinician ratings. In other words raters should be cautious when attempting to compare a score assigned from a video recording with one assigned from an audio recording.

Dyadic interviews

- The scale measures agenda mapping in dyadic interviews.
- This measure may be also used in clinical encounters with triadic interviews e.g. a clinician, patient and significant other. Some developmental work has been done using the measure in these instances although it has been less robust than the development in dyadic clinical encounters.

Development of EAGL-I

The content of this rating scale was identified from review of the published literature and refined through a consensus study among patients, clinicians, educators and researchers. A model of agenda mapping was proposed through this work.

Six content domains of agenda mapping form the basis of the scale design. These domains describe elements that must be present for agenda mapping to be occurring. They are:

- (1) Patients talk about their concerns, requests, wishes and/ or goals
- (2) Clinicians raise subjects they consider to be important
- (3) Clinicians and patients agree shared priorities
- (4) A focus of what to talk about in the session is agreed
- (5) The conversation is collaborative
- (6) Patients are involved and engaged in the conversation

Core skills used in agenda mapping are: (a) active listening (b) asking; and (c) summarizing.

The design of the measure is influenced by existing measures of patient centeredness and Motivational Interviewing in particular by the Yale Adherence and Competence Scale (YACS)

Design of EAGL-I – 2 parts – fidelity and competence

Agenda mapping is a clearly identifiable skill. It occurs as a collection of tasks and skills taken together for a specific purpose (to agree shared focus). As a result it can be said to be occurring or not occurring. So before we can determine whether a clinician is “agenda mapping” skillfully, we first have to agree that the clinician is “agenda mapping” (and not doing something else such as establishing rapport or establishing a diagnosis).

As a result EAGL-I is made up of two parts:

1. A “**fidelity subscale**” that answers the question “*is agenda mapping happening?*”
2. A “**competence subscale**” that answers the question “*is agenda mapping happening skillfully?*”

If we determine that agenda mapping is not happening, then the second question (“*is it happening skillfully?*”) makes no sense.

The way the measure is used reflects this logic.

EAGL-I - Instructions for use:

Step 1: Which part of the audio do you rate?

Raters need a clear consistent strategy for identifying the part of the audio to be listened to. There are two decisions to be made here: (1) where in the audio might you identify agenda mapping, (2) how long should agenda mapping be occurring for?

In many clinical contexts agenda mapping occurs at the start of the clinical encounter which makes this decision clear – raters should listen from the start of the audio.

Raters are then advised to listen for a proportion of the overall clinical encounter time (20%) to determine if agenda mapping is occurring (using the fidelity subscale).

NOTE: In training environments this step is more easily controlled when rating audio from other contexts raters may choose to adjust this strategy. Provided there is consistency in how the audio segment is identified the reliability of the measure should not be too compromised. Reliability checks should then be done.

Step 2: Is agenda mapping happening?

Raters listen to the pre-identified segment and consider the two items on the fidelity subscale.

These two items capture actions from those present in the encounter that suggest there is (a) some attempt at considering a number of topics before (b) prioritising and agreeing a focus.

If the rater allocates a score of 3 or above on either of the two items, this suggests agenda mapping is happening. If however both items on the fidelity subscale are 1, raters may assume agenda mapping is not happening.

Step 3: If agenda mapping is happening, is it happening skillfully?

Previously we suggested completing the subscales in sequence, however psychometric testing and experience of using the measure suggests raters may allocate ratings to each item on the measure in a single pass. They may then consider in retrospect whether or not agenda mapping is happening.

Note: As the rating scale was developed for use in teaching environments anchors of skilful clinician behaviour are provided. In this way students and clinicians can be provided with qualitative feedback on how to improve their skill.

FIDELITY SUBSCALE – is agenda mapping happening?

(1) To what extent did the clinician attempt to identify all possible talk topics upfront?

1	3	5
One talk topics is raised and provides the sole focus of the interaction	More than one talk topic is raised – from the patient, family members or clinician (An agenda chart may be used)	A number of talk topics are raised – clinician actively elicits a full agenda from all present

Talk topics are specific requests, concerns, symptoms, expectations or behaviours that suggest the need for a focused discussion.

You're looking for evidence of talk topics coming from a number of different sources: the patient, family members, previously identified topics, and/ or the clinician. These may have been identified outside the session time e.g. use of a chart/ list or through a triage system. They may also arise out of talking about the first talk topic raised e.g. a lifestyle topic (smoking, alcohol use) linked with the patients presenting concern.

You should hear: (a) patients/ significant others identifying their concerns, requests, wishes and/ or goals and/ or (b) clinicians raising subjects they consider to be important

Some clinician behaviours you may notice as evidence of this task:

- € Clinician asks for ideas, concerns, talk topics e.g. how can I help today?
- € Clinician asks for additional talk topics e.g. what else would you like us to cover?
- € Clinician asks about goals or aspirations for the session and/ or in general
- € Clinician checks they have understood e.g. by demonstrating listening
- € Clinician asks for brief elaboration on each agenda item raised
- € Clinician raises things that they want to talk about
- € If the clinician has seen this patient before, they raise items discussed in previous sessions.
- € Clinicians state the session's context e.g. "this is your review" and then ask questions about that

(2) To what extent did the clinician attempt to prioritise and agree a shared focus?

1	3	5
No evidence of prioritising or agreement, or no need for it – one item takes focus	Some discussion of talk topics but little consideration of priority. One or other party may suggest focus and agreement is assumed e.g. "let's start here"	Attention is given to agreeing priority focus e.g. "what's most important?" and/ or agreeing a talk topic focus e.g. "where should we start?"

You are listening for efforts to identify a priority talk topic or to jointly agree the conversational focus e.g. summarizing, suggesting a priority or asking a "focusing" question e.g. "where should we start?"

You should hear: (a) discussion about shared priorities, and (b) a focus of what to talk about during the session being agreed

Some clinician behaviours you may notice as evidence of this task:

- € Clinician summarises all talk topics raised
- € Clinician clarifies the patient's priorities
- € Clinician gives the patient options
- € Clinician gives patient choice about where to start

COMPETENCE SUBSCALE: i.e. is agenda mapping happening skillfully?

1. Eliciting the patient's agenda i.e. how well the clinician attempts to identify and understand the patient's primary concerns, requests or expectations for the clinical encounter. It captures the process of both eliciting new content areas for discussion and reflecting understanding of those topics already raised.

1	2	3	4	5
Clinician makes little effort to engage with patient's agenda or appears dismissive of it.	Some attempt to elicit agenda. Clinician does not consider additional agenda items. May respond inflexibly when patient initiates several talk topics.	Clinician engages with the patient's agenda. Clinician may attempt to elicit full agenda items but this seems formulaic.	Clinician gives patient time to talk. Makes a clear effort to elicit or respond to agenda. Considers that there may be more than 1 topic to discuss.	Clinician demonstrates excellent listening skills, is responsive, respectful and sensitive. Considers full agenda.

Higher skillfulness: Clinician demonstrates that they have listened, attempts to understand e.g. gives space for reflection, probes for more information, is responsive to patient cues. Clinician checks they have gathered all the patients concerns.

Lower skillfulness: Clinician may get "lost" in a single agenda item and fail to exert any influence on shaping this task. Questions may be closed and may inhibit patient speech. There is little evidence of listening. Clinician may respond inflexibly when patient initiates a number of talk topics.

Note: Once a clinician starts considering more than 1 agenda item they are at a 3 or above. This is because they are immediately starting to engage with a fuller agenda.

Some clinician behaviours you may notice suggesting higher skillfulness:

- € Clinician checks they have understood the talk topics raised by the patient e.g. by listening
- € Clinician asks for brief elaboration on each agenda item raised, but does not go into too much detail on each item and retains a sense of considering options
- € Clinician is responsive to emotional cues from patient – i.e. demonstrates sensitivity
- € Clinician gives patient time to talk
- € Clinician makes several attempts to elicit patient agenda e.g. by asking in different ways
- € Clinician values patient's contributions and allow them to shape the clinical interaction.

2. Raising the clinician/ service agenda i.e. approach to raising new topics for discussion that are not directly on the patient's agenda but could be linked to it. e.g. lifestyle choices (alcohol, smoking, diet etc). Captures respect for patient autonomy and clinician sensitivity to timing and phrasing of their agenda. Also captures skill in raising a service agenda e.g. use of agenda chart

1	2	3	4	5
Clinician assumes their agenda takes the focus. If there is an agenda chart, clinician makes no reference to it.	Clinician suggests agenda then purses it without seeking patient views. May acknowledge agenda chart.	Clinician raises agenda explicitly, acknowledges agenda as their own. Makes reference to chart if applicable. Identifies own agenda in it.	Clinician raises agenda with sensitivity e.g. to timing and phrasing. May link their agenda to patients. Refers to agenda chart to consider options.	Introduction of clinician agenda is respectful, notably skillful and seamless. Clinician actively supports patient autonomy, Uses agenda chart strategically with patient to consider options

NOTE: There is a "not applicable" category under this subscale. N/A is used where no new content is raised by the clinician. Note: unspoken clinician agendas are not considered under this category.

Higher skillfulness: Clinician reinforces patient’s autonomy when presenting their agenda – e.g. through asking permission, providing options, clarifying their own preferences or priorities. Clinicians may raise their agenda by linking it with previously raised content from the patient and this can appear seamless.

Lower skillfulness: Raises their own agenda without sensitivity to patient choice, assumes their agenda provides the focus e.g. by proceeding with a line of questioning without clarifying their agenda.

Some clinician behaviours you may notice suggesting higher skillfulness:

- € Clinician asks for permission to raise a topic not on the patient’s agenda
- € Clinician may raise a number of agenda items thereby giving patients options of what to choose
- € If clinicians identify their own priorities, they state they are doing so
- € Clinicians may provide a rationale for raising their agenda item – and then invite the patient’s response to that which they have raised.
- € Clinicians ask for patient’s ideas in response to agenda items raised
- € Clinicians demonstrate sensitivity to timing and phrasing of their agenda items.
- € Clinician links their agenda to the patient’s expressed concern

3. Establishing shared focus i.e. the extent to which the clinician structures the agenda mapping task to establish focus. Considers the skills the clinician uses e.g. summaries, asking for a priority. Also includes degree of collaboration and effort at agreement.

1	2	3	4	5
Clinician exerts too much (e.g. assuming a focus) or too little (e.g. through non-directive listening) control in determining the focus.	Clinician provides little structure to establishing focus, No consideration of priorities.	Clinician structures conversation to establish focus. May clarify purpose of session and/ or suggest a focus. May be weak efforts to prioritise.	Clinician follows a clear structure is establishing focus. May attempt to consider priorities and engage patient in talk about these. Good use of skill, e.g. summarising	Clinician explicitly considers options <i>with</i> the patient, actively structures the interaction for collaboration and engagement. Is explicit about the process of establishing focus. Excellent use of skill.

Higher skillfulness: The clinician deliberately attends to establishing the conversational focus by asking specific questions to do so, providing summary statements of options for discussion or highlighting the need to agree a focus. Prioritising and efforts to agree a focus are made explicit. The clinician exerts influence over the shape of the conversation e.g. making statements that orientate the patient to the agenda mapping task. Where patients are quieter, clinician structures the interaction to encourage involvement. Where patients are active the clinician engages actively with the patients ideas.

Lower skillfulness: Clinician does not provide structure to allow the conversational focus to be established e.g. by following the patient’s talk without summarising or clarifying the focusing task. No discussion of priorities. The clinician may start to elicit the patients concerns for example and then get lost in following the patient narrative without asking questions or demonstrating listening. The interaction sounds as though the participants are checking off a list.

Note: If the clinician makes a statement that describes the context e.g. “this is you diabetes review” they’re already at a 3 as they’re clarifying clearly the context/ purpose of the session.

Some clinician behaviours you may notice suggesting higher skillfulness:

- € Clinician uses summary statements to capture. both the patient and clinician’s agendas
- € Clinician links agenda topics e.g. “so you’d like to have more energy to run after your grandchildren but you’re getting out of breath easily ... which may have to do with smoking”
- € Clinician considers priorities – asks about these or suggests some
- € Clinician gives the patient choices

EAGL-1 v1.5.1

Tape identifier:	Rater:	Date:
------------------	--------	-------

Overall clinical encounter time:Time rated:

First sentence coded:

Last sentence coded:

Is agenda mapping happening?

	1	3	5	score
Identifying talk topics	One talk topics is raised and provides the sole focus of the interaction	More than one talk topic is raised – from the patient, family members or clinician. (An agenda chart may be used.)	A number of talk topics are raised – clinician actively elicits a full agenda from all present	
Agreeing a focus	No evidence of explicit prioritising or agreement, or no need for it –one item takes focus	Some attempt to <u>explicitly</u> prioritise or agree a focus e.g. a focus may be suggested with agreement assumed e.g. “let’s start here”	Explicit attempt at agreeing priority focus e.g. “what’s most important?” and/ or agreeing a talk topic focus e.g. “where should we start?”	

Is agenda mapping happening skillfully?

	1	2	3	4	5	score
Eliciting the patient’s agenda-	Clinician makes little effort to engage with patient’s agenda. or appears dismissive of it.	Some attempt to elicit agenda. Clinician does not consider additional agenda items. May respond inflexibly when patient initiates several talk topics.	Clinician engages with the patient’s agenda. Clinician may attempt to elicit full agenda items but this seems formulaic.	Clinician gives patient time to talk. Makes a clear effort to elicit or respond to agenda. Considers that there may be more than 1 topic to discuss.	Clinician demonstrates excellent listening skills, is responsive, respectful and sensitive. Considers full agenda.	
Raising the clinician/ service agenda - mark N/A if there is no new content raised by the clinician.	Clinician assumes their agenda takes the focus. If there is an agenda chart, clinician makes no reference to it.	Clinician suggests agenda then purses it without seeking patient views. May acknowledge agenda chart.	Clinician raises agenda explicitly, acknowledges agenda as their own. Makes reference to chart if applicable. Identifies own agenda in it.	Clinician raises agenda with sensitivity e.g. to timing and phrasing. May link their agenda to patients. Refers to agenda chart to consider options.	Introduction of clinician agenda is respectful, notably skillful and seamless. Clinician actively supports patient autonomy, Uses agenda chart strategically with patient to consider options	
Establishing shared focus	Clinician exerts too much or too little control in determining the focus.	Clinician provides little structure to establishing focus, No consideration of priorities.	Clinician clarifies purpose of session. May suggest a focus. May be weak efforts to prioritise.	Clinician follows a clear structure is establishing focus. May attempt to consider priorities and engage patient in talk about these. Good use of skill, e.g. summarising	Clinician explicitly considers options <i>with</i> the patient, actively structures the interaction for collaboration and engagement. Is explicit about the process of establishing focus. Excellent use of skill.	

Notes: