GUIDELINES FOR USING COMMON GROUND ASSESSMENT INSTRUMENT

Family Medicine Interview Study Group
East Tennessee State University

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INTRODUCTION

Before using the CGRF first review the digital training modules, which describe the six categories of Core Communications Skills. These Core Skills include: rapport, information management, agenda setting, active listening for the patient's perspective, addressing emotions, and reaching common ground.

WHAT IS AN EXCHANGE?

– Everything that a patient or interviewer says between expressions of the other person is an exchange. Frequently an exchange has a number of different notable elements of communications. For example a clinician exchange may include, "I can see you're upset. (acknowledge feelings) How long have you had it?" (closed-ended question)

RATING COMPOUND EXCHANGES

- When several examples from a single type of expression occur in one exchange, give credit once. For example, "You're worried about the cause of your pain." (acknowledges feeling) "I want to ask you some questions about your pain, but first I wonder how you're dealing with your father's death?" (explores feelings to a difficult situation) This exchange gets credit for "feelings" once.

- If there's an open-ended question followed by a closed-ended question (closing an open-ended question) in one exchange, record as the <u>last</u> type of question, whatever that is. For example, "Tell me about your pain…How long have you had it?" Record as a closed-ended question.

- When elements from <u>different</u> categories occur in one exchange give credit to all that apply. For example, "Mrs. Jones, I'm going to do everything in my power to help. (collaborative/caring) Now you mentioned your concern, (acknowledge feeling) what has you most concerned about this swelling?" (active listening) Record as credit in all three areas.

- In the rapport category, if there is social conversation and positive speak in the same exchange record both.

- In the common ground category, if the interview uses two <u>different</u> examples of patient engaging strategies in one exchange, give credit for both. For example makes a patient centered suggestion then does brainstorming is recorded as two engaging strategies.

GLOBAL ASSESSMENTS

– **Note** that in each category you will be asked to provide your global assessment of that particular skill. This rating is not necessarily the sum of the points listed in the check- off area in that category. For example, an interviewer who greeted a patient warmly, provided support and reassurance, expressed interest in the patient's work and home, but made an unwanted sexual advance at the end of the interview would receive a low score for global rapport. Typically, however, there will be a close match between the interviewer's behavior and the global score in any category.

- **What to do when there are elements of two global ratings.** In a teaching and feedback situation it is acceptable and often desirable to mark two ratings when there are near equal amounts of each rating represented. That interview skill will then receive a rating of 2.5 if both two and three are selected.

  Consider the situation in which there are some elements of both two and three as follows:

	% of level 2	**% of level 3**	**Record as:**
Example 1:			
	100	0	2
Example 2:			
	75	25	2
Example 3:			
	less than 75 but more than 25	more than 25 but less than 75	2 and 3
Example 4:			
	25	75	3
Example 5:			
	0	100	3

- **Additional clarification for "Official Raters"** When rating to determine inter rater reliability, record only one level, whichever is closer. When there are equal elements of two levels present, use your judgment about the "quality" of those elements to choose whether to select one category over another.

Converting Assessments Into Grades

- The instrument uses observations of specific checklist items to guide trained raters or faculty raters to provide a global rating for each of the skills and for the overall interview. Rater/expert correlations of global ratings were closely linked.[i] Therefore I'd recommend using the 6 core skills ratings and the overall interview global rating to calculate a final grade. We provide feedback on each of the core skills and the global interview assessment and then calculate the mean (of all global assessments) for the final "score".

- Grade determination and competency determination are of course a separate decision but in general an overall mean global rating below two is incompetent with 2.0 to 2.5 being borderline incompetent. An average global score of 3 is competent but not strong (improvement recommended). 4 is a strong mean and between 4 and 5 is excellent. For our residents we require an average of 3 or else remediation with one of our interactive digital modules is required. With an average below 4 we ENCOURAGE remedial review of the module in question.

- If you want to calculate the check list percentage, count the maximum possible points in a particular category (some of the negative speak and interruptions counting negative point) and place the interviewers checklist points over this denominator.

I. Rapport

— Initial introduction/Preferences

A person receives credit for this if they use one or both of the patients' names and their own name at the beginning of the interview, in those situations where the patient is new to the interviewer. In situations where the interviewer knows the patients, credit is given for mentioning one or both of the patients' names. Credit is given for eliciting patient's preferences. For example, "How would you like to be called" or "Are you comfortable?"

– **Social Conversation**

Interactions about the weather and polite comments like, "It's a pleasure to meet you," or "Have a good day," whether at the beginning or at the end are social conversations.

– **Explicit "positive speak" to patient**

The interviewer receives credit for all statements, which 1) **demonstrate interest for the patient's personal situation or behavior** or 2) **provides praise**, support, or a pat on the back for the patient. Examples include the following:

- Any **personal** individualized statements of interest for example, "How's work going?" or "What are you reading?"
- Statements of individualized interest in the patient that go beyond professional, social conversation.
- **"Pats on the Back."** If the patient describes an accurate knowledge of diabetic complications and the interviewer says, "You've really learned a lot." or "I'm impressed with what you know." or, "You're working very hard to get your weight under control." or "You handle your diet changes very well."
- **Note!** 1) – Questions in the middle of an interview which ask about how things are going on the job or at home, or with regards to stress are **not** positive talk; but are usually diagnostic questions looking for stress disorders.
  2) – Statements that say, "I like to reassure you that your condition is not serious" are professional but **not** positive speak.

– **Explicit caring, commitment or collaborative language to patients**

To be identified as a collaborative statement, the statement should indicate the **Interviewer's Personal Commitment** to help with one of the patient's identified issues. This commitment needs to go beyond the usual responsibility of the clinician to provide information, order tests or write prescriptions. To apply, the expression should be in the first person or otherwise directly refer to the clinician's interest. Provide credit for any of the following:

- "Let's work together to get your diabetes under control." (collaboration)
- "I'd like to help in any way I can." (commitment)
- "I'm interested in doing everything I can to help you over this difficult time." (caring and commitment)
- But not, "I'm going to prescribe a new medication for you."
- **Note** that the use of the generic "we" or "us" alone does not constitute a collaborative statement e.g., "We'll follow up on your blood sugars in a week." or "Let's get an ECG."

– **Verbal interruption**

Record this if the interviewer begins to talk or ask a question while the patient is still responding to a previous question.

– **Negative talk**

Record any comments or expressions that would likely criticize, belittle, or disrespect the patient. Also include here any comments, which discourage the expression of the patient's perspective, feelings, or devalue feelings. For example:

- "You worry too much."
- "You got upset over nothing."
- "You've got to try to cooperate."
- "I'd like you to be more responsible." (implies patient is irresponsible)
- "The problem is you're irresponsible."
- "You're just too lazy."
- Include comments that feel racist, sexist, ageist, or biased in some other way.
- **Note** a negative tone of voice is addressed in nonverbal expression not negative talk.

– **Nonverbal interests**

Regarding lean and eye contact. In this category and in voice tone, someone who is absolutely professional but without specific identifiable elements of warmth or notable personal connection would receive a neutral score in both. If the interest in terms of body language and eye contact are noticeably positive they should be recorded as (+)1. If the interviewer exhibits **remarkable** positive tones mark as (+)2. Similarly if there is something that is ill defined which feels somewhat uncomfortable regarding either the body language or the voice tone record as (-)1. If the non-verbal tone is clearly and remarkably negative, record as (-)2. **Note**, only a small number of interviewers will receive (+)2 or
(-)2.

– **Rapport Building-Global Criteria**

5. Demonstrates rapport-building skills such that most patients would subsequently go out of their way to tell friend or family about this interviewer with extraordinary interpersonal skills. Usually include two or more elements of "positive speak" and expressions of non-verbal interest that are exceptionally warm.

4. Notably warm and makes effective connection via identifiable elements of both verbal and non-verbal connection

3. Clearly, professional, respectful and interested but minimal or ineffective specific verbal or non-verbal efforts to make a more personal connection

2. For the most part professional and respectful. Absent of specific effective efforts at rapport building. **Present** are some comments, expressions or non-verbal behaviors, which **might have a negative reception** by a least some patients.

1. Absent are positive elements of relationship building. Present are **clearly negative** comments or expressions, which would leave many patients with negative feelings about the interviewer.

II. Eliciting All Agenda Items

OVERVIEW

Research shows that early complete agenda settings helps both the doctor and the patient structure the interview more effectively. Early full agenda setting decreases "by the way" statements late in the interview. Early complete agenda setting is achieved when the patient finally says, "No, that's all." To another request for additional agenda.

Most interviewers begin with one agenda seeking exchange, which is usually, "What brings you in today?" or "How can I be of help?" In some situations an interviewer will begin by jumping right into the chief complaint, which is taken from the chart. This is not an agenda setting activity. For example, "It says here your blood sugar is 233 how's your diabetes coming?"

Note! At times an initial "social conversation" like, "How are you doing?" leads to the patient providing agenda items for the day. In such cases give credit for "social conversation" and for agenda setting.

- **Record all additional agenda setting activities, which occur at any time in the interview.**
  Frequently these occur at the beginning for example, "What else?" (Reference to agenda items) or "Are there other issues we need to deal with?" but they also occur towards the end and can occur at any time. In addition the interviewer gets credit for the patient saying, "That's all." to an agenda setting, question.

  Note! While asking diagnostic questions, the interviewer frequently asks, "What else?" The patient will interpret this as an open-ended question regarding the current line of questioning, not a request for other agenda. To receive credit for agenda setting the interviewer will need to focus on agenda, for example, "Is there anything else you would like to bring up?"

- **Agenda Setting – Global Criteria**

5. Explores complete agenda at the beginning (first 2 minutes after rapport building) till the point that the patient says, "Nothing else" Explicitly plans agenda and If several agenda, prioritize amongst them. Explores for additional agenda later or at the end.

4. Explores complete agenda early till "Nothing else" but does not summarize or prioritize or explore for more agenda at end.

3. Explores for agenda partially with at least two efforts at agenda setting. One can be at beginning and one at end.

2. Asks only once at the beginning e.g., "What brings you in today?" or "How can I be of help?" or at the end "Is there anything else?"

1. Doesn't explore for agenda at beginning but begins addressing an established problem. Doesn't return to agenda at any point.

III. Information Management

OVERVIEW

In this category you will be assessing the use of appropriate **questioning and facilitating skills**. A good way to do this is by categorizing the first ten interviewer questions as open vs. closed ended questions. Begin the count once the interview turns to medical history (namely after the introduction and social comments cease.) This usually begins with, "What brings you in?" or "How can I be of help?" (Both non-directed facilitation and open-ended, see below.) You will be recording those comments, which encourage the patient to speak in thoughtful, long answers; these are called non-directed facilitation and open-ended questions. You will compare this to the interviewer's exchanges, which are closed ended questions.

The second element of this category is how the interviewer handles **the flow and management of information.** Ideally the interviewer manages the flow of information by doing the following:

- Having an internal guide (see the figure, "Classic Organization of Medical Data Collection.) to organize and guide the collection of medical data. This can be observed by noting the content flow of the interview.
- Using **Segues** that explain to the patient how and why the interviewer is moving from area of data collection to another. For example, "now I'd like to ask some questions about your past medical history"
- Providing guided **direction**, for example, "Next, please tell me about your family history of illnesses."
- **Summarizes** elements of the history as the interviewer has heard and understands.

– **Non-directed facilitation - definition**

When the interviewer encourages the patient to continue to speak without defining at all the content of that response; this is called non-directed facilitation. Examples include: "How can I be of help?" "Uh-huh." 'Go on." "What else?" Record as open-ended question.

– **Silence**

At times after the patient stops speaking, the interviewer will remain silent. When silence of more than 3 seconds is used to the point where the patient responds with some more information; record as open-ended question. Do not give credit for silence if the interviewer's next comment or question breaks the silence.

– **Open-ended question - definition**

These are questions that define content but ask the patient to talk about that area without defining a specific or limited set of information options. Examples include: "Could you let me know what you'd like to talk about today?" or " How can I be of help?" also include here those open-ended questions which encourage the patient to talk about their symptoms, for example, "Please describe your headaches." or "Can you let me know what sorts of things affect your headaches coming or going?" **Note** the last example literally is a yes/no question but functionally asks for "sorts of things." It is an open-ended question.

Note—Active Listening in response to a patient clue is an open-ended question since it asks the patient to continue and explain or describe their thoughts and feelings in greater detail.

– **Closed-ended question - definition**

When an interviewer asks a question for which the literal answer is a "yes," or "no," or other one or several word answers then consider this a closed-ended question. This includes: "How would you rate your pain on a scale of one to ten?" or "Is the pain sharp, dull or aching? or "In addition to your chest where else do you feel the pain?"

- **Clarifications are closed-ended**

  Note a reflection or clarification of 1-2 pieces of information is a closed-ended question. For example, "So you've been having a sharp pain for a week?" (If there were 3 elements, it would be a summary.)

- **Summary - definition**

  A summary needs to restate information that came from the patient and must have 3 information elements. Lots of times an interviewer will restate something that has been said and then ask another question. For example, "You said the pain was aching, how long does it last?" This is **not** a summary because it does not include three elements. A summary would be, "So your pain has been coming on for three weeks, it's aching and it is located in the middle of your chest. Anything else?"

The Classic Organization of Medical Data Collection

In observing the pattern of data collection you should observe an effort to collect data in the following areas. In general, the interviewer completes one area before moving to another. Jumping around from category to category and back with repetition of questions is a sign of a disorganized interview.

Problems/Agenda identification leads to:

- History of Present Illness
  - Symptom Description (quality, location, intensity, radiation)
  - Time line (Onset, setting, frequency, duration.
  - Modifying Factors (aggravating/relieving/treatment attempts
  - Associated Symptoms (other symptoms that occur in relationship with the primary or chief complaint.)
  - Relevant Review of systems
- Medical History
  - Illnesses
  - Surgery
  - Allergy
  - Medicines and Doses
- Family History Relevant to the problem
- Social History (work, home life, recreational drugs and alcohol, tobacco, travel, pets etc.)
- Complete Review of Systems.

Information Management – Global Criteria

5. Begin interview with effective open-ended question and non-directed facilitation. Continue in this mode (with occasional closed-ended points of clarification) till most/all of patient's information about the condition has been expressed. Notably effective information flow with explicit summary(s), directives and/or segues. Asks appropriate focused (closed) questions towards the end.

4. Begins with a majority of effective open-ended questions/facilitations. (Required) Appropriate mixes of open and closed-ended questions. Effectively manages info flow Uses some form of summary, directives or segues.

3. Uses some open-ended and closed-ended questions from the beginning. Doesn't use summaries, directives or segues. Organization adequate.

2. Mostly closed-ended questions. Info flow weak on organization.

1. Mostly closed-ended questions. Uses flawed, leading or repeated questions. Disorganized info flow.

IV. Active Listening for Full Understanding of the Patient's Perspective on Illness

OVERVIEW

Active Listening demonstrates an explicit and focused curiosity or interest in what the patient believes may be going on or what their greatest concern is or what are their expectations. There are two ways that the interviewer can understand the patient's ideas, concerns and expectations about their illness. First they can follow up the deeper or underlying meaning of a clue. ***A clue is defined as a statement by the patient that implies, but does not state, some underlying idea, concern or expectation regarding the illness or problem.*** When a clue is delivered the interviewer must restate or otherwise explore the meaning of the implied statement to get credit for active listening. The second way of identifying the patient's perspective is to ask explicitly about the patient's ideas or concerns or expectations.

Responses to transcribed clues

- If the clue is not given for any reason record N/A or not applicable
- A positive response to a clue ideally begins with an acknowledgment of what has been heard and an invitation to the patient to provide more information about patient's ideas about what is causing the problem or what concerns or expectations exist. For example the patient says, "I was wondering what could be causing this?" The interviewer responds, "I'll be glad to give you my opinion. Obviously you've given the cause some thought. What things cross your mind about the cause of this problem?" This is active listening. Another example is where a patient would say, "I'm upset about this pain." The interviewer responds, "What about the pain has you upset?" This is active listening.
- Statements by the interviewer that focus the patient on sharing more of their perspective are active listening, even if they don't repeat the clue. For example the patient says, "I've got to figure out what is going on here." The interviewer responds, "You're worried?" This is active listening because it encourages the patient to express the implied meaning.
- Asking about the symptoms further is not active listening. For example, the patient says, "I wonder what could be causing this pain?" The interviewer responds, "How would you describe the pain?" This is not active listening.
- Sometimes after a clue, an interviewer will directly ask about a patient's ideas. For example, the patient says, "I wonder what could be causing this pain?" The interviewer responds, "What do you think the cause may be?" When this question arises **immediately** after a stated clue, consider this active listening.

Diagnosis oriented questions which are <u>not</u> active listening:

- "When did this begin?"
- "How severe is it?" (Looking for intensity not patient's meaning)
- "What's it like?" (Description not meaning)
- "Describe how this has changed over the past weeks?"
- "What helps with the pain?" (Relief factors not meaning)
- "What brings on the pain?" (Antecedent not etiology)
- "What do you do to make the pain better?"
- "What other symptoms do you find are associated with the pain?"
- "I understand you're concerned (acknowledges feelings.) When does it come on?"
- "How did your cough start?"

Questions which <u>are</u> active listening:

- "You mentioned being concerned. About what?" (Exploring meaning)
- "This is worrisome to you?" (Exploring fear)
- "You've been giving this some thought?" (Explores meaning)
- "You mentioned it being awful. What did you mean by that?"

When is non-directed facilitation active listening and when is it an open-ended question?

At times after a clue – which includes medical information and patient's implied meaning, the interviewer will respond with, "Go on" or "Tell me more." If the patient responds with personal ideas or concerns, record as active listening. If the patient responds with more medical information, record as an open-ended question but not active listening.

On the other hand, when the discussion is in the active listening mode, (has just made an explicit explanation for the patient's ideas or concerns) non-directed facilitation continues the active listening. For example:

Pt.: "I'm concerned about this headache." (Clue)
Dr.: "What has you concerned?" (Active listening)
Pt.: "It's better to be safe than sorry." (Another clue)
Dr.: "Go on." or "Tell me about that." (Facilitation and active listening since it continues the exploration for the patient's meaning.)

When is addressing feelings also active listening?

The essence of exploring the patient's perspective is a search for understanding of the patient's ideas and concerns and expectations. Since many clues to the patient's perspective are statements of feelings (concern, worry, being upset) acknowledging those feelings and exploring the sources of those feelings is active listening. For example,

Pt. "I'm concerned about this headache."
Dr. "You're concerned." [silence, expecting the patient to continue]
Pt. "Yes, I'm afraid this could be a growth or tumor."

C **When is addressing feelings NOT active listening?**

At times an interviewer can acknowledge a feeling and instead of pausing to have the patient continue may change the topic to medical data collection. For example:

Pt.: "I'm concerned about this headache." (Clue)
Dr.: "I can see you are concerned. [Acknowledges feelings] How long have you had the headaches?" [Not active listening]

When clues are repeated

If a clue is not explored when 1st given, record as "No".
If that clue is repeated and is explored, record as "Asks about patient's ideas" and note the clue and response in the right hand column.

When clues are combined

If two clues are combines and the interviewer responds to one, record active listening for the clue that received the response and not applicable to the other combined clue.

Delayed response

Sometimes a patient will provide a clue and the interviewer does not respond immediately but comes back later to note what has been previously been said and to explore this. This is effective active listening. For example, the patient says, "I wonder what could be causing this pain?" The interviewer goes on to ask, "Describe the pain." and proceeds with further questioning. Several minutes later the interviewer says, "Earlier you were wondering what could be causing that pain, what thoughts do you have?" This **is** active listening.

Asking directly about the patient's perspective

At times the interviewer will ask, "What do you think is causing your symptom?" When they do this unrelated to the clues and when this does not quantify as a delayed response, record under "Asks about ideas, concerns, and expectations. **Note!** Do not include active listening responses to transcribed clues in this category.

Active Listening to understand the Patient's Perspective on Illness-Global Criteria

5. Very effective at identifying the patients perspective on illness PPI (i.e. what the patient thinks may be going on; the greatest concern about the problem; and the expectations for the visit) The PPI is repeatedly explored using active listening to understand the meaning behind the patients "clues" Once the PPI is disclosed these elements are acknowledged, normalized and used as part of a plan to address the medical diagnosis and the PPI.

4. Demonstrates genuine interest in the PPI by using active listening at least part of the time. Does explore the clues initially, but not always fully. Once identified PPI will be partially addressed with some elements of acknowledgment, normalization, and building a plan based on the PPI.

3. Demonstrates some interest in the PPI through occasional exploration of clues (efforts may not be effective). May not pick up on clues but rather asks about the patient's ideas.

2. Fails to demonstrate effective interest in what the patient thinks may be going on; his/her greatest concern about the problem; and the expectations for the visit.

1. Actively discourages or devalues the PPI.

V. Addressing Feelings with the Patient

C Nonverbal and transcribed feeling clues

For the feeling comments or clues transcribed on the rating form, provide the credit for responses, which acknowledge, restate, legitimize or normalize, or further explore the patient's feelings in regard to these statements. For example, the patient says, "I'm concerned about these headaches." Give credit for, "I can see you're concerned." "What has you concerned?" "It would be normal to be concerned in a situation like this." "Would you like to talk about your concerns?" Clearly a person does not get credit if they respond, "How long have you been having these headaches?"

C When is Active Listening NOT addressing feelings?

A person would get credit for active listening but not for addressing feelings with a response like: "What do you think may be causing this headache?"

C When DOES active listening count for both active listening and addressing feelings?

The interviewer gets credit if they do **both** active listening and addressing feeling, for example: "I can see you're concerned (addresses feelings), what do you think may be causing your headaches?"(active listening) OR they would get credit for both if they respond, "You're concerned." [Followed by a pause and silence with expectation that the patient will continue. The patient does continue to describe WHY he or she is concerned.]

C Exploring or addressing other feelings

Note any time that the interviewer explicitly brings up or asks about the patient's feelings in other areas of the interview aside from the response to feeling clues. For example in the middle of the interview, an interviewer asks, "Does your high blood sugars worry you?" Or the patient describes a sick or dying grandparent and the interviewer responds with a statement, "I bet that's upsetting." or "How are you handling the loss?" Do not record statements that imply feelings (but do not state these especially). For example, "You think that this pain might be serious?"

C Addressing Feelings-Global Criteria

5. Responds to all opportunities to Address Feelings. When feelings surface, these are effectively addressed and then incorporated into the visit. Also effectively seeks out the "potential feelings" when situations with high likelihood of feelings surface in the interview.

4. Acknowledges feeling when expressed. Does not fully address/incorporate into visit. Does not fully address "potential" feeling situations.

3. Acknowledges expressed feelings but does not attempt to integrate into visit.
2. May not acknowledge any of the feelings of the case or does so ineffectively.

1. Comments or responds in a way which demeans, criticizes, or devalues patients' feeling

VI. Closing the Interview

A. Identifies Patient's Perspective (knowledge, concerns, values) and Builds Plan Accordingly

No = Little or not at all. For example, in this situation the patient's perspective has been implied through clues or nonverbal communication. The clinician fails to explore that perspective. There is no effort to identify and incorporate the patient's values and beliefs into the treatment plan.

1 = Partially. In this situation, there is some effort to accommodate at least part of the patient's ideas, concerns, expectations into a treatment plan. However it is clear that there are significant pieces of the patient's perspective that go without acknowledgment and which are not incorporated into the plan.

2 = Adequately. In this case the interviewer demonstrates clear and explicit efforts to elicit the patient's perspective. Once elicited this set of beliefs and values are partially included in the intervention plan. Not all of the patient's perspective may be completely elicited and not every piece of it will be incorporated into the plan, but there is clearly interest in connecting the plan to the patient.

3 = Notably. In this case the interviewer makes an effort to fully explore the patient's perspective regarding the problem and the intervention. There are multiple explicit efforts to address the patient's perspective in developing a plan.

B. Explains Impressions

No = Strikingly ineffective. In this case there are striking omissions, mis-explanations, confusing explanations, contradictions, and unnecessary repetitions as part of the explanation such that the patient would likely be confused and unable to adequately apply the plan after leaving the office.

1 = Somewhat ineffective. In this case, the interviewer explains the plan in a way that includes a smaller number of the problematic examples listed above. In this situation some but not all patients would be confused by the explanation and some would be unable to initiate the desired plan.

2 = Effective. Explanations are generally clear with a minimum of jargon. The explanation may be reasonably but not fully complete. It should be free of errors while there are ways to improve the explanation for clarity, consistency, and thoroughness, most patients will be able to follow the plan after the visit.

3 = Notably effective. In this case, the explanation is clear and thorough, identifies most all of the potential areas needed and explains them simply yet thoroughly so that the patient has an excellent understanding of the problem, the treatment and what to expect. The great majority of patients will be able to return home with all the information needed to initiate the plan and will understand the condition adequately to successfully to explain that to friends and family.

C. Agreement Feasibility

No = None. Fails anywhere in the end of the interview to check whether the proposed plan is feasible and agreeable to the patient.

1 = Minimal. In this situation there is a simple closed ended or leading question regarding feasibility. For example, "That's OK with you, isn't it?"

2 = Effective. In this situation there is some form of initiated dialogue regarding feasibility. For example the interviewer asks, "How does this sound to you?" The patient then goes on to say that the plan sounds fine and they don't see any problems doing it.

D. Checks for Understanding

No = None. No attempt made to check whether the patient understands what has been explained.

1 = Minimal. Asks a simple closed ended question, for example, "Do you understand?"

2 = Effective. In this situation the interviewer asks the patient to describe or explain what they understand about the plan that has been described.

E. Mutual Responsibility

No = None. In this case there is no clear effort to describe what it is that the patient needs to do and what it is that the physician commits to do as follow up.

1 = Partial. In this case the interviewer makes at least a minimal attempt to identify the clinician's responsibility with a statement like, "If you have any problems you can reach me anytime by calling our office." Or explaining at least one contingency situation like, "If the fever doesn't go away by Sunday you will need to start this medication."

2 = Thorough. In this case the interviewer finishes the plan development by describing what appears to be a pretty complete palate of options and contingencies. Explains several or many situations that may occur and what the patient would be expected to do in these situations and what the clinician would be expected to do in these situations.

Closing the Interview –-Global Criteria.

5. Plan linked explicitly to a thorough understanding of the patient's knowledge and perspective. Discusses feasibility, and decision making and matches plan to patient's apparent or explicit preference. Explains the diagnosis and treatment clearly and concisely, checks effectively for understanding (tell-back required)and feasibility.

4. Plan begins with a considerable understanding of patient's knowledge and perspective. Explains clearly with only occasional use of jargon. Checks for understanding and feasibility explicitly . Supports patient's decision making preference.

3. Partial or minimal understanding of patient's knowledge and perspective. Provides information with general clarity. May include some jargon. Some effort to determine understanding and/or feasibility. (Often with a single closed ended question)

2. Minimal or absent understanding of patient's knowledge and perspective. Information provided is somewhat confusing. Minimal effort to check understanding and feasibility.

1. No patient baseline assessment. Explanations confusing/disorganized/misleading. Minimal or absent attempt to check understanding or feasibility.

VI. Reaching Common Ground - In Non Common Ground situations. In some interviews tension exists between the interviewer and the patient's plans and expectations. Observe how the interviewer responds to such disagreement and what skills or strategies are used to resolve the differences of opinion. You will only be asked to rate this category in situations that require such negotiations. Use these rating categories for what happens **after** the "non common ground" situation develops.

In an ideal situation the interviewer will do the following:

To a greater degree:

A. Informational strategies (See below)
B. Patient engaging strategies (See below)

To a lesser degree:

C. Less effective strategies (See below)

A. **Informational Strategies**

In the face of a non common ground situation, frequently, the initial clinician response is to provide relevant information. The information provided is the type of information suggested to all patients. It does not specifically relate to patients' needs or requests. This strategy initially is neither engaging nor is it ineffective.

If the information provided in response to the situation is repeated information, the response should fall into the category of restating and should be noted as less effective (see below)

When the interviewer uses the "Ask-Tell-Ask" approach, this should be recorded under the engaging strategies.

B. **Patient Engaging Strategies PRIDE Strategies**

1. **Patient' Perspective.** Exploring for additional information to help understand the patient's perspective. Record this category when the interviewer first appreciates a difference of opinion with the patient and then asks the patient questions about sources of the problem from the patient's perspective. Such comments include like, "Help me understand why it's so hard to lose weight." or "What kind of problems interfere with checking you sugars at lunch time at school?" Include here the "why" questions e.g., "Why aren't you checking your sugar?" or "Why don't you take your medicine?" Note! Do not record any statements or questions about active listening, which were previously recorded earlier in the interview.

2. **Readiness** for change or Assessing readiness to change. Record here if the interviewer specifically asks the patient, "Would you consider working on increasing your exercise at this time?" or "What are your thoughts about starting a smoking reduction program in the near future?"

3. **Information** Exchange using Ask-Tell-Ask approach to patient education. Instead of providing a short "canned talk" about a medical condition or its treatment, it is often useful to first ASK the patient what he or she knows about the situation. Then the interviewer can TELL the patient information that is new or needed by the patient and at times correct mis-conceptions. The final step in this approach is, at times, to ask the patient to "tell-back" or repeat what he or she has heard and understands. The final step is not necessary to get credit for "ask-tell".

4. **Decision Analysis** There are four elements of decision analysis which include specifically asking about:
    a. Current **problems** with a particular behavior or activity, "What problem does smoking cause you?"
    b. Identifying specific **benefits** of a behavior or activity in question, "What benefits or enjoyment come from smoking?"
    c. Exploring for perceived **incentives** for a change in behavior that may result from such a change, "What are reasons for stopping smoking?"
    d. Identifying barriers to a change in behavior, "If you were to try to stop smoking what problems would stand in your way?" Rarely are all four elements ever explored in one interview. At times you will see one or the other of these four elements explored. **Give credit for each explored element.**

5. **Empathic Connection** Reaching Common Ground frequently involves emotionally charged elements. When the clinician makes clear and accurate connection with the patient's feelings, this greatly facilitates reaching Common Ground

C. **The A-B-C-D-E-F Strategies to help move towards Common Ground:**

.

1. **Ambivalence:** This strategy identifies explicitly the way the disagreement has several sides and states what has been heard about the pros and cons from the patient's point of view

2. **Brainstorming**: Record this category when the interviewer identifies a problem and asks **the patient** for possible solutions, e.g., "What do you think might help with this?"

3. **Criteria Setting** – Record this when the interviewer seeks to identify some objective measurable criteria for helping to decide on a plan. For example, establishing an agreement with a patient that if the blood sugars go over 200 that she will join Weight Watchers. Or deciding what criteria the mother should use to assess the infection of a child to know whether she should call the interviewer back.

4. **Compromise** – Record this when the interviewer seeks to find a solution by modifying his own position to some point between the patient's and the interviewer's original positions. For example, in an effort to get the patient to check blood sugars more frequently the interviewer backs off of the original four times a day and seeks to identify a solution involving checking sugars only two times a day.

5. **Doctor's suggestion that is patient-centered.** Record this category when the interviewer recommends a solution to a problem and either refers explicitly to a previously stated patient issue or where the solution clearly connects with a problem previously identified by the patient. For example a patient states that she's not taking medication because of problems remembering whether she took them or not. Later, the interviewer suggests, "One thing that can help somebody remember to take medicines is using reminder box. How does that sound?" This is a patient-centered suggestion. On the other hand, the suggestion that, "Let me prescribe a medicine that you only have to take once a day." Or "This medicine will be cheaper than the one you're taking." These statements are **not** patient-centered suggestions. They may be a good idea for patients but they don't connect in a meaningful way to what the patient has said. Similarly a patient says she's losing weight because, "It's no fun to eat

alone." Later on an interviewer suggests, "How about if we can get you to have lunch over at the senior citizens' center with a number of people who go there?" This is a patient-centered suggestion. On the other hand a suggestion that, "How about if we bring in meals on wheels?" is **not** a patient-centered suggestion.

6. **Encouragement.** While it is a problem to rely exclusively on encouragement, well placed encouragement and support for the patient's ability to make change can be useful.

7. **Framing from a different perspective i.e. Reframing**. Reframing is the technique of taking a problematic, thorny, or conflictual statement or situation and looking at it from a different point of view in a way that the patient will be able to see things differently and perhaps respond differently. The most frequent reframe is moving from a patient's position (for example, "I'd like a prescription of Lortab" or "I'd like a CAT scan of my back" or "I'd like to be hospitalized") and then identifying the interest that underlies that position. Then the interviewer proceeds to address the interest while not necessarily agreeing with the patient's original position. For example, the request for Lortabs becomes, "You're having a lot of pain that is not being adequately controlled. We need to work on getting you better control." Or the request for a CAT scan or MRI is reframed as, "It's important for you to find the exact cause of what's going on. I agree with that and let me make some suggestions on how we can get those answers for you." Similarly, the request for hospitalization could be reframed as, "You're worried that there may be some serious complication that might make matters worse if you don't get it taken care of. Let's work out a plan so that you're assured that if anything changes, it will be taken care of promptly and effectively."

8. **Family of community involvement –** When in disagreement, it can sometimes be helpful to involve others in the discussion. This strategy involves using family or community resources to help find a solution that meets the needs of all the parties.

9. **Follow-up** – Whether there is agreement or not, the interviewer establishes explicit follow up plans. If disagreement is not achieved, respects the difference establishes what to do next to address non-common ground.

D. Less Effective Strategies—Certain strategies are less effective because they fail to engage the patient in the change process.

1. **Restating suggestions –** The first time that an interviewer makes a particular recommendation, this is recorded as an informational approach. Frequently if there is a disagreement or if the patient is not following suggestions then the interviewer restates the suggestion. These restatements of earlier suggestions are often stronger, louder, slower, and/or with more authority. Record each time the interviewer restates any previously stated position without using additional strategies. In some interviews the initial directive was made on a previous visit and clearly the patient is back in for a follow up and has not followed the directions. In this situation, record the directives to the patient to take all of the medicines as a restatement. This is simply restating the recommendations from the previous visit.

2. **Personal appeal –** Record in this category when the interviewer is asking the patient to follow his/her direction or guidance and implies or states personal appeal rather than threats or the use of authority. For example, "I'd really like you to promise me that you will take the insulin."

3. **Use of authority or defensiveness –** This occurs when the interviewer orders or directs the patient to follow suggestion. For example, "You need to start insulin now." or "It's essential that you go to the hospital now." Sometimes information or other initial responses are expressed with a nonverbal (paralinguistic) tone or edge of defensiveness that carries an air of authority or criticism. When observed record as less effective.

4. **Attempting to persuade using morbidity and mortality data –** Among the most frequently used strategies is explicitly telling a patient about some significant complication or death related to the behavior in question. When the interviewer tries to get the patient to follow directions by using these techniques, record in this category. **Note** If the interviewer says, "I don't mean to scare you, but people with diabetes can develop blindness." Even though the interviewer states that there is not an attempt to scare the patient, the reference to complication is frightening.

Reaching Common Ground (Differences in expectations apparent)—Global Criteria

Note—Rating is based on what the interviewer does; not how the patient responds.

5. Works very effectively at bridging differences between the interviewer and the patient. Performs a full exploration of the PPI and uses the PPI to reach common ground. Uses a number of the more effective skills in reaching common ground, e.g. decision analysis, ask/tell/ask approach, reframing, patient centered suggestions, criteria setting, brainstorming, compromise etc. Avoids less effective methods, e.g. use of authority, personal appeal, repetition of serious complications or chance of death. Would likely facilitate a desirable change in behavior towards health.

4. Demonstrates clear skills in reaching common ground. Does obtain most of the PPI and attempts to use at least some (but not all) of its elements in a plan. Uses a mix of strategies to reach the plan. Heavier use of the more effective skills.

3. While does not connect the plan with PPI, uses a balanced mix of skills to reach common ground that includes at least one of the more effective strategies.

2. Does not use the patient's issues to help to solve the difference. Uses more of the less effective strategies in trying to create a plan, e.g. use of authority, personal appeal, and repetition of serious complications. For most patients this plan would not significantly affect the long-term behavior in question.

1. Uses less effective strategies almost exclusively. In missing the patient's issues and in using authority or threat, the patient would be unlikely to change long-term behavior and would probably leave upset with the interviewer's approach to problem solving.

VII. Overall Interview Global Criteria

5. At the level of an experienced clinician who is expert in using all communications skills effectively. Skills demonstrated such that a patient would likely note such skills to friends and family

4. Uses all communication skills effectively; minor suggestions for change are noted which are unlikely to have measurable importance on encounter.

3. Uses most communication skills effectively; some interview behaviors present which, if modified, could lead to an even more effective impact on a real encounter.

2. Uses some communication skills effectively and others ineffectively; certain areas of communication might cause clinical problems. (Patient dissatisfaction or confusion)

1. Inadequate communication skills; likely to create significant clinical problems (Patient dissatisfaction or confusion)

APPENDIX – FORMS

GLOBAL RATING OF CORE, COMMON GROUND INTERVIEW SKILLS

Rapport Building-Global Criteria

5. Demonstrates rapport-building skills such that most patients would subsequently go out of their way to tell friend or family about this interviewer with extraordinary interpersonal skills. Usually include two or more elements of "positive speak" and expressions of non-verbal interest that are exceptionally warm.
4. Notably warm and makes effective connection via identifiable elements of both verbal and non-verbal connection
3. Clearly, professional, respectful and interested but minimal or ineffective specific verbal or non-verbal efforts to make a more personal connection.
2. For the most part professional and respectful. Absent of specific effective efforts at rapport building. Present are some comments, expressions or non-verbal behaviors, which might have a negative reception by a least some patients.
1. Absent are positive elements of relationship building. Present are clearly negative comments or expressions, which would leave many patients with negative feelings about the interviewer.

Agenda Setting - Global Criteria

5. Explores complete agenda at the beginning (first 2 minutes after rapport building) till the point that the patient says, "Nothing else" Explicitly plans agenda and if several agenda, prioritize amongst them. Explores for additional agenda later or at the end.
4. Explores complete agenda early till "Nothing else" but does not summarize or prioritize or explore for more agenda at end.
3. Explores for agenda partially with at least two efforts at agenda setting. One can be at beginning and one at end.
2. Asks only once at the beginning e.g., "What brings you in today?" or "How can I be of help?" or at the end "Is there anything else?"
1. Doesn't explore for agenda but begins addressing an established problem. Identical in chart. Doesn't return to agenda at any point.

Information Management - Global Criteria

5. Begin interview with effective open-ended question and non-directed facilitation. Continue in this mode (with occasional closed-ended points of clarification) till most/all of patient's information about the condition has been expressed. Notably effective information flow with explicit summary(s), directives and/or segues. Asks appropriate focused (closed) questions towards the end.
4. Begins with a majority of effective open-ended questions/facilitations Appropriate mixes of open and closed-ended questions. (Required) Effectively manages info flow Uses some form of summary, directives or segues.
3. Uses some open-ended and closed-ended questions from the beginning. Doesn't use summaries, directives or segues. Organization adequate.
2. Mostly closed-ended questions. Info flow weak, repetitive or disorganized.
1. Mostly closed-ended questions. Uses numbers of flawed, leading or repeated questions. Disorganized, confusing, misleading info flow.

Active Listening to understand the Patient's Perspective on Illness-Global Criteria

5. Very effective at identifying the patients perspective on illness PPI (i.e. what the patient thinks may be going on; the greatest concern about the problem; and the expectations for the visit) The PPI is repeatedly explored using active listening to understand the meaning behind the patients "clues" Once the PPI is disclosed these elements are acknowledged, normalized and used as part of a plan to address the medical diagnosis and the PPI.
4. Demonstrates genuine interest in the PPI by using active listening at least part of the time. Does explore the clues initially, but not always fully. Once identified PPI will be partially addressed with some elements of acknowledgment, normalization, and building a plan based on the PPI.
3. Demonstrates some interest in the PPI through occasional exploration of clues (efforts may not be effective). May not pick up on clues but rather asks about the patient's ideas.
2. Fails to demonstrate effective interest in what the patient thinks may be going on; his/her greatest concern about the problem; and the expectations for the visit.
1. Actively discourages or devalues the PPI.

Addressing Feelings-Global Criteria

5. Responds to all opportunities to Address Feelings. When feelings surface, these are effectively addressed and then incorporated into the visit. Also effectively seeks out the "potential feelings" when situations with high likelihood of feelings surface in the interview.
4. Acknowledges feeling when expressed. Does not fully address/incorporate into visit. Does not fully address "potential" feeling situations.
3. Acknowledges expressed feelings but does not attempt to integrate into visit.
2. May not acknowledge any of the feelings of the case or does so ineffectively.
1. Comments or responds in a way which demeans, criticizes, or devalues patients' feeling

Reaching Common Ground –Closing the Interview-Global Criteria.

5. Plan linked explicitly to a thorough understanding of the patient's knowledge and perspective. Discusses feasibility, and decision making and matches plan to patient's apparent or explicit preference. Explains the diagnosis and treatment clearly and concisely, checks effectively for understanding (tell-back required)and feasibility.
4. Plan begins with a considerable understanding of patient's knowledge and perspective. Explains clearly with only occasional use of jargon. Checks for understanding and feasibility explicitly . Supports patient's decision making preference.
3. Partial or minimal understanding of patient's knowledge and perspective. Provides information with general clarity. May include some jargon. Some effort to determine understanding and/or feasibility. (Often with a singel closed ended question)
2. Minimal or absent understanding of patient's knowledge and perspective. Information provided is somewhat confusing. Minimal effort to check understanding and feasibility.
1. No patient baseline assessment. Explanations confusing/disorganized/misleading. Minimal or absent attempt to check understanding or feasibility.

Reaching Common Ground (Differences in expectations apparent)—Global Criteria

Note—Rating is based on what the interviewer does; not how the patient responds.

5. Works very effectively at bridging differences between the interviewer and the patient. Performs a full exploration of the PPI and uses the PPI to reach common ground. Uses a number of the more effective skills in reaching common ground, e.g. decision analysis, ask/tell/ask approach, reframing, patient centered suggestions, criteria setting, brainstorming, compromise etc. Avoids less effective methods, e.g. use of authority, personal appeal, repetition of serious complications or chance of death. Would likely facilitate a desirable change in behavior towards health.
4. Demonstrates clear skills in reaching common ground. Does obtain most of the PPI and attempts to use at least some (but not all) of its elements in a plan. Uses a mix of strategies to reach the plan. Heavier use of the more effective skills.
3. While does not connect the plan with PPI, uses a balanced mix of skills to reach common ground that includes at least one of the more effective strategies.
2. Does not use the patient's issues to help to solve the difference. Uses more of the less effective strategies in trying to create a plan, e.g. use of authority, personal appeal, and repetition of serious complications. For most patients this plan would not significantly affect the long-term behavior in question.
1. Uses less effective strategies almost exclusively. In missing the patient's issues and in using authority or threat, the patient would be unlikely to change long-term behavior and would probably leave upset with the interviewer's approach to problem solving.

Overall Interview Global Criteria

5. At the level of an experienced clinician who is expert in using all communications skills effectively. Skills demonstrated such that a patient would likely note such skills to friends and family
4. Uses all communication skills effectively; minor suggestions for change are noted which are unlikely to have measurable importance on encounter.
3. Uses most communication skills effectively; some interview behaviors present which, if modified, could lead to an even more effective impact on a real encounter.
2. Uses some communication skills effectively and others ineffectively; certain areas of communication might cause clinical problems. (Patient dissatisfaction or confusion)
1. Inadequate communication skills; likely to create significant clinical problems (Patient dissatisfaction or confusion)

In general, the numbers above translate into the following:

5 = Exemplary 4 = Very Effective 3 = Competent/Adequate 2 = Marginal 1 = Needs Improvement

GLOBAL CRITERIA-SPECIAL SITUATIONS – FAMILY INTERVIEWING

Global Assessment of Family Interviewing Skills

5. Notably involves all those present, establishing rapport and agenda and exploring the perspective of each appropriately so that each would feel involved with the visit and would likely remark to family and friends on the family communication skills of the clinician.
4. Involves all those present successfully.
3. Partially involves all those present. Includes welcome and some input from others on some issues.
2. Minimally involves all those present. May include welcome but encourages little other input into the visit from the others. Communications such that some others might feel that the visit excluded them.
1. Minimally involves all those present or absent. May include welcome, but no other efforts in involve others. May include active blockade of input from others. Communicates with others such that patient or others would likely feel excluded/ignored or disrespected.

In general, the numbers above translate into the following:
5 = Exemplary 4 = Very Effective 3 = Competent/Adequate 2 = Marginal 1 = Needs Improvement

Common Ground Assessment Instrument (Generic)

Family Medicine Interview Study Group
East Tennessee State University

Interviewer _____ Faculty/Rater _____ Patient (Generic) Date _____

1. Rapport

(Number of Occurrences)

No	1	2	3	4	5	
O	O	O	O	O	O	Initial introduction/preference
O	O	O	O	O	O	Social conversation
O	O	O	O	O	O	Explicit "Positive Speak"
O	O	O	O	O	O	Explicit caring/commitment
O	O	O	O	O	O	Verbal interruption
O	O	O	O	O	O	Negative talk (implied or explicit)

Comments:

Nonverbal Rating Scale	**-2** Strong Negative	**-1** Negative	**0** Neutral	**+1** Positive	**+2** Strong Positive
Body position & Eye contact	O	O	O	O	O
Voice Qualities	O	O	O	O	O

(Rating Scale)

1	2	3	4	5	NA	**Overall Rapport**
O	O	O	O	O	O	

2. Eliciting all Agenda Items

(Number of Occurrences)

No	1	2	3	
O	O	O	O	Agenda setting effort "What brings you in?
O	O	O	O	Early (1-2 min.) full exploration i.e., "That's it."
O	O	O	O	Checks for additional agenda later.

(Rating Scale)

1	2	3	4	5	NA	**Overall Agenda**
O	O	O	O	O	O	

3. Information Management O C

Comments:

(Number of Occurrences)

0-1	2-3	4-5	6-7	8-10	
O	O	O	O	O	For the first ten questions record the open ended questions.

0	1	2	3	4	
O	O	O	O	O	Performs summary (3 or more items), segues, organizing directives.

(Rating Scale)

1	2	3	4	5	NA	**Overall Information Management**
O	O	O	O	O	O	

4. Active Listening for Full Understanding of Ideas, Concerns, and Expectations

No	Yes	N/A	PT's clues or statements needing follow up.
O	O	O	**#1**
O	O	O	**#2**
O	O	O	**#3**
O	O	O	**#4**

(Number of Occurrences)

0	1	2	3	4	
O	O	O	O	O	Asks (or affirms) about patients' ideas, concerns, expectations.

Comments:

(Rating Scale)

1	2	3	4	5	NA	**Overall Active Listening**
O	O	O	O	O	O	

5. Addressing Feelings with Patient

No	Yes	N/A	PT's stated or implied feelings needing follow up.
O	O	O	**#1 -**
O	O	O	**#2 -**
O	O	O	**#3-**
O	O	O	**#4**

(Number of Occurrences)

0	1	2	3	4	
O	O	O	O	O	Explore or address other feelings..

Comments:

(Rating Scale)

1	2	3	4	5	NA	**Overall Deals with Feelings**
O	O	O	O	O	O	

Additional Comments:

Common Ground Assessment Instrument (Generic)

Family Medicine Interview Study Group
East Tennessee State University

Interviewer _____ Faculty/Rater _____ Patient (Generic)___ Date_____

6. Closing the Interview

(Rating Scale)

No	1	2	3	N/A	
O	O	O	O	O	Identifies **patient's perspective** (knowledge, concerns, expectations) and **builds plan accordingly:** No = Little or not at all; 1= Partially, 2 = Adequately; 3 = Notably
O	O	O	O	O	**Explains Impressions** (Dx, Tx, options): No = Strikingly ineffective, 1= Somewhat ineffective, 2 = Effective, 3 = Notably effective
O	O	O		O	Checks for **agreement/feasibility** No = None, 1 = Minimal, 2 = Effective
O	O	O		O	Checks for **understanding** No = None, 1 = Yes/No, 2 = Teach back
O	O	O		O	Establishes **mutual responsibility** No = None, 1 = Partial, 2 = Thorough

7. Reaching Common-Ground--Uses:

(Number of Occurrences)

No	1	2	3	
O	O	O	O	**Informational Strategies** Provides information, explanations, and recommendations.
	4	**5**	**6**	_____
	O	O	O	_____
				_____
				_____

No	1	2	3	
O	O	O	O	**Patient Engaging Strategies** ➔ _____
	4	**5**	**6**	_____
	O	O	O	_____
				_____
				_____

No	1	2	3	
O	O	O	O	**Less Effective Strategies**
	4	**5**	**6**	Direction, repetition of position, using morbidity/mortality data (fear); clinician centered recommendations, personal appeal or authority
	O	O	O	

(Rating Scale)

1	2	3	4	5	NA	
O	O	O	O	O	O	**Overall Reaching Common Ground**

8. Global Interview Performance

(Rating Scale)

1	2	3	4	5	NA	
O	O	O	O	O	O	**Overall Global Interview**

Observations and Comments

Patient Engaging Strategies

___**P**t centered (ideas, concerns, expectations)
___**R**eadiness to change
___**I**nformation – Ask, Tell, Ask
___**D**ecision analysis (1-4 elements)
___**E**mpathic Connection

___**A**mbivalence
___**B**rainstorming
___**C**riteria
___**D**octor's recommendation
___**E**mpathic response
___**F**amily involvement
___**F**raming differently (reframing)
___**F**ollow up

Common Ground Assessment Instrument (Generic with Family)

Family Medicine Interview Study Group
East Tennessee State University

Interviewer _____ Faculty/Rater _____ Patient (Generic w Family) Date _____

1. Rapport

(Number of Occurrences)

No	1	2	3	4	5	
O	O	O	O			Initial introduction/preference
O	O	O	O	O	O	Social conversation
O	O	O	O	O	O	Explicit "Positive Speak"
O	O	O	O	O	O	Explicit caring/commitment
O	O	O	O	O	O	Verbal interruption
O	O	O	O	O	O	Negative talk (implied or explicit)

Nonverbal Rating Scale	**-2** Strong Negative	**-1** Negative	**0** Neutral	**+1** Positive	**+2** Strong Positive
Body position and Eye contact	O	O	O	O	O
Voice Qualities	O	O	O	O	O

(Rating Scale)

1	2	3	4	5	NA	**Overall Rapport**
O	O	O	O	O	O	

2. Eliciting all Agenda Items

(Number of Occurrences)

No	1	2	3	
O	O	O	O	Agenda setting effort "What brings you in?
O	O			Early (1-2 min.)full exploration i.e., "That's it."
O	O	O		Checks for additional agenda later.

(Rating Scale)

1	2	3	4	5	NA	**Overall Agenda**
O	O	O	O	O	O	

3. Information Management O C

(Number of Occurrences)

0-1	2-3	4-5	6-7	8-10	
O	O	O	O	O	For the first ten questions record the open ended questions.

0	1	2	3	4	
O	O	O	O	O	Performs summary (3 or more items), segues, organizing directives

(Rating Scale)

1	2	3	4	5	NA	**Overall Information Management**
O	O	O	O	O	O	

4. Active Listening for Full Understanding of Ideas, Concerns, and Expectations

No	Yes	N/A	PT's clues or statements needing follow up.
O	O	O	**#1**
O	O	O	**#2**
O	O	O	**#3**
O	O	O	**#4**

(Number of Occurrences)

0	1	2	3	4	
O	O	O	O	O	Asks (or affirms) about patients' ideas, concerns, expectations.

(Rating Scale)

1	2	3	4	5	NA	**Overall Active Listening**
O	O	O	O	O	O	

5. Addressing Feelings with Patient

No	Yes	N/A	PT's stated or implied feelings needing follow up.
O	O	O	**#1 -**
O	O	O	**#2 -**
O	O	O	**#3-**
O	O	O	**#4**

(Number of Occurrences)

0	1	2	3	4	
O	O	O	O	O	Explore or address other feelings..

(Rating Scale)

1	2	3	4	5	NA	**Overall Deals with Feelings**
O	O	O	O	O	O	

Common Ground Assessment Instrument (Generic with Family)

Interviewer _____ Faculty/Rater _____ Patient (Generic w Family) Date _____

6. Closing the Interview

(Rating Scale)

No	1	2	3	N/A	
O	O	O	O	O	Identifies **patient's perspective** (knowledge, concerns, expectations) and **builds plan accordingly:** No = Little or not at all; 1= Partially, 2 = Adequately; 3 = Notably
O	O	O	O	O	**Explains Impressions** (Dx, Tx, options): No = Strikingly ineffective, 1= Somewhat ineffective, 2 = Effective, 3 = Notably effective
O	O	O		O	Checks for **agreement/feasibility** No = None, 1 = Minimal, 2 = Effective
O	O	O		O	Checks for **understanding** No = None, 1 = Yes/No, 2 = Teach back
O	O	O		O	Establishes **mutual responsibility** No = None, 1 = Partial, 2 = Thorough

Observations and Comments

7. Reaching Common-Ground--Uses:

(Number of Occurrences)

No	1	2	3	
O	O	O	O	**Informational Strategies** Provides information, explanations, and recommendations.
	4	5	6	_____
	O	O	O	_____ _____ _____

No	1	2	3	
O	O	O	O	**Patient Engaging Strategies** ➔ _____
	4	5	6	_____ _____ _____
	O	O	O	_____

No	1	2	3	
O	O	O	O	**Less Effective Strategies**
	4	5	6	Direction, repetition of position, using morbidity/mortality data (fear); clinician centered recommendations, personal appeal or authority
	O	O	O	

(Rating Scale)

1	2	3	4	5	NA	
O	O	O	O	O	O	**Overall Reaching Common Ground**

8. Special Situations: Family Interviewing Skills

(Number of occurrences)

0	1	2	3	4	5	
O	O	O	O	O	O	Communications to build rapport/provide support to "other" person(s) in the room.

(Rating Scale)

0	1	2	N/A	
				0 = Absent; 1 = Partial; 2 = Thorough; N/A = Not Available
O	O	O	O	Determines agenda of "other" person(s) in the room.
O	O	O	O	On potentially relevant issues, explores the perspective of the "other" person(s) in the room.
O	O	O	O	In situations where two individual have differences, fairly reframes/restates both sides/maintains neutrality (avoids triangulation.)
O	O	O	O	If separation is appropriate, negotiates with input from the patient.
O	O	O	O	Respects privacy/confidentiality

Agency/Focus/Siding

Focuses: Pt/Only		Balanced Interest		Focus: Other Only
1	2	3	4	5
O	O	O	O	O

(Rating Scale)

1	2	3	4	5	
O	O	O	O	O	**Overall Family Interviewing**

9. Global Total Interview Performance

(Rating Scale)

1	2	3	4	5	
O	O	O	O	O	**Overall Global Interview**

Observations and Comments

Patient Engaging Strategies

___**P**t centered (ideas, concerns, expectations)
___**R**eadiness to change
___**I**nformation – Ask, Tell, Ask
___**D**ecision analysis (1-4 elements)
___**E**mpathic Connection

___**A**mbivalence
___**B**rainstorming
___**C**riteria
___**D**octor's recommendation
___**E**mpathic response
___**F**amily involvement
___**F**raming differently (reframing)
___**F**ollow up

East Tennessee State University
Patient's Comments for Interviewer

Interviewer: _____ Level of training: _____

Patient: _____ Date: _____ Time: _____

Situation/Role: _____ Location: _____

Positive Feelings/Impressions *

Areas of your needs/interests which could have been addressed more effectively *

*Please phrase statements beginning with "As the patient…" or "I …"

The interviewer . . . . . (Please check appropriate box.)

	**Exemplary	Very Effective	Competent/ Adequate	Marginal	Needs Improvement	N/A
➢ appeared **professionally competent** ……						
& **personal rapport/support** – showed interest in me as a person, not just my condition ……						
& **agenda setting** – encouraged me to identify everything that I needed to say ……						
& **information management**– moves from an open-ended to closed line of questioning, summary ……						
& **active listening** – explored my clues for my full meaning, my ***real*** concerns, my expectations ……						
& **addressed feelings** – expressed interest in my personal feelings and experience …….						
& **reaching common ground** – worked toward a plan which addressed both the diagnosis and my concerns about my illness ….						
Overall Impression of Interviewer's Ability……						

****Exemplary** should be used only for a few interviewers who do something out of the usual

FEEDBACK AND RECOMMENDATIONS – COMMON GROUND INTERVIEWING SKILLS

Interviewer:_____ Date _____ Feedback Provider : _____

I. Interview Skills Profile - See Global Rating Guide and report score – 5 (max) to 1 (min)

Rapport ____ Agenda ____ Information Management _____ Active Listening _____

Feelings ____ Reaching Common Ground ____ Overall Interview _____

II. Strengths and Comments – Those skills done notably well that should be reinforced and used regularly:

III. Suggestions for reinforcing/improving skills – (N=Noteworthy P=Present to some degree I=Improvement suggested)

Rapport N P I	**OBSERVATIONS**
__ __ __ Begins non-emergent visits with a brief personal interaction. __ __ __ Provides pats on the back/words of encouragement. __ __ __ States a personal interest and commitment to the care of the patient. __ __ __ Uses body lean/eye contact to demonstrate interest. __ __ __ Effectively modifies voice tone, speed, loudness to the situation.	Positive speak Non verbal
Agenda Setting __ __ __ Specifically and repeatedly explores the reasons for the visit. __ __ __ Regarding complete agenda patient states, "That's about it."	
Information Management __ __ __ Early on, uses more open-ended questions and non-directed facilitation. __ __ __ Avoids jargon/leading/and closing open ended questions. __ __ __ Summarizes as needed. __ __ __ Uses transitions (segues);effectively organizes interview.	Open: Closed: Summary:
Active Listening—Exploring the patient's perspective __ __ __ Thoroughly explores patient's clues. __ __ __ Acknowledges/legitimizes/ normalizes patient's ideas about their illness. __ __ __ Only at the end, uses directed, sequenced question to determine PPI.	Clues: Response:
Feelings __ __ __ Acknowledges/legitimizes/normalizes expressions of feelings. __ __ __ Explores for likely but unspoken feelings.	Feelings: Response:
Reaching Common Ground __ __ __ Builds plan explicitly on a base of what patient knows or believes. __ __ __ Explains patient's opinion clearly without jargon __ __ __ Checks for understanding. (teach-back) __ __ __ Checks for agreement/feasibility	
When in a "non-Common Ground situation" __ __ __ Before providing information identifies patient's baseline knowledge. __ __ __ Explores for a more thorough understanding of the patient's position/expectations. __ __ __ Uses brainstorming/suggestions linked explicitly with patient's statements/ decision analysis/criteria setting/reframing/compromise. __ __ __ Avoids: repetition, authority, personal appeal, excess emphasis on M & M.	

Other Suggestion/Comments:

FEEDBACK AND RECOMMENDATIONS – COMMON GROUND *FAMILY* INTERVIEWING SKILLS

Interviewer:_____ Date _____ Feedback Provider : _____

I. Interview Skills Profile - See Global Rating Guide and report score – 5 (max) to 1 (min)

Rapport ____ Agenda ____ Information Management _____ Active Listening _____

Feelings ____ Reaching Common Ground ____ Overall Interview _____

II. Strengths and Comments – Those skills done notably well that should be reinforced and used regularly:

III. Suggestions for reinforcing/improving skills – (N=Noteworthy P=Present to some degree I=Improvement suggested)

Rapport N P I	**OBSERVATIONS** Positive speak
__ __ __ Begins non-emergent visits with a brief personal interaction. __ __ __ Provides pats on the back/words of encouragement. __ __ __ States a personal interest and commitment to the care of the patient. __ __ __ Uses body lean/eye contact to demonstrate interest. __ __ __ Effectively modifies voice tone, speed, loudness to the situation.	Non verbal
Agenda Setting __ __ __ Specifically and repeatedly explores the reasons for the visit. __ __ __ Regarding complete agenda patient states, "That's about it."	
Information Management __ __ __ Early on, uses more open-ended questions and non-directed facilitation. __ __ __ Avoids jargon/leading/and closing open ended questions. __ __ __ Summarizes as needed. __ __ __ Uses transitions (segues);effectively organizes interview.	Open: Closed: Summary:
Active Listening—Exploring the patient's perspective __ __ __ Thoroughly explores patient's clues. __ __ __ Acknowledges/legitimizes/ normalizes patient's ideas about their illness. __ __ __ Only at the end, uses directed, sequenced question to determine PPI.	Clues: Response:
Feelings __ __ __ Acknowledges/legitimizes/normalizes expressions of feelings. __ __ __ Explores for likely but unspoken feelings.	Feelings: Response:
Reaching Common Ground __ __ __ Builds plan explicitly on a base of what patient knows or believes. __ __ __ Explains patient's opinion clearly without jargon __ __ __ Checks for understanding. (Direct question – teach back) __ __ __ Checks for agreement/feasibility	
When in a "non-Common Ground situation" __ __ __ Before providing information identifies patient's baseline knowledge. __ __ __ Explores for a more thorough understanding of the patient's position/expectations. __ __ __ Uses brainstorming/suggestions linked explicitly with patient's statements/ decision analysis/criteria setting/reframing/compromise. __ __ __ Avoids: repetition, authority, personal appeal, excess emphasis on M & M.	

Other Suggestion/Comments: (See over)

Family Interviewing – Special Situations

IV. Suggestions for reinforcing/improving skills – (N=Noteworthy P=Present to some degree I=Improvement suggested)

N P I		OBSERVATIONS
__ __ __	Communications to build rapport/provide support to "other" person(s) in the room. Includes introductions.	
__ __ __	Determines agenda of "other" person(s) in the room.	
__ __ __	On potentially relevant issues explores the perspective of the "other" person(s) in the room.	
__ __ __	Addresses/respects issues of agency, primacy, and confidentiality	
N P I N/A		
__ __ __ ___	If separation is appropriate, negotiates with input from patient.	
__ __ __ ___	In situations where two individuals have differences, fairly reframes/restates both sides/maintains neutrality (avoids triangulation.)	

Other Suggestion/Comments: (See over)

COMMON GROUND GLOBAL RATING SCORES TRANSLATED TO FEEDBACK – STATEMENTS

In providing formal feedback to interviewers, you may want to use the following "generic" feedback statements. Ideally the feedback should be personalized making reference to specific examples demonstrated in the interview.

Rapport

[IF 5]
Your overall assessment: Demonstrates rapport-building skills such that most patients would subsequently go out of their way to tell friend or family about this interview with extraordinary interpersonal skills. Usually include two or more elements of "positive speak" and expressions of non-verbal interest that are exceptionally warm.

Suggestions and Recommendations: Your interview demonstrates excellent verbal and non-verbal rapport building skills that express your interest and caring for the patient. Continue to use these skills as you have done.

[IF 4]
Your overall assessment: Notably warm and makes effective connection via identifiable elements of both verbal and non-verbal connection.

Suggestions and Recommendations: Strong rapport skills with this patient. Continue to use and possibly expand your efforts to appropriately "pat the patient on the back" and state your personal commitment to the patient's care.

[IF 3]
Your overall assessment: Clearly, professional, respectful, and interested but minimal or ineffective specific verbal or non-verbal efforts to make a more personal connection.

Suggestions and Recommendations: The interview was professional and respectful. It would be improved by efforts to find additional opportunities to support the patient and provide an appropriate "pat on the back". Look for opportunities to verbally express your commitment to the patient's care.

[IF 2]
Your overall assessment: For the most part professional and respectful. Absent of specific effective efforts at rapport building. Present are some comments, expressions, or non-verbal behaviors, which might have a negative reception by a least some patients.

Suggestions and Recommendations: Attention to rapport building required to optimize patient care. Look for opportunities at the beginning to make a personal connection. Throughout the interview look for opportunities to "pat the patient on the back" and to express your interest and commitment in their care.

[IF 1]
Your overall assessment: Absent are positive elements of relationship building. Present are clearly negative comments or expressions, which would leave many patients with negative feelings about the interviewer.

Suggestions and Recommendations: Rapport building skills require improvement. Please review the rapport building elements of this interview. Look carefully for times when you may have inadvertently interrupted or made a value or personal statements that might be offensive to this or other patients. In addition look for opportunities to establish a personal connection at the beginning of the interview and look for opportunities to provide "pats on the back" and establish your personal commitment to the patient's care throughout the interview.

AGENDA SETTING

[IF 5]
Your overall assessment: Explores complete agenda at the beginning till the point that the patient says, "Nothing else." If several agenda prioritize amongst them. Explores for additional agenda at the end.

Suggestions and Recommendations: The interview demonstrates very effective agenda setting and prioritization, as needed. Continue to use these skills as you have done.

[IF 4]
Your overall assessment: Explores complete agenda but may not prioritize the agenda or may not explore for more agenda at the end.

Suggestions and Recommendations: The interview demonstrates genuine interest and effectiveness in addressing the patient's full agenda. Even if you ask a second time for additional agenda items, you may want to continue to pursue agenda items until the patient tells you, "No, that's about it."

[IF 3]
Your overall assessment: Explores for agenda partially with at least two efforts at agenda setting. One can be at beginning and one at end.

Suggestions and Recommendations: The interview did demonstrate several attempts to elicit the patient's agenda. For maximum efficiency you may want to ask several times at the beginning for the patient's full agenda. Continue this as needed until the patient tells you, "No, that's about it." A final check of agenda towards the end is useful, time permitting.

[IF 2]
Your overall assessment: Asks only once at the beginning e.g., "What brings you in today?" or "How can I be of help?" or at the end "Is there anything else?"

Suggestions and Recommendations: The interview demonstrated only a limited effort to elicit the patient's full agenda. Failure to elicit the full agenda can lead to an inefficient use of the patient's and your time and increase the frequency of, "By the way……." statements at the end of the interview. Please explore for the complete agenda until the patient says, "That's about it." Also close the interview, when possible, with a final solicitation for additional agenda

[IF 1]
Your overall assessment: Doesn't explore for agenda at beginning but begins addressing an established problem. Doesn't return to agenda at any point.

Suggestions and Recommendations: Agenda setting should happen at the beginning of the interview even if the chart identifies the patient's chief complaint. Remember that many patients will tell the screening health care worker an issue which serves as the "ticket of admission." Unless you fully explore the agenda, the patient's real reason for the visit may be missed. Make sure that you elicit the patient's agenda as many times as necessary until the patient lets you know, "That's about it." Also it is a good idea to check for any final agenda items at the end of the interview, time permitting.

INFORMATION MANAGEMENT

[IF 5]
Your overall assessment: Begin interview with open-ended questions and non-directed facilitation. Continue in this mode (with occasional closed-ended pints of clarification) till most/all of patient's information about the condition has been expressed. Performs appropriate summary(s). Asks appropriate focused (closed) questions towards the end.

Suggestions and Recommendations: Excellent use of open-ended questions and skills to encourage the patient to tell the whole story. Effective use of summary. Continue with these skills as performed.

[IF 4]
Your overall assessment: Begins with open-ended questions. Mixes open and closed-ended questions. Uses some form of partial summary.

Suggestions and Recommendations: Interview included effective use of open-ended and facilitating questioning to elicit the patient's uninterrupted ideas. Some use of summary evident. Consider the appropriate time to do a summary and check for accuracy.

[IF 3]
Your overall assessment: Uses some open-ended and closed-ended questions from the beginning. Doesn't summarize or does so weakly.

Suggestions and Recommendations: Interview demonstrated some use of open-ended questions. Interview would likely benefit from using more open-ended questions at the beginning (i.e. until they no longer elicit valuable information.) The use of summary is recommended.

[IF 2]
Your overall assessment: Mostly closed-ended questions. No summary or inadequate summary.

Suggestions and Recommendations: The interview included mostly closed-ended questions. Take the opportunity at the beginning to use open-ended and non-directed "continuers" to encourage patients to tell their own story and identify their own important issues without interruption. Use of summary at various times is useful and is encouraged.

[IF 1]
Your overall assessment: Mostly closed-ended questions. May use leading questions or repeats questions.

Suggestions and Recommendations: Interview demonstrated mostly closed-ended questions and some of these may have been leading questions that could provide inaccurate of misleading information. Practice using open-ended and non-directive facilitative questions early on in the interview. Follow these up with a summary, checking for accuracy.

ACTIVE LISTENING

[IF 5]
Your overall assessment: Very effective at identifying the patient's perspective on illness (PPI i.e. what the patient thinks may be going on; the greatest concern about the problem; and the expectations for the visit) The PPI is repeatedly explored using active listening to understand the meaning behind the patient's "clues". Once the PPI is disclosed these elements are acknowledged, normalized and used as part of a plan to address the medical diagnosis and the PPI.

Suggestions and Recommendations: Interview demonstrates a thorough and effective interest in understanding the patient's illness from the patient's point of view. Interviewer picks up on patient's implied but less than explicit statements. Asks specifically and explores for the patient's ideas, concerns, and expectations about the problem and illness. Continue to use these effective skills.

[IF 4]
Your overall assessment: Demonstrates genuine interest in the patient's perspective on illness (PPI) by using active listening at least part of the time. Does explore the clues initially, but not always fully. Once identified PPI will be partially addressed with some elements of acknowledgment, normalization, and building a plan based on the PPI.

Suggestions and Recommendations: The interview demonstrates a genuine interest in understanding the patient's ideas, concerns, and expectations. Interviewer explores at least some of the patient's clues (implied statements about their ideas, concerns, or expectations). Continue to look for opportunities to enter the world of the patient's ideas and especially to use these ideas explicitly as you develop a plan to address the problems of the day's visit.

[IF 3]
Your overall assessment: Demonstrates some interest in the patient's perspective on illness through occasional exploration of clues (efforts may not be effective.) May not pick up on clues but rather asks about the patient's ideas.

Suggestions and Recommendations: The interview demonstrates some interest in understanding the illness from the patient's point of view. There are clues that, if explored would provide additional information about the patient's ideas, concerns, and expectations. In addition to eliciting information about the patient's symptoms and medical data, equal efforts should be made to understand the patient's point of view on their condition and what they want for the visit. This information should be used in a plan that addresses the patient's expectations in a very direct and explicit manner.

[IF 2]
Your overall assessment: Fails to demonstrate effective interest in what the patient thinks may be going on; his/her greatest concern about the problem; and the expectations for the visit.

Suggestions and Recommendations: The interview appears to be focused predominantly on identifying those pieces of or medical data that would be useful in diagnostic considerations. Take advantage of the opportunities to follow up on the patient's implied statements about their ideas, concerns, and expectations when these arise in the interview. If you have not heard clues during the interview consider asking at the end of the interview session about the patient's ideas, greatest concerns, or expectations. Remember that direct questioning for these ideas, concerns, or expectations at the very beginning of the interview is often ineffective and to be avoided.

[IF 1]
Your overall assessment: Actively discourages or devalues the patient's perspective on illness.

Suggestions and Recommendations: Interview demonstrates such a strong focus on biomedical data as to communicate disinterest in the patient's ideas, concerns, and expectations. This will have a negative effect on the outcomes of many interviews. Look for opportunities to explore for the meaning behind patient's statements that imply their ideas, concerns, and expectations. If you have not identified such opportunities during the interview take a moment at the end of the interview to see if the patient cares to share any particular etiologic ideas, concerns, or expectations regarding their illness

ADDRESSING FEELINGS

[IF 5]
Your overall assessment: Responds to all opportunities to Address Feelings. When feelings surface, these are effectively addressed and then incorporated into the visit. Also effectively seeks out the "potential feelings" when situations with high likelihood of feelings surface in the interview.

Suggestions and Recommendations: The interview demonstrates considerable interest in and involvement with the patient's feelings as they relate to the illness and problem of the day. Feelings are acknowledged when expressed and when feelings are likely to be present they are explored for with interest and sensitivity. Continue with this excellent effort at addressing patient's feelings.

[IF 4]
Your overall assessment: Acknowledges feeling when expressed. Does not fully address/ incorporate into visit. Does not fully address "potential" feeling situations.

Suggestions and Recommendations: The interview clearly acknowledges feelings that are expressed explicitly by patients. Recall that many situations that are described by patients carry with them the very high likelihood of significant feelings being present. Explore the patient's interest or willingness to address feelings in these situations.

[IF 3]
Your overall assessment: Acknowledges expressed feelings but does not attempt to integrate into visit.

Suggestions and Recommendations: The interview demonstrates acknowledgment of feelings when they are present. Recall that there are other ways to deal with feelings which include normalizing, legitimizing, and exploring whether the patient has interest in further discussing these feelings. In addition look for situations in which feelings are likely to be present because of the context of the discussion. In such situations explore for the presence of patient's feelings and whether the patient would like to discuss these with you.

[IF 2]
Your overall assessment: May not acknowledge any of the feelings of the case or does so ineffectively.

Suggestions and Recommendations: The interview demonstrates a minimal interest in the feelings expressed by the patient. Take the opportunity to at least acknowledge as well as normalize or legitimize the patient's feelings that are expressed. In addition look for and consider the feelings that are present in many of the situations that patients describe around their health. When the situation is likely to include feelings it is recommended to open the discussion with patients whether the feelings are present and whether the patient would like to discuss them.

[IF 1]
Your overall assessment: Comments or responds in a way which demeans, criticizes, or devalues patient's feeling.

Suggestions and Recommendations: The interview demonstrates a lack of interest in the patient's feelings to the point that the patient may interpret this as a lack of personal interest in them. Take the opportunity to acknowledge and responds to feelings when they are expressed and actually look for opportunities to explore for feelings when the patient describes situations that are likely to be charged with significant personal feelings.

REACHING COMMON GROUND

[IF 5]
Your overall assessment: *In developing an unconflicted plan,* starts with thorough understanding of the patient's knowledge and perspective. Discusses feasibility. Explains the diagnosis and treatment clearly and concisely, checks for understanding.
*In reaching common ground with disagreement present, w*orks very effectively at bridging differences between the interviewer and the patient. Performs a full exploration of the patient's perspective on illness (PPI) and uses the PPI to reach common ground. Uses a number of the more effective skills in reaching common ground, e.g. full exploration of the PPI, decision analysis, reframing, patient centered suggestions, criteria setting, brainstorming, compromise, etc. Avoids less effective methods, e.g. use of authority, personal appeal, repetition of serious complications, or chance of death. Would likely facilitate a desirable change in behavior towards health.

Suggestions and Recommendations: *In developing an unconflicted plan,* the interview demonstrates very effective skills in clear explanations of the conditions at hand. Feasibility is fully discussed. In situations where understanding is required a thorough check of patient's understanding is achieved. The plan directly involves everything that has been learned from the patient's perspective on illness and clearly defines the roles of the patient and the physician.

In reaching common ground with disagreement present, the interviewer uses a variety of effective skills to reach common ground. Continue to use these effective skills in all interviews.

[IF 4]
Your overall assessment: *In developing an unconflicted plan,* begins with some understanding of patient's knowledge and perspective Explains clearly with only occasional use of jargon. Checks for understanding and feasibility.
In reaching common ground with disagreement, demonstrates clear skills in reaching common ground. Does obtain most of the patient's perspective on illness and attempts to use at least some (but not all) of its elements in a plan. Uses a mix of strategies to reach the plan. Heavier use of the more effective skills.

Suggestions and Recommendations: *In developing an unconflicted plan,* the interview demonstrates a clear and effective plan. The plan is built on a number of elements built on the patient's perspective that surfaced throughout the interview. Explanations are clear and some effort is made at checking feasibility and understanding and in defining mutual responsibilities. Look for opportunities to make the understanding and feasibility explicit.

In reaching common ground with disagreement, uses a number of effective skills to negotiate common ground. Also uses some of the less effective skills like repetition, use of the threat of serious complications, personal appeal, etc. Try to use more of the effective skills like decision analysis, criteria setting, brainstorming, and patient centered suggestions.

[IF 3]
Your overall assessment: *In developing an unconflicted plan,* demonstrates partial or minimal understanding of patient's knowledge. Provides information with general clarity. May include some jargon. Some effort to determine understanding and feasibility. (Often with a closed ended question.)
In reaching common ground with disagreement, while does not connect the plan with patient's perspective on illness, uses a balanced mix of skills to reach common ground that includes at least one of the more effective strategies.

Suggestions and Recommendations: *In developing an unconflicted plan,* the interview demonstrates a reasonably clear explanation to the patient but one that fails to identify and use elements of the patient's ideas, concerns, and expectations in the development of the plan. If understanding and feasibility is checked for they are often in a closed-ended question. It is suggested that every plan begin with an understanding of the patient's point of view around the condition at hand and explicit efforts to incorporate those ideas into the achievement plan. Many times a more thorough explanation of feasibility and understanding should occur to be maximally effective.

In reaching common ground with disagreement, the interviewer uses a higher percentage of less effective skills like repetition, use of morbid complications, personal appeal, etc. It is recommended that you practice using more decision analysis, brainstorming, criteria setting, patient centered suggestions in your efforts to reach common ground with patients.

[IF 2]
Your overall assessment: *In developing an unconflicted plan,* minimal or absent understanding of patient's knowledge. Information provided is somewhat confusing. Minimal effort to check for understanding and feasibility.

In reaching common ground with disagreement, does not use the patient's issues to help to solve the difference. Uses less effective strategies in creating a plan, e.g. use of authority, personal appeal, and repetition of serious complications. For most patients this plan would not significantly affect the long-term behavior in question.

Suggestions and Recommendations: *In developing an unconflicted plan,* the interview lacks effort to develop a plan that involves the patient's perspective on their illness. There are also issues of clarity and organization of explanations to patients and the feasibility and understanding of the patient are not effectively elicited. You should work to develop a plan that always incorporates the patient's perspective. In explanations be clear, concise, and check for the patient's understanding of what was said and checking for the patient's feasibility of complying. Clearly define the responsibility of the patient and yourself.

In reaching common ground with disagreement, make every effort to use more effective negotiation skills like criteria setting, common decision analysis, brainstorming, patient centered suggestions instead of the use of morbid complications, repetition, authority and other less effective strategies.

[IF 1]
Your overall assessment: *In developing an unconflicted plan,* no patient baseline assessment. Explanations confusing/disorganized/misleading. Minimal or absent attempt to check understanding or feasibility.

In reaching common ground with disagreement, uses less effective strategies almost exclusively. In missing the patient's issues and in using authority or threat, the patient would be unlikely to change long-term behavior and would probably leave upset with the interviewer's approach to problem solving

Suggestions and Recommendations: *In developing an unconflicted plan,* the interview lacks an effort to develop a plan with the patient in mind. There is no effort to check for understanding or feasibility and the likelihood that the patient will comply is low. Make every effort to elicit the patient's ideas, concerns, and expectations and incorporate these explicitly into a plan. Once explained check what the patient understands about what you have just described. Check specifically, "How does that sound?" Make sure that the mutual responsibilities of the patient and physician are stated explicitly.

In reaching common ground with disagreement, please review and practice a variety of common ground negotiation skills that include criteria setting, decision analysis, brainstorming, patient centered suggestions, etc. Avoid the use of repetition and heavy use of morbid complications, use of authority or personal appeal to attempt to achieve common ground.

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i Forrest Lang, M. D., Leo Harvill, Ron McCord, Delia Anderson. "Communication assessment using the common ground instrument: psychometric properties." *Fam Med.* 2004;36(3):189-98.