GUIDELINES FOR USING COMMON GROUND RATING FORMS

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GUIDELINES FOR USING COMMON GROUND RATING FORM (CGRF)

INTRODUCTION

Before using the CGRF first review the training document “Reaching Common Ground”, which describes the six categories of Core Communications Skills in some detail. 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 categories of communications. For example, “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 category 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 last 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 different 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.

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. Frequently, however, there will be a close match between the interviewer’s behavior and the global score in any category.
I. Rapport

— Initial introduction to patient
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 scenarios where the interviewer knows the patients, credit is given for mentioning one or both of the patients’ names.

— 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 statements of interest except the initial exchange of names and introductions. Include for example, “How are you today?” or “I hope you’re having a good day.” or “How do you find the weather?” If the interviewer proceeds to another non-medical topic additional credit is given. For example, “How’s work going?”

• 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.”

• Comments like, “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. 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. Comments that are mildly offensive or insensitive receive one “negative speak” for each expression. Comments that are unequivocally rude or offensive should be scored two “negative speak” for each expression. Also include here any comments, which discourage the expression of feelings or devalue feelings. For example:

- “You worry too much.” (one point)
- “You got upset over nothing.” (one point)
- “You’ve got to try to cooperate.” (one point)
- “I’d like you to be more responsible.” (implies patient is irresponsible) (one point)
- “The problem is you’re irresponsible.” (two points)
- “You’re just too lazy.” (two points)
- Include comments that feel racist, sexist, ageist, or biased in some other way. (two points)
- 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 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+.

— 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

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 “positive speak” like, “How are you doing?” leads to the patient providing agenda items for the day. In such cases give credit for “positive speak” 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 asks, “What else?” The patient will interpret this as an open-ended question, 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 till the point that the patient says, “Nothing else” If several agenda prioritize amongst them. Explores for additional agenda at end.

4. Explores complete agenda but may not summarize or prioritize or may not 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 recording the first ten interviewer exchanges once the interview turns to medical history, namely after the introduction and social commentary ceases. This usually begins with, “What brings you in?” or “How can I be of help?” (Both non-directed facilitation, 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.

— 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.

— 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?”
Information Management – Global Criteria

5. Begin interview with 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. Performs appropriate summary(s). Asks appropriate focused (closed) questions towards the end.


3. Uses some open-ended and closed-ended questions from the beginning. Doesn’t summarize or does so weakly.

2. Mostly closed-ended questions. No summary or inadequate summary.

1. Mostly closed-ended questions. May use leading questions or repeats questions.
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, which is provided by the standardized patient. In these situations there needs to be active exploration for the meaning implied beneath the clue to receive credit. 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, “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 not 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 are 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 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 a good 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 partially, 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 with the Patient

— **Nonverbal and transcribed feeling clues**
For the feeling comments or clues labeled on the SPSRF, 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?” Likewise 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?” On the other hand they would get credit if they do both active listening and addressing feeling, for example: “I can see you’re concerned (feelings), what do you think may be causing your headaches?” (active listening)

— **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?”

— **Addressing Feelings-Global Criteria**
5. Responds to all opportunities to Address Feelings. When the patient expresses a feeling, these are acknowledged, normalized or legitimized, and are addressed with a follow-up, which at least explores how the patient would like these feelings to be addressed. Also seeks out the “potential feelings” when situations with high likelihood of feelings surface in the interview.

4. Acknowledges feeling when expressed and does some but not all of the normalization, follow-up with a plan of activities. Does not fully address “potential” feeling situations.

3. Acknowledges feelings but does not use the other skills mentioned above

2. May superficially acknowledge one of a small portion of the feelings expressed or which are “potential” in an interview. May not acknowledge any of the feelings of the case.

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

— **Developing a Plan (No disagreement apparent)-Global rating criteria.**

5. Plan development starts with thorough understanding of the patient’s knowledge and perspective. Discusses feasibility. Explains the diagnosis and treatment clearly and concisely, checks effectively for understanding and feasibility.

4. Plan begins with some understanding of patient’s knowledge and perspective. Explains clearly with only occasional use of jargon. Checks for understanding and feasibility.

3. 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)

2. Minimal or absent understanding of patient’s knowledge. 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

OVERVIEW
Some of the interviews only involve doing a medical history and don’t require the interviewer to negotiate a plan. Others are designed specifically to create a tension between the interviewer and the patient so that we can 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 (usually after the interviewer receives additional information on a piece of paper for the patient).

— Checks for agreement feasibility with patient
This is a simple “Yes” or “No” which describes whether the interviewer asks the patient, “How does that sound to your?” or “How difficult is that going to be for you to start the medication?” or “Do you think you’ll be able to get to the referral next week?” etc.

— Checks for understanding
This similarly refers to whether the interviewer asks the patient if they understand the information provided. With statements like, “Do you understand the need for the medication?” or “Do you understand what the problems are with this condition?” or “Do you understand how to take the medication?” etc.

WAY OF ATTEMPTING TO RESOLVE DISAGREEMENTS
Heavier use of authority, threat, or unrelated suggestions

— Restating suggestions
The first time that an interviewer makes a particular recommendation this is not recorded per se. 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 the 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.

Note! If the patient repeats any of the following categories record the 1st in that category. If two different sets of morbidity data is used, then record twice in that category.

— Personal appeal and those repeated efforts in the restatement category
This is actually a subset of restating suggestions. 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. So if an interviewer says, “I’d really like you to promise me that you will take the insulin.” Record in this category even though it is a type of restatement. We are interested in knowing how often the restatements are made in the terms of personal appeal.

— Attempting to persuade using morbidity and mortality data
Among the most frequently used alternative 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 their directions by using these techniques, record in this category. Note that the addendum to this kind of statement, which 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.

Note! When the interviewer restates the same risks or threats, record as “restating suggestions”. If new elements of morbidity are introduced, record as “persuading with morbidity and mortality”.

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— **Making a doctor-centered recommendation**
This type of recommendation comes from the interviewer’s “bag of tricks” that they learned as a routine response to a particular situation like a high blood sugar. If the suggestion for improved management refers in no way to something specifically identified by the patient then record as a doctor-centered recommendation. (See below under Patient-Centered Suggestions for Additional Clarification.)

**MORE CREATIVE AND MORE PATIENT-CENTERED STRATEGIES**

— **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?”

— **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 in lieu of making recommendation or using morbidity and mortality rather asks the patient questions about source 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.

— **Making a patient-centered recommendation**
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 wheel?” is **not** a patient-centered suggestion.

— **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?”
— **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.”

— **Performing elements of decision analysis**

There are four elements of decision analysis which include specifically asking about

1) Current **problems** with a particular behavior or activity, “What problem does smoking cause you?”

2) Identifying specific **benefits** of a behavior or activity in question, “What benefits or enjoyment come from smoking?”

3) Exploring for perceived **incentives** for a change in behavior that may result from such a change, “What are reasons for stopping smoking?”

4) 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 element, which is specifically asked about.

— **Setting criteria**

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.

— **Compromise**

Record this when the interviewer seeks to find a solution by modifying his own position to some point between the patient 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.
— Reaching Common Ground-Global Criteria

5. Works very effectively at trying to bridge 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. 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, and repetition of serious complications or chance of death. Would likely lead to 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 the 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 or chance of death. 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 confusions)
APPENDIX – FORMS

Global Rating of Core, Common-Ground Interview Skills ............................................ Pages 19 – 20
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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 at 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 till the point that the patient says, “Nothing else” If several agenda prioritize amongst them. Explores for additional agenda at end.
4. Explores complete agenda but may not summarize or prioritize or may not 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.

Information Management - Global Criteria
5. Begin interview with 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. Performs appropriate summary(s). Asks appropriate focused (closed) questions towards the end.
3. Uses some open-ended and closed-ended questions from the beginning. Doesn’t summarize or does so weakly.
2. Mostly closed-ended questions. No summary or inadequate summary.
1. Mostly closed-ended questions. May use leading questions or repeats questions.

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 the patient expresses a feeling, these are acknowledged, normalized or legitimized, and are addressed with a follow-up, which at least explores how the patient would like these feelings to be addressed. Also seeks out the “potential feelings” when situations with high likelihood of feelings surface in the interview.
4. Acknowledges feeling when expressed and does some but not all of the normalization, follow-up with a plan of activities. Does not fully address potential feeling situations.
3. Acknowledges feelings but does not use the other skills mentioned above.
2. May superficially acknowledge one of a small portion of the feelings expressed or which are “potential” in an interview. May not acknowledge any of the feelings of the case.
1. Comments or responds in a way that demeans, criticizes, or devalues patients’ feeling.

**Developing a Plan (No disagreement apparent)—Global rating criteria.**

5. Plan development starts with thorough understanding of the patient’s knowledge and perspective. Discusses feasibility. Explains the diagnosis and treatment clearly and concisely, checks effectively for understanding and feasibility.
4. Plan begins with some understanding of patient’s knowledge and perspective. Explains clearly with only occasional use of jargon. Checks for understanding and feasibility.
3. 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)
2. Minimal or absent understanding of patient’s knowledge. 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**

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. 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.
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 Rating Form (Real Patient)

Interviewer ________________  Patient ________________  Faculty ________________  Date __________

1. Rapport
(Number of Occurrences)

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<thead>
<tr>
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Initial introduction to patient
Explicit “Positive Speak”
Explicit caring/commitment
Verbal interruption
Negative talk (implied or explicit)

Nonverbal Rating Scale

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2. Eliciting all Agenda Items
(Number of Occurrences)

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Agenda setting effort “What brings you in?”
Early full exploration i.e., “That’s it.”
Checks for additional agenda later.

3. Information Management
(Number of Occurrences)

<table>
<thead>
<tr>
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For the first ten questions record the open ended questions.
Performs summary with 3 or more items.

4. Active Listening for Full Understanding of Ideas, Concerns, and Expectations
(Number of Occurrences)

<table>
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PT’s clues or statements needing follow up.

(Rating Scale)

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Overall Active Listening

5. Addressing Feelings with Patient
(Number of Occurrences)

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PT’s stated or implied feelings needing follow up.

(Rating Scale)

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Explore or address other feelings..

(Rating Scale)

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Overall Deals with Feelings

Overall Rapport

Overall Agenda

Overall Information Management
6. Reaching Common Ground
Checks Feasibility and Understanding

(Rating Scale)

<table>
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</table>

Identifies patient’s baseline (knowledge, interest in participation, barriers) and builds plan incorporating patient’s perspective:

- No = Little or not at all;
- 1 = Partially, 2 = Adequately; 3 = Notably

Explains Impressions (Dx, Tx, options):

- No = Strikingly ineffective, 1 = Somewhat ineffective, 2 = Effective, 3 = Notably effective

Checks for agreement/feasibility

- No = None, 1 = Minimal, 2 = Effective

Checks for understanding

- No = None, 1 = Minimal, 2 = Effective

Defines follow up plan (mutual responsibility)

- No = None, 1 = Partial, 2 = Thorough

6a. In situations requiring behavior change or resolution of patient-clinician positions that begin in Non-Common-Ground, uses:

(Number of Occurrences)

<table>
<thead>
<tr>
<th>No</th>
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Less Effective Strategies

- Direction, repetition of position, using morbidity/mortality data; clinician centered recommendations, personal appeal

<table>
<thead>
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More Effective Strategies

- Assessing readiness to change; exploring patient’s ideas, knowledge, expectations; making patient-centered recommendations; reframing; brainstorming; decision analysis; criteria setting; compromise

(Rating Scale)

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7. Global Interview Performance

(Rating Scale)

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Observations and Comments
## 1. Rapport
(Number of Occurrences)

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Initial introduction to patient
Explicit “Positive Speak”
Explicit caring/commitment
Verbal interruption
Negative talk (implied or explicit)

### Nonverbal Rating Scale

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Body position and Eye contact
Voice Qualities

(Rating Scale)

1 2 3 4 5 NA

Overall Rapport

### 2. Eliciting all Agenda Items
(Number of Occurrences)

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Agenda setting effort “What brings you in?”
Early full exploration i.e., “That’s it.”
Checks for additional agenda later.

(Rating Scale)

1 2 3 4 5 NA

Overall Agenda

### 3. Information Management
(Number of Occurrences)

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For the first ten questions record the open ended questions.

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Performs summary with 3 or more items.

(Rating Scale)

1 2 3 4 5 NA

Overall Information Management

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

<table>
<thead>
<tr>
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(Rating Scale)

1 2 3 4 5 NA

Overall Active Listening

### 5. Addressing Feelings with Patient

<table>
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<th>No</th>
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<th>PT’s stated or implied feelings needing follow up.</th>
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(Rating Scale)

1 2 3 4 5 NA

Overall Deals with Feelings

Explores or address other feelings..

(Rating Scale)

1 2 3 4 5 NA
### 6. Reaching Common Ground

**Checks Feasibility and Understanding**

<table>
<thead>
<tr>
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</table>

- Identifies patient’s baseline (knowledge, interest in participation, barriers) and builds plan incorporating patient’s perspective:
  - No = Little or not at all;
  - 1 = Partially, 2 = Adequately; 3 = Notably

- Explains Impressions (Dx, Tx, options):
  - No = Strikingly ineffective, 1 = Somewhat ineffective, 2 = Effective, 3 = Notably effective

- Checks for agreement/feasibility
  - No = None, 1 = Minimal, 2 = Effective

- Checks for understanding
  - No = None, 1 = Minimal, 2 = Effective

- Defines follow up plan (mutual responsibility)
  - No = None, 1 = Partial, 2 = Thorough

#### 6a. In situations requiring behavior change or resolution of patient-clinician positions that begin in Non-Common-Ground, uses:

<table>
<thead>
<tr>
<th>Number of Occurrences</th>
<th>No</th>
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</table>

- **Less Effective Strategies**
  - Direction, repetition of position, using morbidity/mortality data; clinician centered recommendations, personal appeal

- **More Effective Strategies**
  - Assessing readiness to change; exploring patient’s ideas, knowledge, expectations; making patient-centered recommendations; reframing; brainstorming; decision analysis; criteria setting; compromise

#### 7. Global Interview Performance

<table>
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**Observations and Comments**

(C:CommonGrnd\Guideto Com-Grd Rating2-04)

Mnd 2-23-04
## Common Ground Rating Form (Standardized Patient)

### 1. Rapport
**No. of Occurrences**

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</tbody>
</table>

- Initial introduction to patient
- Explicit “Positive Speak”
- Explicit caring/commitment
- Verbal interruption
- Negative talk (implied or explicit)

#### Nonverbal Rating Scale

-2 Strong Negative
-1 Negative
0 Neutral
+1 Positive
+2 Strong Positive

<table>
<thead>
<tr>
<th>Body position and Eye contact</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
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<th>3</th>
<th>4</th>
<th>5</th>
<th>NA</th>
</tr>
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</tr>
</tbody>
</table>

#### Rating Scale

1 2 3 4 5 NA Overall Rapport

O O O O O O

### 2. Eliciting all Agenda Items
**No. of Occurrences**

<table>
<thead>
<tr>
<th>No</th>
<th>1</th>
<th>2</th>
<th>3</th>
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</thead>
<tbody>
<tr>
<td>O</td>
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</tr>
</tbody>
</table>

- Agenda setting effort “What brings you in?”
- Early full exploration i.e., “That’s it.”
- Checks for additional agenda later.

#### Rating Scale

1 2 3 4 5 NA Overall Agenda

O O O O O O

### 3. Information Management
**No. of Occurrences**

<table>
<thead>
<tr>
<th>0-1</th>
<th>2-3</th>
<th>4-5</th>
<th>6-7</th>
<th>8-10</th>
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<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

- For the first ten questions record the open ended questions.
- Performs summary with 3 or more items.

#### 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

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>N/A</th>
<th>PT’s clues or statements needing follow up.</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td>#1</td>
</tr>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td>#2</td>
</tr>
<tr>
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<td>#3</td>
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<tr>
<td>O</td>
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<td>O</td>
<td>#4</td>
</tr>
</tbody>
</table>

#### Rating Scale

1 2 3 4 5 NA Overall Active Listening

O O O O O O

### 5. Addressing Feelings with Patient

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>N/A</th>
<th>PT’s stated or implied feelings needing follow up.</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td>#1</td>
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<td>#4</td>
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</tbody>
</table>

#### Rating Scale

1 2 3 4 5 NA Overall Deals with Feelings

O O O O O O

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C:CommonGrnd Guideto Com-Grd Rating2-04
Muf 2-23-04
Common Ground Rating Form (Standardized Patients)

<table>
<thead>
<tr>
<th>Interviewer</th>
<th>Faculty</th>
<th>Date</th>
<th>S.P. (Generic w/Family)</th>
</tr>
</thead>
</table>

6. Reaching Common Ground
Checks Feasibility and Understanding
(Rating Scale)
<table>
<thead>
<tr>
<th>No</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<tbody>
<tr>
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</tbody>
</table>

Identifies patient’s baseline (knowledge, interest in participation, barriers) and builds plan incorporating patient’s perspective:
No = Little or not at all;
1 = Partially, 2 = Adequately; 3 = Notably

Explains Impressions (Dx, Tx, options):
No = Strikingly ineffective, 1 = Somewhat ineffective, 2 = Effective, 3 = Notably effective

Checks for agreement/feasibility:
No = None, 1 = Minimal, 2 = Effective

Checks for understanding:
No = None, 1 = Minimal, 2 = Effective

Defines follow up plan (mutual responsibility):
No = None, 1 = Partial, 2 = Thorough

6a. In situations requiring behavior change or resolution of patient-clinician positions that begin in Non-Common-Ground, uses:
(Number of Occurrences)
<table>
<thead>
<tr>
<th>No</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<tbody>
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</tbody>
</table>

Less Effective Strategies
Direction, repetition of position, using morbidity/mortality data; clinician centered recommendations, personal appeal

More Effective Strategies
Assessing readiness to change; exploring patient’s ideas, knowledge, expectations;
making patient-centered recommendations; reframing; brainstorming; decision analysis; criteria setting; compromise

7. Special Situations:
Family Interviewing Skills
(Number of occurrences)
<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
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<th>3</th>
<th>4</th>
<th>5</th>
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</tbody>
</table>

Communications to build rapport/provide support to “other” person(s) in the room.

(Rating Scale)
<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>N/A</th>
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<tbody>
<tr>
<td>O</td>
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</tbody>
</table>

Determines agenda of “other” person(s) in the room.

On potentially relevant issues, explores the perspective of the “other” person(s) in the room.

In situations where two individual have differences, fairly reframes/restates both sides/maintains neutrality (avoids triangulation.)

If separation is appropriate, negotiates with input from the patient.

Respects privacy/confidentiality

Agency/Focus/Siding
Focuses:
Balanced Interest
Focus: Other Only

(Rating Scale)
<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
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<th>4</th>
<th>5</th>
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Overall Family Interviewing

8. Global Total Interview Performance
(Rating Scale)
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<th>4</th>
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Overall Reaching Common Ground

Observations and Comments
East Tennessee State University
Patient’s Comments for Interviewer

Interviewer: ____________________________  Level of training: ____________________________
Patient: ________________________________  Date: __________  Time: ________________
Situation/Role: __________________________ Location: ________________________________
Positive Feelings/Impressions  Please phrase statements beginning with “As the patient…” or “I …”

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

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

& 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 ….

**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)

<table>
<thead>
<tr>
<th>Rapport</th>
<th>Agenda</th>
<th>Information Management</th>
<th>Active Listening</th>
</tr>
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<tbody>
<tr>
<td>N</td>
<td>P</td>
<td>I</td>
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</table>

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)

<table>
<thead>
<tr>
<th>Rapport</th>
<th>OBSERVATIONS</th>
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<table>
<thead>
<tr>
<th>Rapport</th>
<th>OBSERVATIONS</th>
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<table>
<thead>
<tr>
<th>Agenda Setting</th>
<th>OBSERVATIONS</th>
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<table>
<thead>
<tr>
<th>Information Management</th>
<th>OBSERVATIONS</th>
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<table>
<thead>
<tr>
<th>Active Listening—Exploring the patient’s perspective</th>
<th>OBSERVATIONS</th>
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<thead>
<tr>
<th>Feelings</th>
<th>OBSERVATIONS</th>
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<table>
<thead>
<tr>
<th>Reaching Common Ground</th>
<th>OBSERVATIONS</th>
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<tr>
<th>When in a “non-Common Ground situation”</th>
<th>OBSERVATIONS</th>
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</table>

Other Suggestion/Comments:
**FEEDBACK AND RECOMMENDATIONS – COMMON GROUND FAMILY INTERVIEWING SKILLS**

Interviewer: ___________________ Date ______________ Feedback Provider: ___________________

I. Interview Skills Profile (See Global Rating Guide)

<table>
<thead>
<tr>
<th>Rapport</th>
<th>Agenda</th>
<th>Information Management</th>
<th>Active Listening</th>
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</thead>
<tbody>
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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)

<table>
<thead>
<tr>
<th>Rapport</th>
<th>Observations</th>
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<tbody>
<tr>
<td>N  P  I</td>
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**Rapport**

- 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.

**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.

**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.

**Feelings**

- Acknowledges/legitimizes/normalizes expressions of feelings.
- Explores for likely but unspoken feelings.

**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.
- 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)

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

Other Suggestion/Comments: (See over)