We appreciate your participation in the BRIDGE (Blacks Receiving Interventions for Depression and Gaining Empowerment) Study. This study is funded by the Agency for Healthcare Research and Quality and the National Institute of Mental Health and The AETNA Foundation for the purpose of improving patient-physician communication about management of depression, increasing treatment adherence, and reducing ethnic disparities in mental health.

As you know, a critical component of the study is to give individualized feedback on your interview with our simulated patient, Ms. Anita Jones. The videotape of your visit has been saved to CD-ROM within software that shows the categorization of every statement spoken. The coding scheme applied to your videotape is the Roter Interaction Analysis System (RIAS), a widely used approach to assessment of medical interaction.

The software allows you to:
go directly to those parts of the visit that interest you
see a visual summary of your conversation with your patient over the course of the visit
review the different kinds of talk that comprise the conversation, and select samples of the talk, by category, for review
listen to Glossary examples of talk categories and specific skills that are useful in the management of depressed patients

The workbook will:

- direct you to the primary features of the program
- help with self-assessment and goal-setting
- provide documentation of your completion of the CME program

A feedback and evaluation form is enclosed with this packet. We hope you will take a few minutes to complete this and return, in the enclosed, stamped envelope.

Please complete workbook and evaluation by: _____

To complete the CME session:

Your personalized review has been organized into an introduction, a video review of your visit with the simulated patient, and nine brief study sections as follows:

Part I: BRIDGE Study Introduction

1. Installation of RIAS_PLAYER software (p.3)
2. Introduction to Ms. Jones and description of RIAS (pp.4-5)

Part II: Personalized Review and Workbook

Detailing Visit 1

1. Improved recognition of depression
2. Evaluation of depressed patients for associated conditions
3. Evaluation of depressed patients for suicidal ideation
4. Assessment of functioning and coping strategies (lifestyle and psychosocial issues)
5. Medical Visit Function: Data gathering
6. Medical Visit Function: Building rapport

Detailing Visit 2

7. Probing for knowledge and beliefs about depression
8. Probing for treatment preferences and concerns
9. Treatment options/ patient education
10. Elicit commitment to a therapeutic plan
11. Medical Visit Function: Patient education and counseling
12. Medical Visit Function: Facilitation and patient activation

Recap:

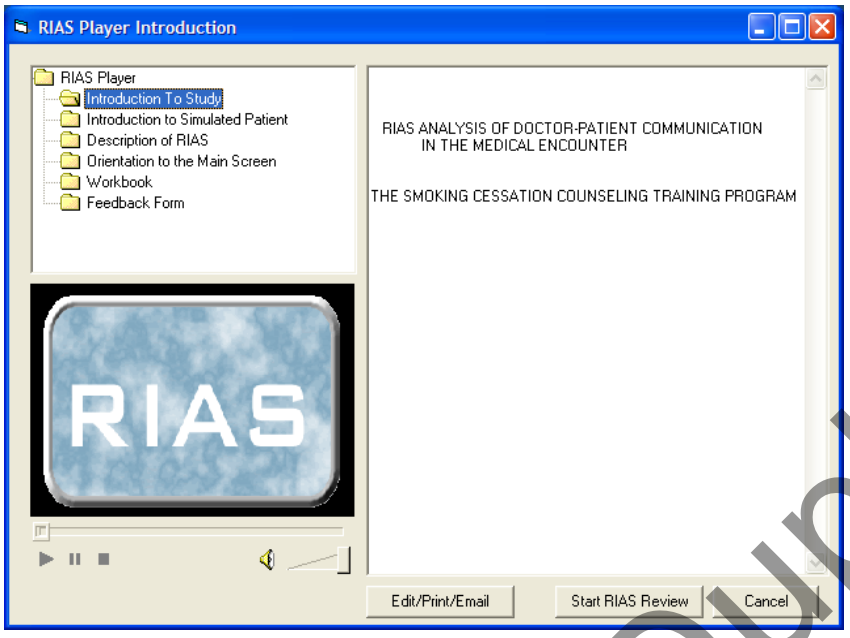
1. Medical Visit Function: Data gathering
2. Medical Visit Function: Building rapport
3. Medical Visit Function: Patient education and counseling
4. Medical Visit Function: Facilitation and patient activation

Each section will take about 10 minutes, for a total time commitment of 1-1/2 to 2 hours. The exercises need not be completed in one session.

Finally, we would appreciate completion of an evaluation form (enclosed).

To open the RIAS_PLAYER program:

- From your start button, go to Programs and select RIAS_PLAYER, from the drop-down list.
- Click the folder "Introduction to Simulated Patient" to play the video introduction of Ms. Jones.



- Use the media playback controls under the playback window to stop or re-start the video, or to adjust the volume.
- The text of Ms. Jones' introduction follows.

As you know, I'm Anita Jones. I'm 38 years old and I live in Baltimore City where I was born and raised. I am a graduate of the University of Maryland and I now work as a claims Adjuster. I'm divorced and I have two children, ages 7 and 11. I go to my mother and sister for emotional support.

I've had hypertension for the past two years and I am currently taking HCTZ 25 mg once a day.

I have a family history of health problems. My mother has hypertension and my father has coronary heart disease. My Brother had a heart attack three years ago. There is no history of mental health problems in the family.

I eat fast food for lunch but I usually have a healthy dinner. I do not smoke and I drink socially (at holiday parties).
I do not take street drugs.
I have trouble sleeping and I've been feeling tired; I feel like I just need more time to myself.

Description of the Roter Interaction Analysis System (RIAS):

The RIAS is applied to units of speech ("utterances") that convey a complete thought expressed by either the patient or physician, or anyone else present during the medical visit. An utterance may be a simple sentence or a sentence fragment. These speech units are assigned to mutually exclusive and exhaustive categories that reflect both the **content** and **form** of medical conversation. The categories specify areas of **content** such as medical history and symptoms, therapeutic regimen and testing, health promotion and prevention, or psychosocial topics related to feelings, emotions and social relationships at home and at work. Conversational **form** is reflected by categorization into questions (open and close-ended), information giving, counseling and persuasion, rapport building and emotional responsiveness, and dialogue facilitators. Coders apply the RIAS directly to the medical dialogue without transcription, using direct entry software and the digitized video file.

The RIAS is a highly reliable method of interaction analysis that has demonstrated predictive validity to a variety of patient outcomes, including patient and physician satisfaction, patient recall, patient compliance, utilization, and physical and emotional well being (see **HELP MENU** for the Bibliography**).**

The RIAS reflects medical interaction necessary for the accomplishment of the four main functions of the medical visit: **Data Gathering, Patient Education and Counseling, Building Rapport, and Facilitation and Patient Activation.** The medical functions, and the specific categories of talk that fall within each, are described in detail in the following pages of the Workbook. You may also use the **HELP MENU** to display operational definitions of each RIAS category, or use the **Glossary** to retrieve illustrative videotape clips.

Study ID: _____

Skills for Patient Centered Depression Care for African Americans: General Concepts of Effective Communication

Before beginning the exercises, **CLICK the PLAYBACK** button to re-acquaint yourself with your visit.

Verbal Dominance:

Overall, you contributed XX% of the talk to this visit; the simulated patient contributed XX%. On average, the verbal dominance ratio of your peers is XX to XX%.

The hatch marks across the hatchbar represent the timing and sequence of statements made by both speakers, and indicate the balance of talking and listening functions.

In contrast to dense clusters along the physician axis, frequent turn taking is indicated by hatchmarks on both sides of the axis.

Visit Functions:
The communication during a medical visit can be grouped into **five broad functions**:

Data Gathering
Patient Education and Counseling
Rapport Building
Facilitation and Patient Activation
Procedural

The talk during your visit has been coded using the Roter Interaction Analysis System (RIAS)—by counting "utterances" which are then assigned to the appropriate RIAS category of talk. The following table shows the **distribution of utterances into these five functions** for both you and the standardized patient.

#Dr	#Pt	
XX	XX	Data Gathering
XX	XX	Patient Education and Counseling
XX	XX	Rapport Building

XX	XX	Facilitation and Patient Activation
XX	XX	Procedural

Within three of these broad groupings are **sub-composites of talk**, specifically:

Data Gathering
Biomedical
Lifestyle/Psychosocial
All Open Questions
All Closed Questions
Patient Education and Counseling
Biomedical
Lifestyle/Psychosocial
Rapport Building
Emotional Talk
Positive Talk
Negative Talk
Social Talk
Facilitation and Patient Activation
Procedural

A summary table of **all talk for your visit** follows on the next page. This specifies the counts—for each of the RIAS categories, and for both speakers—included in the functions and sub-composite groupings.

Comparison to Peer Group:

Percentages of your talk--by visit function—may be compared to the talk of your peers:

My visit:		As compared to my peers:	
XX%		XX%	Standard Deviation
	Data Gathering		
	Biomedical		
	Life style/Psychosocial		
	All Open Questions		
	All Closed Questions		
	Patient Education and Counseling		
	Behavioral		
	Lifestyle/Psychosocial		
	Rapport Building		
	Emotional Talk		
	Positive Talk		
	Negative Talk		
	Social Talk		
	Facilitation and Patient Activation		
	Procedural		

Skills for Patient Centered Depression Care for African Americans: Personalized Review and Workbook

Introduction:

Depression:Burden of Suffering

- Lifetime risk in population is 15-20%
- Functional impairment as great as most chronic diseases
- Direct treatment and indirect costs from lost productivity approximate 43 billion dollars per year
- Over half of depressed patients seeking help are seen by primary care providers
- Approximately 3-6% of all primary care patients meet full criteria for major depression

Racial and Ethnic Disparities in Depression Care

- African Americans and Hispanics use **specialty mental health services** at half the rate of whites *Vernon 1982, Sussman 1987, Hough 1987, Scheffler 1989, Gallo 1995*
- Disparities in mental health care not explained by differences in education or health insurance *Padgett 1994, Charbonneau 2003*
- Use of outpatient mental health services in **primary care** settings has increased for African Americans and Hispanics *Cooper-Patrick 1999, Vega 1999*

Depression Under-Recognition and Under-treatment

- 30%-70% of depression is missed
- Ethnic minorities are less likely to be recognized as depressed or to receive guideline-concordant care in primary care settings

  Wang 2000, Borowsky 2000, Harman 2001, Young 2001

Study Objective and Specific Goals:

Study Objective

- Does a patient-centered, culturally targeted intervention that focuses on the concerns and preferences of African American patients with depression and their primary care providers improve processes and outcomes of care?
- Our goal is to specifically target primary care, providers (PCP) serving ethnic minorities, include rigorous evaluations of PCP performance, patient adherence, and health outcomes

Patient-Provider Communication Related to Important Outcomes

- Patient recall of information
- Patient adherence
- Patient satisfaction
- Clinical outcomes
  - Glycemic control
  - BP control
  - Pain reduction
  - **Depression resolution**

Communication approaches that foster an active working partnership may improve management of depression, increase treatment adherence, and reduce ethnic disparities in mental healthcare. Specific communication skills that are useful to therapeutic management of depressed patients are identified and addressed in the exercises that follow.

GENERAL INSTRUCTIONS: Each of the following exercises will help you to review your performance in 12 major areas of the interview

Exercise 1: IMPROVE RECOGNITION OF DEPRESSION

The first step in improving recognition of depression is awareness of the diagnostic criteria:

Diagnostic Criteria for Major Depressive Disorder

At least 5 of the following 9 symptoms most of the day, nearly every day for at least 2 weeks:

- Depressed mood
- Diminished interest or pleasure in almost all activities
- Insomnia or hypersomnia
- Significant weight loss or gain
- Feelings of guilt or worthlessness
- Fatigue (loss of energy)
- Impaired concentration
- Psychomotor retardation or agitation
- Recurrent thoughts of death or suicide

DSM-IV Diagnostic Criteria for Major Depression

- Depressed mood or anhedonia
- A total of 5 out of 9 symptoms*
- Symptoms that persist most of the day, nearly every day, for 2 weeks

*See Clinician Resources Appendix I

You may choose to use the PHQ for assessment of high-risk patients (see Appendix I).

Case-Specific Tasks:
GO to the Study Lessons Grid and CLICK the "+" to the left of "Ms. Jones" to expand the lessons menu.

CLICK the "1" to the right of "Concerns" to hear Ms. Jones tell of her other symptoms. Click Exit when the clip is finished.

Which of Ms. Jones' symptoms did you elicit? (check any that apply)

- ☐ Been waking up early in the mornings
- ☐ Feeling more angry and irritable—like she's "losing it"
- ☐ Is unable to concentrate
- ☐ Been having feelings of guilt and self blame
- ☐ Loss of interest in usual activities
- ☐ Has an increased appetite
- ☐ Worried about not being able to care for children
- ☐ Worried about taking too many sick days from work
- ☐ Feeling selfish about not wanting to spend time with her family
- ☐ Feeling down or depressed
- ☐ Feeling fatigued / lack of energy

GO to the Proficiency Grid and CLICK the number to the left of "Recognition of Distress" to review those instances where you may have elicited the patient's concerns to recognize her distress.

CLICK the number to the right of "Recognition of Depression" to view glossary examples.

COMPLETE the following:

1. In your practice, how IMPORTANT is it to screen for depression in all patients?

Not at all Somewhat Moderately Very Extremely

2. .In what percentage of your visits do you ROUTINELY PROBE for the diagnostic criteria for depression?

0% 10 20 30 40 50 60 70 80 90 100%

3. How CONFIDENT are you that you can incorporate these probes into your routine practice?

Not at all Somewhat Moderately Very Extremely

4. In future visits with patients, how LIKELY is it that you will improve recognition of depression?

Not at all Somewhat Moderately Very Extremely

Exercise 2: EVALUATION OF DEPRESSED PATIENTS FOR ASSOCIATED CONDITIONS.

Many general medical conditions are risk factors for major depression. Approximately 10% or more of MDD cases are caused by medical illness or other conditions. In general, optimize treatment for the general medical disorder and/or provide specific treatment for the depression.

Co-Morbidity in Depression is Common

- Alcohol/substance abuse
- Concurrent medication
- General medical disorder
- Other current psychiatric condition
- Grief reaction

(See Appendix III, p. 37 for Somatic Treatments of depression in patients with medical illness.)

Case-Specific Tasks:
In the Study Lessons Grid, CLICK the number to the right of "Associated Conditions" to listen to Ms. Jones' current status.

Which of the following did you elicit?

- ☐ Continues to take hypertension medication every day
- ☐ Drinks alcohol occasionally (unchanged status)
- ☐ Does not use illicit drugs (unchanged status)
- ☐ Recent negative life events or loss (divorce in past year)
- ☐ Does not have additional medical conditions/problems

GO to the Proficiency Grid and CLICK the number to the left of "Associated Conditions" to review those instances where you may have evaluated the patient's associated conditions.

CLICK the number to the right of "Associated Conditions" to view glossary example

Complete the following:

1. In your practice, how IMPORTANT is it to explicitly probe for associated conditions with a patient?

Not at all Somewhat Moderately Very Extremely

2. With what percentage of your depressed patients do you ROUTINELY PROBE for associated conditions?

0% 10 20 30 40 50 60 70 80 90 100%

3. How CONFIDENT are you that you can incorporate these skills into your routine practice?

Not at all Somewhat Moderately Very Extremely

4. In future visits with depressed patients, how LIKELY is it that you will routinely evaluate for associated conditions?

Not at all Somewhat Moderately Very Extremely

Exercise 3: EVALUATION OF DEPRESSED PATIENTS FOR SUICIDAL IDEATION

Detection of Suicidal Ideation

- 9th question of PHQ is a suicide screening question
- If NOT using PHQ start by asking patients about sleep disturbance, mood disturbance, guilt or worthlessness, and hopelessness*
  - A positive answer to each question receives one point (scores range from 0-4)
  - Those with higher scores are more likely to have suicidal ideation

*Cooper-Patrick et al, JAMA 1994; 272:1757-1762

Suicide Screening Questions

- When a diagnosis of Depression is made, suicide risk requires assessment. For all depressed patients the following question may be asked:
  - Have you thought a lot about death -- your own, someone else's, or death in general?
  - Have you had any thought that life is not worth living or that you would be better off if you were dead?
  - What about thoughts of hurting or even killing yourself?
  - If YES, what have you thought about? Have you actually done anything to hurt yourself?

Assessment of Suicide Risk

Risk	Description	Action
□Low Risk	No current thoughts, no major risk factors	Continue follow-up visits and monitoring
□Intermediate Risk	Current thoughts, but no plans, with or without risk factors	Assess suicide risk carefully at each visit and contract with patient to call you if suicide thoughts become more prominent; consult with an expert as needed
□ High Risk	Current thoughts with plans	Emergency management by qualified expert.

Case-Specific Tasks:

In the Study Lessons Grid, CLICK the number to the right of "Suicidal Ideation" to listen to Ms. Jones' thoughts.

Which of the following did you elicit?

- ☐ I have had thoughts about dying, but no thoughts of hurting myself
- ☐ I believe I have my kids to live for
- ☐ I am not experiencing hopelessness

GO to the Proficiency Grid and CLICK the number to the left of "Suicidal Ideation" to review those instances where you may have assessed the patient's suicidal thoughts.

CLICK the number to the right of "Suicidal Ideation" to view glossary examples.

Complete the following:

1. In your practice, how IMPORTANT is it to explicitly probe for suicidal ideation with depressed patients?

Not at all Somewhat Moderately Very Extremely

2. With what percentage of your depressed patients do you ROUTINELY PROBE for suicidal ideation?

0% 10 20 30 40 50 60 70 80 90 100%

3. How CONFIDENT are you that you can incorporate this skill into your routine practice?

Not at all Somewhat Moderately Very Extremely

4. In future visits with depressed patients, how LIKELY is it that you will routinely evaluate for suicidal ideation?

Not at all Somewhat Moderately Very Extremely

Exercise 4: ASSESSING FUNCTIONING AND COPING STRATEGIES (LIFESTYLE AND PSYCHOSOCIAL ISSUES)

Assessment of functioning and coping strategies is particularly relevant for encouragement of lifestyle changes that range from eating and exercise habits to stress-related coping strategies. Inclusion of patients in a negotiation process creates buy-in to a plan and enhances the likelihood of successful follow-through.

Lifestyle Factors

- Depression can be associated with weight gain/loss
- Very appropriate to discuss importance of healthy diet and exercise
- Correlation between overweight and depressive symptoms among African American women*
- Aerobic exercise at a dose consistent with public health recommendations is an effective treatment for MDD of mild to moderate severity**

*Siegel, JM et al. J of Prev Med 2000; 31; 232-240

**Dunn, AL, et al, Am J Prev Med 2005; 28;1: 1-8

Assessing Psychosocial Factors

- Occupational: Have you been able to get to work/school most days in the past week?
- Family: How do your family members think you are doing? How are you handling your household chores/child care responsibilities?
- Social: Are you going out and spending time with people as much as you usually do?

Case-Specific Tasks:
In the Summary Lesson Grid, CLICK the number to the right of "Lifestyle Factors" to listen to Ms. Jones' activities related to daily activities, work, diet and exercise.

Which of the following did you elicit?

- Eats late at night when she can't sleep
- Eats sweets to feel better
- Used to belong to walking group, but now seldom exercises
- Thinks exercising is important, but can't get motivated.
- Needs help with transporting children, household chores.
- Not always able to pay bills.
- Unable to concentrate at work and meet deadlines
- Has been reprimanded for tardiness

Spirituality has been documented to be an important coping strategy for many African Americans. Some patients learn to cope with and understand their suffering through their spiritual beliefs, or the spiritual dimensions in their lives. It is important to assess a patients' 'Spiritual History' in order to maintain an individual approach to care for your patients.

A *spiritual history* is defined as the assessment of beliefs or values that explicitly open the door to a conversation about the role of spirituality and religion in a person's life.

Spiritual History Tool

- F: What is your faith or belief?
  Do you consider yourself spiritual or religious?
- I: Is it important in your life?
  What influence does it have on how you take care of yourself?
- C: Are you part of a spiritual or religious community?
  Is this of support to you and how?
- A: How would you like me, your healthcare provider, to address these issues in your healthcare?

Puchalski, C J. of Palliative Med, 1999; 5:12-13

Case-Specific Tasks:
In the Lesson Summary Grid, CLICK the number to the right of "Psychosocial Factors" to listen to Ms. Jones' stressors, coping strategies, and spiritual beliefs.

Which of the following did you elicit?

- ☐ Sense of failure due to divorce in last year
- ☐ Burdened by responsibilities for caring for her children.
- ☐ Hopes ex-husband will realize his mistake and come back
- ☐ Would like time to do things for herself (beauty parlor, exercise, see friends)
- ☐ Poor interpersonal relationship with supervisor.
- ☐ Prayer gives her inspiration; she prays that God will help her to feel better
- ☐ Belongs to prayer group, but doesn't feel like going
- ☐ Talks to friends on phone for support

GO to the Proficiency Grid and CLICK the number to the left of "Functioning and Coping" to review those instances where you may have elicited this information.

CLICK the number to the right of "Functioning and Coping" to view glossary examples.

Complete the following:

1. In your practice, how IMPORTANT is it to understand the patient's lifestyle and psychosocial factors before counseling of a patient with depression?

Not at all Somewhat Moderately Very Extremely

2. With what percentage of your depressed patients do you ROUTINELY PROBE for lifestyle and psychosocial factors?

0% 10 20 30 40 50 60 70 80 90 100%

3. How CONFIDENT are you that you can incorporate these skills into your routine practice?

Not at all Somewhat Moderately Very Extremely

4. In future visits with depressed patients, how LIKELY is it that you will routinely explore patients' lifestyle and psychosocial factors?

Not at all Somewhat Moderately Very Extremely

Exercise 5: DATA GATHERING

Effective data gathering incorporates the use of open and closed questions for different content, as well as listening skills that signal interest and receptivity.

- Open-ended questions elicit the patient's perspective and meaning. They are especially useful early in the visit to identify the medical complaints, and during counseling when decision-making and treatment options are discussed.
- Closed-ended questions—when judiciously used--may confirm or rule out a specific hypothesis by requests for short, direct answers.
- Open to closed question cone—beginning with open-ended questions, narrowing to closed-ended questions, and finally re-opening questions for additional information—is an effective and efficient data gathering strategy.

Content-specific domains:

- Biomedical questions probe medical history, symptoms, treatment or testing.
- Psychosocial questions probe the patient's relationships, values, emotions and lifestyle.
- Data Gathering is most effective when combined with active listening skills, signs of interest ("go on, right yes, a-hmmm") as well as nonverbal cues.

REVIEW SAMPLES of your questions by question type and content.
REVIEW GLOSSARY examples of these questions.

In future visits with depressed patients, how LIKELY is it that you will attempt the following?

	Not at all	Somewhat	Moderately	Very	Extremely
Increase your use of open questions	1	2	3	4	5
Decrease use of close-ended questions	1	2	3	4	5
Increase open to closed question cones	1	2	3	4	5
Probe medical concerns more fully	1	2	3	4	5
Probe therapeutic concerns more fully	1	2	3	4	5
Probe psychosocial concerns more fully	1	2	3	4	5
Probe lifestyle concerns more fully	1	2	3	4	5

Exercise 6: BUILDING RAPPORT

Rapport building skills focus on the emotional aspects of the doctor-patient relationship. These help establish an emotional connection that is helpful as patients face the uncertainties and difficulties associated with health challenges.

- Empathy statements identify or name the patient's emotional state.
- Legitimation statements convey that the patient's actions, emotions or thoughts are understandable and normal.
- Concern or Worry statements establish commitment, conscientiousness, and caring.
- Partnership statements explicitly state collaboration and the intention to continue a relationship.
- Reassurance statements encourage the patient, and provide realistic optimism at appropriate times during the visit.

REVIEW SAMPLES of your Empathy, Legitimation, Partnership, Reassurance and Concern statements.
REVIEW GLOSSARY examples of these statements.

---

1. What was the extent of your emotional repertoire? (note the number of utterances)
   Empathy_____ Legitimation_____ Partnership_____Reassurance_____ Concern_____

2. CLICK the number in the "Patient" column to the right of Concerns to review Ms. Jones' expressions of concern during your visit. Consider your responses to these statements.

   a) Which of the statements seemed particularly helpful?
   b) Which did not appear to have the effect you intended?
   c) Were there any "lost opportunities" during the visit when another response would have been more appropriate?

END OF SESSION 1:
NOTE THAT THE REMAINING 2 FUNCTIONS OF THE MEDICAL VISIT WILL BE ADDRESSED IN SESSION 2.

BEGINNING OF SESSION 2:
YOU MAY WANT TO REVIEW THE GENERAL CONCEPTS OF COMMUNICATION AT BEGINNING OF SESSION 1, AND PRIOR EXERCISES.

Exercise 7: PROBING FOR KNOWLEDGE AND BELIEFS ABOUT DEPRESSION.
It is important to know what the patient knows and thinks about her health and depression so that expectations about treatment can be clarified, and misunderstandings and misinformation discussed and addressed.

Case-Specific Tasks:
In the Study Lessons Grid, CLICK the number to the right of "Knowledge/Beliefs" to listen to Ms. Jones' beliefs.

Which of the following did you elicit?

- ☐ She feels that depression is caused by lack of faith or by disappointing God.
- ☐ She thinks that depression is a white person's illness
- ☐ She feels that depression is a sign of personal weakness of character

GO to the Proficiency Grid and CLICK the number to the left of "Knowledge/Beliefs" to review those instances where you may have elicited the patient's knowledge and beliefs about depression.

CLICK the number to the right of "Knowledge/Beliefs" to view glossary examples.

Complete the following:

1. In your practice, how IMPORTANT is it to probe for the patient's knowledge and beliefs before negotiating treatment for depression?

Not at all Somewhat Moderately Very Extremely

2. With what percentage of your patients do you ROUTINELY PROBE for their knowledge and beliefs?

0% 10 20 30 40 50 60 70 80 90 100%

3. How CONFIDENT are you that you can incorporate these probes into your routine practice?

Not at all Somewhat Moderately Very Extremely

4. In future visits with depressed patients, how LIKELY is it that you will routinely probe for knowledge and beliefs?

Not at all Somewhat Moderately Very Extremely

Exercise 8: TREATMENT PREFERENCES AND CONCERNS

Elicitation of patients' concerns and reservations about depression care--as well as their ideas regarding treatment options and alternatives--is an important starting point for brainstorming and problem solving.

Important Aspects of Depression Care to Patients

- Health provider interpersonal skills
  - Trust
  - Good communication
- Treatment effectiveness
  - Medication
  - Counseling
- Treatment problems
- Patient education, information, and understanding
- Intrinsic spirituality * (African Americans)
- Financial access
- Primary care provider recognition of depression
- Stigma, stereotypes and cultural myths

Cooper LA et al, Gen Hosp Psychiatry 2000;22:163-173
*Cooper LA et al, JGIM 2001;16:634-638

African Americans' Most Important Concerns about Depression Care

- Intrinsic Spirituality*
- Primary care provider recognition of depression
- Education and information
- Trust in and communication with health professionals
- Concerns about antidepressant medication (less likely to find acceptable than whites, and more likely to believe addictive)
- Concerns about counseling
- Financial barriers
- Stigma, stereotypes, and cultural myths**

Cooper LA et al, Gen Hosp Psychiatry 2000;22:163-173
*Cooper LA et al, JGIM 2001;16:634-638

**Primm AB, et al. J National Med Assoc. 2002; 94: 1007-1016

Eliciting and Identifying Treatment Preferences

- If the diagnosis is confirmed, the clinician and staff educate the patient about
  - depression
  - the care process
- Clinicians should consider patients *cultural and social context* when negotiating treatment decisions for depression
- Incorporate patient's view of the illness
- Determine patient preferences for treatment
- Provide educational materials and support in terms the patient can understand*

*Samples, Appendix II: Patient Education Tools

Case-Specific Tasks:

In the Study Lessons Grid, CLICK the number to the right of "Treatment Concerns" to listen to Ms. Jones' concerns in this area.

Which of the following did you elicit?

- ☐ She thinks that antidepressant medication makes her gain weight.
- ☐ She feels that medication does not fix problems, just covers them up.
- ☐ She worries that antidepressant medication is addictive.
- ☐ She feels that counseling may bring up painful feelings.

GO to the Proficiency Grid and CLICK the number to the left of "Treatment Concerns" to review those instances where you may have elicited treatment concerns.

CLICK the number to the right of "Treatment Concerns" to view glossary examples.

Complete the following:

1. In your practice, how IMPORTANT is it to explicitly ask about concerns about treatment for depression before negotiating treatment with a patient?

Not at all Somewhat Moderately Very Extremely

2. With what percentage of your patients do you ROUTINELY PROBE for these preferences and concerns?

0% 10 20 30 40 50 60 70 80 90 100%

3. How CONFIDENT are you that you can incorporate these skills into your routine practice?

Not at all Somewhat Moderately Very Extremely

4. In future visits with depressed patients, how LIKELY is it that you will routinely ask for preferences?

Not at all Somewhat Moderately Very Extremely

Exercise 9: ELICIT COMMITMENT TO A THERAPEUTIC PLAN

Engaging patients in problem-solving and brainstorming are important precursors to building commitment to a therapeutic plan. Having the patient make an explicit commitment to you to follow through on the plan, even if only until the next visit, is a powerful motivator that has been linked to regimen adherence in many studies.

Engage Patient in Therapeutic Plan

- Depressed patients are three times more likely to be noncompliant with medical treatment recommendations*
- Identify two to three coping strategies that may be helpful for the patient and clarify if the strategies will be consistent with their personality and lifestyle
- Set reasonable goals→ pick at least one goal in which the patient can have a success rate of > 70%

*DiMatteo MR, et al. Arch Intern Med, 2000; 160, 2101-2107

Participatory Decision Making (PDM)

- Physicians who routinely involve patients in treatment decisions (presenting options, discussing the pros and cons of those options, eliciting patient preferences, and reaching mutually agreed-on treatment plans) can be said to have a "shared" or "participatory" decision-making style
- Visits in which the physician used a PDM style have been associated with higher levels of patient satisfaction and continuity of care*
- African American patients rate their visits with physicians less participatory than whites**

*Kaplan, SH et al. An Intern Med 1996; 124: 497-504
** Cooper-Patrick, LA et al. JAMA 1999; 282: 583-589

Case-Specific Tasks:

In the Study Lessons Grid, CLICK the number to the right of "Problem-Solving Ideas" to listen to Ms. Jones' ideas about ways to address her problems.

Which of the following did you elicit?

- ☐ Will take antidepressant medication regularly, as long as it doesn't make her gain weight.
- ☐ Will try counseling, but wants to see a mental health professional who is an African American woman.
- ☐ Will eat fruits and use sugar substitutes instead of sweets.
- ☐ Will increase physical activity to at least 20 minutes 3 times a week (walk with co-workers at lunchtime)
- ☐ Will follow-up by phone
- ☐ Will return for follow-up visit

GO to the Proficiency Grid and CLICK the number to the left of "Commitment to Plan" to review those instances where you may have elicited a commitment to the therapeutic plan.

CLICK the number to the right to view glossary examples.

Complete the following:

1. In your practice, how IMPORTANT is it to elicit the patient's commitment to a negotiated plan?

Not at all Somewhat Moderately Very Extremely

2. In what percentage of your visits do you ROUTINELY PROBE for the patient's commitment to the plan?

0% 10 20 30 40 50 60 70 80 90 100%

3. How CONFIDENT are you that you can incorporate this skill into your routine practice?

Not at all Somewhat Moderately Very Extremely

4. In future visits with depressed patients, how LIKELY is it that you will routinely elicit patient commitment?

Not at all Somewhat Moderately Very Extremely

5. Please provide an example of a statement that demonstrates eliciting commitment to antidepressant medication and eliciting commitment to giving counseling for mental health specialists.

_____

_____

_____

_____

Exercise 10: PATIENT EDUCATION AND COUNSELING

Patient Education provides the patient with information about the medical condition; therapeutic regimen; lifestyle information on self care and prevention; and psychosocial information. Comprehensive health education covers all four dimensions.

Patient Counseling is distinguished from the factual emphasis of Patient Education in that its purpose is to motivate and encourage the patient to undertake recommended behaviors in the areas of therapeutic regimens (Counsels –Medical/Therapeutic Regimen), or lifestyle/psychosocial changes (Counsels–Lifestyle/Psychosocial).

It is important to communicate information to patients in small blocks--pausing frequently to check for understanding and readiness to move on before proceeding.

REVIEW SAMPLES of your talk by type and content.

1. Did you communicate information to the patient in small blocks—pausing frequently?

2. Did you ask for understanding during the counseling segments—to allow the patient to periodically pose questions and to clarify the information given?

Patient Education Points

- Depression is a medical illness, not a character defect or weakness
- Recovery is the rule, not the exception
- Treatments are effective, and there are many options
- The aim of treatment is getting and staying completely well
- The risk of recurrence is high
- Patients and their families should be alert to early signs and symptoms of recurrence and seek treatment early
- What to do if patient does *not* want to start treatment

Which of the following patient education points did you address with Ms. Jones?

- ☐ What is depression?
- ☐ Treatment options
- ☐ Advantages and disadvantages of treatment options
- ☐ Side effects
- ☐ What to do if there are treatment complications (e.g. patient wants to stop taking medication)

Exercise 11: FACILITATION AND PATIENT ACTIVATION

Facilitation and patient activation skills encourage the patient to enter into the medical dialogue.

- ➢ Back channel responses (i.e. "go on, right, aha, hmmm") encourage patient disclosure by indicating interest and attentiveness.
- ➢ Asking for Opinion questions (What do you think would help? What do you think would work for you?) give the patient an opportunity to elaborate on expectations, preferences, and judgments regarding their condition or treatment.
- ➢ Checks for Understanding by paraphrasing and interpretation (Let me make sure I have heard you right, you said…. It sounds like you are saying…) assures the patient that he or she has been heard and understood.
- ➢ Asks for Understanding (Are you with me? Do you follow? Does that make sense?) provide

opportunities for the patient to confirm that they are following your explanations.

- Facilitative nonverbal cues reinforce the verbal cues of interest and acceptance

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REVIEW SAMPLES of your talk.
REVIEW GLOSSARY examples.

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1. Who did most of the talking during the interview—you or the patient? _____

2. What was the balance of talk during the segments of the visit when you asked many questions (usually the history segment)? _____

3. What was the balance of talk during education and counseling segments? _____

4. In retrospect, how might these segments have been more interactive? _____

5. How important do you believe it is to limit the physician's verbal dominance?

Not at all Somewhat Moderately Very Extremely

6. What was the extent of your facilitative repertoire? Note the frequency of the following types of statements.

Asks for patient understanding_____ Checks for understanding_____
Asks for patient opinion_____ Back channel responses_____

7. How important do you believe these facilitators are?

Not at all Somewhat Moderately Very Extremely

8. Were your nonverbal messages consistent with your verbal expressions? (check any that apply)

Eye contact_____ Forward lean_____Head nods_____Smiles_____

9. How important do you believe these nonverbal messages are?

Not at all Somewhat Moderately Very Extremely

10. In future visits with patients, how LIKELY is it that you will attempt the following?

	Not at all	Somewhat	Moderately	Very	Extremely
Explicitly ask for patient understanding of explanations	1	2	3	4	5
Explicitly ask for patient opinions	1	2	3	4	5
Explicitly check for understanding of what patient has said	1	2	3	4	5
Cue interest using back channel responses	1	2	3	4	5
Consciously use non-verbal cues (eye contact, body lean, etc)	1	2	3	4	5
Become less verbally dominant	1	2	3	4	5

Exercise 12: TREATMENT OPTIONS

SEE SEPARATE TREATMENT HANDOUT.

"Listen to the patient, he is telling you the diagnosis"

-Sir William Olser