Supplementary Online Content

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This supplementary material has been provided by the authors to give readers additional information about their work.

eAppendix 1. DECIDE-PC (Provider Intervention) Training Materials

Disparities Research Unit Massachusetts General Hospital

DECIDE Provider Coaching (PC) Manual:

An Intervention to Improve Shared Decision Making between Patients and Providers

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DECIDE-PC
OVERVIEW

Rationale

As mental health care systems continue to evolve in the United States, pressures are mounting to develop systems that are accountable to standards of quality and patient outcomes. Health care disparities appear to partly stem from the incompatibility of mainstream services with social and cultural values of minority populations, poor provider-patient interaction and different expectations about treatment. Patients' involvement in their mental health treatment may improve the quality of their care, particularly for those holding traditional role expectations of the passive patient.

Shared decision making between patients and providers is increasingly advocated as best practice in medicine,[1, 2] though few interventions have been developed for the large population of patient who may have low health literacy[3] or lower education.[4, 5] Patients with lower health literacy[6] have sometimes been found to prefer less shared decision making with their providers compared to those with higher literacy. However, such preferences do not necessarily appear to be stable; some patients with low health literacy and low preferences for shared decision making were still more satisfied with patient/provider encounters that incorporate shared decision making[7] and preferences of patients shifted to increased desire for shared decision making when provided with the experience of using a decision support tool[8] and practicing shared decision making.

Understanding this variability in preferences for shared decision making for individuals is critical for several reasons. On the one hand, if providers incorrectly assume patients with low health literacy prefer a more authoritative approach. Yet this type of interaction may not lead to positive outcomes. Preferences for shared decision making could vary depending upon multiple factors, including the physical health condition being addressed in the patient/provider encounter,[9] the patient's familiarity with models of shared decision making,[3] and the experience of collaborative decision making in the context of a patient/provider encounter.[3] So, this program is designed to improve shared decision making between providers and their patients with behavioral health problems. It is essential to help patients formulate and ask questions about mental health concerns and treatment, and focus effectively on key decisions affecting their treatment.

Studies of ethnic/racial minority patients have identified important findings about patient preferences. Minority patients tend to prefer a warm personal relationship with their providers and worry that asking questions and stating their concerns might jeopardize their therapeutic relationship. Patients may also hold traditional role expectations that discourage assertiveness in the clinical encounter. Some minority patients (such as Asian patients) prefer that their own interpretation and meaning of symptoms be incorporated into the assessment and treatment process and may have difficulty with nondirective ambiguous therapeutic approaches. Other minority groups (like Latinos) may avoid confrontation while others may have low expectations of receiving quality care, given their limited service options. These actions or expectations might in turn make patients passive recipients of poor quality care or may lead to negative perceptions of care if treatment does not match expectations. A disproportionate number of people of color discontinue behavioral health care as early as the first session, which may be in part explained by miscommunication and therapeutic alliance failures.

Meredith et al. (2001)[10] also showed that patients reporting stronger interpersonal relationships with providers were more likely to receive quality care. Meta-analyses[11, 12] confirm that the quality of the patient-provider relationship is associated with symptom reduction, regardless of treatment modality. Among the therapist variables studied in a large multi-site study of depressed patients, the best predictor

of symptom reduction was the emphasis placed on the patient-therapist relationship.[13]

This provider coaching manual focuses on augmenting patient-centered communication and therapeutic alliance as a possible underlying pathway by which Shared Decision Making can take place. Provider Coaching will target three areas that were identified in our previous study as problematic in forming good provider-patient interactions as well as using recommended coaching on patient-centered communication shown to be effective in clinical encounters.

Structure of Provider Training

The training consists of three parts totaling approximately 19 hours:

The first session will include twelve hours of a group experiential workshop on the three targeted areas of intervention mentioned above. The current manual describes this workshop.

Part 1: **Workshop**

Provider receptivity to shared decision making (SDM) is introduced in a group workshop administered by workshop leaders, who serve as coaches for specific participants during the workshop and in up to 6 individualized coaching sessions following the workshop. Providers are given an overview of the goals and logistics of the trainings, followed by a brief presentation of the research behind patient activation and study findings from the Disparities Research Unit. We explain how the provider intervention teaches communication skills in listening, eliciting the patient's agenda, encouraging question asking, and illness management education.

Transcripts of two contrasting interviews (responsive and non-responsive providers) are presented and discussed, focusing on attentiveness (how patients' concerns and understandings are taken seriously by the provider), facilitation (encouraging patients to express concerns in their own words and facilitating self-management and activation) and collaboration (supporting patients as partners in the process of mental health care). Techniques demonstrated include "giving the floor" to the patient (attentiveness), focusing on the voice of the patient rather than the voice of medicine (facilitation), and validating the patient as a co- producer/partner of treatment outcomes (collaboration).

The training emphasizes that allowing patient-initiated topics signals to patients that they are responsible for their treatment. The non-responsive interview exemplifies non-specific attention markers (e.g., Um hum), narrow medically-focused questions, ignoring patient distress and confusion, and interrupting the patient. Facilitation is covered by showing how provider utterances can effectively elicit patients' accounts and reinforce question asking. Providers role play both types of providers and reflect on the experience, with an assignment to audio record one or two sessions with their patients (with consent) to practice responsive interviewing.

To increase the effectiveness of the intervention, many of the exercises during the workshop will be based on recordings of two audio taped sessions conducted by the participating provider prior to the training (after securing patient consent). These audio recordings are reviewed by workshop coaches with relevant sections transcribed to provide feedback in the next training session. Reviews of audio-recordings support the development of attentiveness, facilitation and collaboration in patient encounters. By specifying features of the verbal interaction in the transcription that distinguish between provider "successes" and "challenges" in responsive interviewing, the providers identify how to responsively ask, listen and collaborate. Providers also recognize how patient disclosures lead to exploration of the conditions and circumstances that contribute to mental health problems, activation, and self-management.

Part 2: Individualized Coaching Sessions

Here we reinforce providers' reactions to the idea that their responsiveness to patients can change clinical practice. This phase of the training is given in the months following the workshop using sections of the recorded sessions assigned as homework from Training 1. The second part of the training will include up to six hours of individual feedback based on audio recordings of the providers' actual clinical encounters. Each provider has 6 participating patients that are recruited and consented to be in the study (half participating in the DECIDE PA and half in the usual care condition). Each call lasts 30-45 minutes, and focuses on a recording of an actual treatment session recorded <u>after</u> the provider workshop in Part 1. These will be done within a time frame of two to four months from the time of the provider coaching workshop. The feedback conversation can be conducted face to face or via telephone and is based on written structured feedback that is sent to the provider ahead of time.

The goal of the coaching in Part 2 is to deepen the reflection process and learning through application of skills acquired in real life case material. The emphasis is on giving the provider feedback based on an analysis of their SDM, attributional style, and perspective taking, as well as receptivity to patient's activation and self-management. After the recordings, providers are asked how they would "refine and improve" the interview using responsive interviewing. Most of the integration of the trainings is done by reviewing with providers a detailed summary of coaching comments following the main themes of the workshop in Part 1. Through this discussion, they learn how to conduct the interview differently to promote patient activation and self-management.

Part 3: Wrap-Up

The goal of this final 60-minute call is to summarize the areas of strength and areas for continued learning demonstrated by the participating providers. The coach summarizes these in a one page form that is used to guide the feedback during this call. Providers are invited to discuss any remaining questions regarding the training, and to share their thoughts about the entire training experience. Providers are asked what they liked the most and least about the training; when/why they deviated from the training; how their interactions with patients have been influenced by the training, and what kind of preparation they find helpful to integrate the training content into their usual work.

Part 1

COACHING TRAINING 1 – GROUP WORKSHOP

T he goals of this workshop is to raise awareness of the importance of taking the patient's perspective in effective cross-cultural care, exploring barriers to engaging in this type of care, and developing skills to improve taking
the patient's perspective.

Activities

A. Introduction: Patient-Provider Communication and Racial/Ethnic Disparities

B. Perspective Taking: Forming an Effective Therapeutic Alliance in Cross-Cultural Contexts
Role Plays Group discussion

C. Emotion Recognition Accuracy and the Effective Clinician
Measurement of In Vivo Provider Accuracy

D. Individualized feedback based on recording of patient visits

E. Patient and Provider Attribution Errors: Presentation of research on the negative consequences of making assumptions using limited information

Brief introduction to the role of attribution errors in forming a good therapeutic alliance in a cross cultural context
Review of Mock Patient-Provider Transcripts Discussion of Attribution Errors and Mindfulness
Role Play #5

F. Engaging the Patient: The importance of patient engagement and provider receptivity

Introduction

Presentation and discussion of videos of responsive and non-responsive provider behaviors that affect patient engagement
Developing skills to improve patient participation

Review of case material
Improving implementation of communication skills
Conclusions and Wrap-Up

G. The Theory of the Relational Self and Bias
  Role Play #2
H. Techniques for Being a Responsive Provider
  Role Play #3
  Presentation of Techniques Videos and Discussion
I. Conclusions and Wrap-Up

A. Introduction: Patient-Provider Communication and Racial/Ethnic Disparities

Workshop leaders will describe the importance of targeting communication to reduce disparities, regarding relevant health communication literature that demonstrates providers communicate differently with minority patients.[14] The logistics of the 12-hour workshop and subsequent coaching sessions are described. Several concepts are then briefly introduced to help participants understand how they can increase receptivity to patient participation and collaboration. These include recognizing how one partners with patients (top- down or collaborative), working collaboratively to identify patient preferences, using inclusive language, setting an agenda and related goals, making decisions together, and supporting patient activation.

B. Perspective Taking: Forming an Effective Therapeutic Alliance in Cross Cultural Contexts

Workshop leaders will introduce perspective taking as the ability to step outside of one's own experience and imagine the emotions and perceptions of others.[15] They will discuss how providers vary in the degree to which they include patients' perspectives in medical decisions.[16] The ability to take the patient's perspective will be emphasized as the core of the therapeutic alliance (i.e., cooperative and trusting provider-patient relations[17]). Leading researchers in health disparities have emphasized the need to increase provider's ability to engage in perspective taking, particularly in discordant encounters.[18] This includes the development of "cognitive empathy," defined as the active attempt to understand another person, not rooted in emotional reactivity, and which is described as ideal for the clinical context. Leaders extend this to cross-cultural situations, teaching how perspective taking can minimize the role of cultural stereotypes and unconscious bias ("in-group bias"). Practical tips are shared to improve perspective taking and empathy, such as greeting the patient and using "social talk" to start off; identifying and reflecting the patient's frame of reference, agreeing on what is wrong, and identifying barriers to the treatment plan. To enhance learning a brief video on empathy by Brené Brown is presented.

Role Plays

Please see Role Plays 1 and 4, which focus on agenda setting and perspective taking. Participants are instructed as follows:

In this activity, you will play yourself. Imagine that you are meeting a patient who has just been referred to you. Review the following information about the patient and complete the brainstorming exercise below. Then begin your conversation the way you would normally start an intake session, but try to explicitly set an agenda for the session when you think it appropriate.

Also, before you begin, take a minute to think about how the patient described might be thinking or feeling when s/he walks into your office for the first time. Write down 3 of these thoughts, feelings or emotions in the space below.

Group discussion

After two participants complete the role play, lead a group discussion which addresses the experience of agenda setting and of developing empathy.

In discussion, emphasize the importance of the following points:
- The explicit setting of an agenda that includes both the patient's and the providers' concerns for the session
- Consideration of how the patient is feeling and thinking during the clinical encounter.
- The provider's sense of self-competence in assisting the patient as a possible barrier to perspective taking

Reflect on the content of how the group perceived the patient's experience in the role plays as well as a reflection on the process of taking his perspective. Place emphasis on what helped take their perspective and increased understanding of their ambivalence about seeking care.

C. Emotion Recognition Accuracy and the Effective Clinician: Measurement of In Vivo Provider Accuracy

Provider participants will engage in two brief interventions to enhance their skills in recognizing patients' emotions, including immediate assessment.

The first intervention is the Practice and Feedback Intervention[19] to improve accuracy on the ***Patient Emotion Cue Test***[20] (PECT). Providers will complete the PECT prior to this initial training.

In this training, providers will take the PECT <u>alternate</u> form, which is an identical test but contains different audiovisual clips of the same actress enacting the same five emotions with different scripts for each (thus it is a different test with identical structure). After answering each item on the PECT alternate form, they will receive feedback on the correct answers. For example, if the clip depicted high verbal anger intensity in the patient's words with low anger intensity in her nonverbal cues, the feedback would read, "She was angry. She conveyed anger strongly through her words and weakly through her nonverbals."

Test-takers are given time to compare their answers to the correct answer but are instructed <u>not</u> to change their original answer.

The second intervention is the Practice and Feedback Intervention developed for improving recognition of patients' emotions, as tested by the ***Test of Accurate Perception of Patients' Affect*** (TAPPA).[21] The Practice and Feedback Intervention to be used with the TAPPA is closely modeled on the one described above for the PECT and will use 10 TAPPA items (audiovisual clips) not used in the Baseline assessment. Immediately following the intervention, the original 10 items used at Baseline are administered as a short-term indicator of intervention effectiveness.

In the final follow-up with providers, the same PECT and TAPPA tests of emotion recognition that were used at Baseline will be re-administered as a more long- term assessment of the effectiveness of the emotion recognition training.

Measurement of *in vivo* provideraccuracy

In vivo accuracy is <u>the skill to perceive the affective states of one's own patients</u> <u>in the here-and-now of a clinical interaction</u>. Providers' in vivo accuracy will be measured using the parallel-ratings methodology[22, 23] where the patient rates his/her feelings on a series of scales immediately after an encounter (e.g., relieved, worried, frustrated, angry, disappointed) and the provider rates the same scales immediately after the interview, regarding the patient's feelings.

D. Individualized feedback based on recording of patient visits

To increase their ability to improve shared decision making and perspective taking, providers will next be asked to review case material from their own patient-provider encounters, which were recorded prior to the workshop. Workshop leaders ("coaches") meet individually with each participant to provide detailed feedback on the main themes of the training: Shared Decision-Making, Perspective Taking, Attribution Errors, Positive Patient Activation, and Encouraging Open Communication.

Coaches will have coded the recording prior to the workshop and listed specific feedback along three columns: Strengths, Average, and Areas for Improvement. Coaches provide the feedback in a respectful, supportive manner that allows participants to observe moments in their sessions that demonstrate strengths or opportunities for improvement across the main themes listed above.

Participants are encouraged to reflect on the feedback and give their reactions to help integrate the trainings into their usual clinical approach.

E. Patient and Provider Attribution Errors: Presentation of research on the negative consequences of making assumptions using limited information

I. Brief introduction to the role of attribution errors in forming a good therapeutic alliance in a cross cultural context

Review the following research findings with the group. Attributions can involve dispositional inferences, which are automatic and rely on preexisting cognitive schemas, or they may rely on more deliberate considerations of situational constraints.[24] People tend to attribute negative behaviors of "outgroup" members to inherent dispositions whereas negative behaviors of "ingroup" members are more often attributed to more situational factors. The Institute of Medicine's report (2003)[25] highlighted that these processes are related to prejudice and stereotyping, and they play a key role in the development of health disparities.

You will teach providers to view the clinical encounter as an opportunity to view the patient's "local moral world,"[26] where exploring "what matters most" or "what is at stake" for the patient today in a holistic context is a priority. Qualitative research from a related publication is shared to demonstrate the actual comments of patient and providers in describing their experience of mental health evaluation in which a shift in their perception of each other occurred.[27]

II.   Review of Mock Patient-Provider Transcripts

To increase awareness of the prevalence of attribution errors in decision making by providers, the group will review mock transcripts of two short interactions between patients and providers.

The transcripts will include two interactions that display the attributions clinicians make of patient and the provider behaviors when faced with limited information. The challenge of interpreting symptoms in an appropriately cultural context should be emphasized.

Interaction A: A missed opportunity to explore an important event in a patient's life:

Interaction B: The provider does a good job understanding the patient's behavior as a response to her context

III.   Discussion of Attribution Errors and Mindfulness

This section ends with a presentation of a final vignette describing a "difficult patient" encounter. Lead the providers in a discussion about how they prepare for such stressful situations in their day, with a consideration of self-care approaches they have found helpful. Introduce mindfulness as one way of dealing with stressful situations and to relieve stress. Present the "three-minute mindfulness meditation" video by O'Grady to lead participants in an *in vivo* experience of mindfulness.

F. Engaging the Patient: The importance of patient engagement and provider receptivity

I.   Further discussion of the importance of patient participation and collaboration in decision making to forming a strong therapeutic alliance in a cross cultural context

Background.

Communication between patients and providers has attracted increasing attention, with research documenting its role in establishing rapport, improving information exchange, and facilitating clinical decisions.[28]   Recent models of patient-provider communication such as the shared decision making model[29, 30] emphasized an egalitarian approach in the clinical encounter, particularly in terms of how patients' participation and sharing of information is to be encouraged.

These models advocate that providers follow the lead of patients in an attempt to understand their experiences and points of view. This iterative process can facilitate the development of good rapport. Findings from the Patient Provider Encounter Study (PPES)[31] highlight the importance of encouraging explicit communication about expectations regarding information exchange style and tensions in styles of communication is recommended. Tailoring the information exchange style to patients' preferences (by explicitly asking them about it) is also imperative in improving patient centered care.

II.   Developing skills to improve patient participation in the clinical encounter (videos)

Group leaders explain how the provider intervention is geared toward communication skills training in listening, eliciting the patient's agenda and concerns, encouraging question asking, and symptom/disorder management education. Videos of two contrasting interviews (i.e., responsive and non- responsive provider) are presented and then discussed. The discussion then focuses on the concepts of _attentiveness_ (addressing the degree that patients' concerns and understandings are acknowledge and taken seriously by the provider), _facilitation_ (encouraging patients to tell their stories and concerns in their own words and facilitating self-management and activation) and _collaboration_ (recognizing and supporting patients as partners with providers in the ongoing process of mental health care). Specific examples and styles that elicit or show attentiveness, facilitation and collaboration are discussed in detail.

Techniques demonstrated include "giving the floor" to the patient (attentiveness), focusing on the voice of the patient rather than the voice of medicine (facilitation), and validating the patient as a co-producer/partner of treatment outcomes (collaboration). The training emphasizes that allowing patient-initiated topics signals to patients that they are responsible for their treatment. Participants will also learn techniques for appropriate use and timing of open- ended questions to improve shared decisions, including supporting patients to define their own agenda during visits.[32] The non-responsive interview is then used to exemplify how the second provider confines his comments to non-specific attention markers (e.g., Um hum), focuses on specific medically-relevant questions, ignores the distress and confusion of the patient, and interrupts the patient.

Facilitation is the next topic covered, showing how utterances can actively elicit patients' accounts of their problems in their own words, as well as reinforce question asked by patients. Using the transcripts of the video clips, the responsive provider is shown providing some rationale for raising certain topics and eliciting the patient's questions to gain an understanding of the patient's concerns relative to these topics. Again, use of open-ended skills will be reinforced (e.g. silence, nonverbal encouragement, neutral utterances).

Additional evidence-based approaches to facilitating communication are discussed, including responding to patient emotion, expressing a willingness to help, checking the patient's understanding of a problem, providing specific information, and eliciting patient choice.[33] In contrast, the non- responsive provider is presented as offering little assistance or encouragement to ask questions or to provide a detailed account of the patient's experience.

This training will convey that inviting collaboration in the clinical encounter requires providers to explicitly validate the patient as a co-producer of treatment outcomes, who can effectively take care of him/herself. For example, the provider would state the request as "Is okay with you to…" In contrast, the non- responsive provider asserts his authority through the form and content of his questions (e.g., "So I am going to give you a prescription for…"). In the last section of the first training, providers role play both types of providers and reflect on how the role plays demonstrate responsive interviewing in terms of how providers question and respond to the patients; whether they encourage and listen to the patient's accounts, questions and problems; and how they share or don't share the responsibility for treatment.

G.   The Theory of the Relational Self and Bias

Participants will review the following information with workshop leaders.
Applying the principles of the interpersonal social-cognitive theory of the _Relational Self_[34, 35] to the clinical encounter may help understand the underlying mechanisms that contribute to attribution errors. This theory suggests:

- That past relations with others around us become mentally represented and can direct our affective,

motivational and behavioral responses and assumptions when encountering a new person. Thus, when a mental health provider encounters a new patient, a mental representation of relations with past patients may be activated leading the provider to make inferences about the new patient mainly through these representations.

- This activation is based on individual exemplars which elicit the association between specific bits of information about a new patient to knowledge acquired through past clinical experience.

- This knowledge about the significant others which gets transferred to the new patient may not only be linked to physical characteristics and personal attributes, but also to the new patient's expression of inner feelings, motivations and interpersonal behaviors. When these specific other-representations get primed, they also activate generic social categories linked to the significant other, such as ethnic group categories or specific mental disorders. Thus, the mental representation of past patients emerges unconsciously and shape the interpretations the provider makes of the patient's behaviors and emotions, as well as the motivation and expectations for connection with the provider.

- The mental health encounter is mostly characterized by "low validity" (i.e., uncertainty related to the unstable relationship between environmental cues such as patient symptoms and the outcomes of actions such as the effect of treatment). This low validity may produce an *illusion* of validity (i.e., over- confidence providers feel) which can affect their tendency to make attribution errors when for example diagnosing patients rather than relying on explicit diagnostic assessment.[36]

- Bias is introduced as one of the factors contributing to disparities in quality of care, as well as patient-provider communication. The concept of the "bias blind spot" is used to illustrate how mental health clinicians, despite their best efforts, may see themselves as objective and others as biased. This concept is extended to cross-cultural interactions, where clinicians may tend to favor "in-groups," even when differences are minimal. Thus, racial/ethnic and gender biases can be present even when an individual claims not to be biased. Participants are urged to consider how specific information could activate biases in their own clinical work.

H.   Techniques for Being a Responsive Provider

This section covers a range of practical clinical tips that participants can use to activate the concepts taught in the workshop. These include "talking about the way you talk," to assess the patient's preferences for communication. Participants are strongly encouraging to solicit questions from their patients, as one of the most important ways for a patient to get involved in treatment. This can be facilitated by "giving the floor" to the patient and listening attentively.

Participants are encouraged to consider how the "voice of medicine" (scientific, abstract, de-contextualized approach to health) might over-shadow the "voice of the lifeworld" (an everyday approach to health, i.e. placed in the context of patient's life, oriented towards understanding a larger picture). The steps to eliciting this "voice of the lifeworld" are described, such as open-ended questions and non-verbal cues (a sample clinical dialogue is reviewed to demonstrate how open-ended questions can be elicited).

Participants are encouraged to present all the options for treatment, with attention paid to describe the pros and cons for each approach, and special consideration paid to any potential barriers that might prevent patients from following through.

Self-management is highlighted as a crucial component of shared treatment, by helping the patient identify resources and skills to use outside the clinical encounter. Conveying hope and appropriate praise while setting realistic expectations are presented as complementary approaches to engage patients.

Videos of mock clinical encounters are used to complement the lecture based component of the workshop. These cover topics of improving patient receptivity; perspective taking, activation; and agenda setting.

I.   Conclusions and Wrap-Up

The workshop leaders review all topics covered in the workshop thus far and offer an opportunity for participants to ask questions and clarify their learning. Participants are invited to reflect on their training experience in their own words. They can be asked to share what they have learned and what they believe has been most and least helpful about the trainings. Workshop leaders describe the next step in the program, which involves further individualized coaching (up to six sessions, with a final "wrap-up" call to summarize the participants overall learning and accomplishments). The workshop ends on a note of hopefulness and positive expectations.

eAppendix 2. Coaches' Coding Manual

Coaches Coding Guide

Day 1: SDM

1. **Negotiates & explicitly works to establish a shared agenda with the patient (adapted from 4H) (RESTRUCTURED)**

NOTE: If the agenda is established at any point in the session, assign a high score.

5 = High if the provider explicitly asks what the patient wants to focus on throughout the session and establishes a plan with him/her. For a score of 5, the agenda needs to be established in the first one-third of the session.

4 = Provider explicitly asks what the patient wants to focus on throughout the session, but fails to establish a concrete plan or agenda for the session. The agenda is set in either the last two thirds of the session.

3 = Provider needs to ask in some sort of way about goals for the session. . Provider asks questions to elicit the patient's goals, without framing it in the context of establishing an agenda.

For example: "How have things been going for you this week?"

Or "What would you like to talk about?" → This is a medium rather than a high, because it elicits goals outside of the context of establishing an agenda for the meeting.

2 = Provider follows the patient's lead for a little bit, but then goes back to his/her own agenda.

1 = Low if provider imposes their own agenda, Or, the provider turns the first concerned mentioned by the patient as the sole agenda for the session, redirecting other topics the patient mentions afterwards back to this first topic. Patient wants to talk about something and the provider goes in a different direction

2. **Provider sticks to the agenda established at the beginning of the session, while still being flexible to *new* and *relevant* clinical information mentioned by the patient mid-session. (RESTRUCTURED, SCALE REVERDED)**

5 = High if is the provider follows the SHARED agenda established in the beginning of the session. If no agenda was established, the provider cannot receive a 5.

4= An agenda was set but it wasn't followed. Or partially followed. Small deviations in the agenda, but goes back.

3 = If the provider does NOT establish a shared agenda with the patient at the beginning of the session but follows the patient's lead throughout their meeting and are able to connect the dots between the topics, and summarizes. This develops a general theme in the session, so even though the topics might be different

2 = The provider effectively follows his/her own agenda throughout the session (this agenda is not established with the patient and does not appear to be very flexible to the patient's input). Patient doesn't know what the agenda is.

1 = Low if the provider follows the conversation or the patient's lead, but there never seems to be any underlying agenda or general topic. Session appears to be disorganized, or there is clearly a lack of agenda shown by the constant/random change in topics.

3. Elicits patient's goals for the visit (Coder Item)

5 = High if provider asks (or responds with interest to) what the patient hopes to get out of the visit; provider elicits and/or responds to the patient's stated goals; provider has to make some sort of explicit comment about these being the goals/plans/intentions for the session for a score of 5; even when there is implicit agreement between the patient and the provider, it would be important for a verbal remark to be made, in order to achieve a code of 5.

1 = Low is there appears to be implicit agreement about what the goals/topics of conversation would be for that session, if a patient's independently states their goals for the session, the provider is encouraging using verbal cues or back-channels encouragement (mm-hmm, ah, really, etc.); provider follows along the conversation started by the patient in warm empathic manner; provider barely acknowledges the patient's goals when stated by the patient;

0 = Provider makes no attempt to determine what the patient hopes to get out of the visit; neither patient nor provider lay out an implicit (or explicit) agenda for the session

4. Involves the Patient in Decisions (Coder Item)

5 = High if provider makes decisions a joint effort that includes patient input; provider clearly encourages the patient's input into the decision making process; acknowledges and supports (if appropriate) patient's decisions about treatment

1 = Low if provider makes decisions without taking the patient's input into account; provider discourages the patient's efforts to be part of decision-making process; provider clearly fails to acknowledge the patient's stated preference; quickly proceeds through the decision-making process without considering the patient's opinion; openly discourages the patient's input

0 = No decisions are made.

5. Involves patient in discussion of treatment options/possibilities (Coder Item)

This item assesses both whether there was <u>any</u> talk about treatment options and, in the case there was, you must rate how participatory/collaborative this conversations was. For this item, <u>treatment is considered</u> as any kind of possible change(s) the patient can engage which might be helpful or therapeutic for the patient. It includes drug or dosage options, other professionals the patient might consult, suggested readings or websites, and a myriad behavioral changes such as getting more sleep, etc.

5 = Provider makes discussion surrounding treatment a joint effort that includes patient input; provider clearly encourages the patient's input in the discussion; patient is very involved in treatment discussions; discussion surrounding treatment is collaborative.

1 = Conversations about treatment options/possibilities are provider-led and only include the provider's opinion or treatment recommendation; patient has no involvement in treatment discussion or ideas

0 = There is no discussion of treatment options or possibilities; no treatment decisions are made.

6. Explores patient's acceptance/acceptability of possible treatment(s) (Coder Item)

This item gages the provider's attempts to explore how the patient's acceptance of possible treatment alternatives.

5 = High if provider thoroughly explores the patient's acceptability of possible treatment (s) by asking for patient's thoughts, feelings o opinions; deliberately questions the patient to determine the acceptability of recommendations; provider clearly asks the patient if they're OK with the suggested treatments

1 = Low if provider makes cursory attempts to check acceptability after making a recommendation For example: 'Sounds like some medication will help you sleep better, right?

OR if provider disregards or dismisses patient's concerns for compliance

For example: "Have you ever actually tried using an ice pack?" "Yes, I really didn't like it!" "Well, try these ones instead. You want to get rid of your pain, and this will help"

0 = Provider makes treatment recommendations *and never checks* with the patient how they feel about it

7. Involves the patient in explicitly made treatment decisions (Coder Item)

For this item only consider explicitly made treatment decisions. Explicit decisions are very explicit and clear-cut instruction about what to do in terms of treatments. For example: "So we'll discontinue this medication. Let me know if there are any changes." If there no explicit decisions, assign a 0. If there were decisions, rate how collaboratively the decision(s) was made.

5 = High if provider explores the patient's acceptability about implementing the established treatment plan at this time.

For example: "How would you feel about calling your mom more this week?"

3 = Medium if provider explores acceptability of treatment possibilities in more abstract ways, <u>without</u> exploring acceptability of starting or implementing the treatment decisions <u>at this time</u>.

For example: How would you feel about calling your mother more?

1= Low if provider disregards or dismisses patient's concerns or hesitance of the treatment plan or compliance; quickly offers recommendations while half-heartedly attempting to determine the patient's potential for compliance.

For example: 'You'll keep up with the journal, right?'

0 = <u>NO</u> explicit treatment decision(s) were made.

Day 1: Perspective Taking

8. Patient and provider agree in problem formulation (MA)

Note: While there are many problems that might be discussed in a session, consider the composite/summation of all of these when answering for this problem, don't bias yourself by just coding the best or worst. Key idea for this item: *Is there an overlap in the way the patient and the provider see the problem(s)*

5 = High if they both explicitly give clear indications that they share a common understanding of what the problem is; provider understands the problems described by the patient; provider is able to effectively reflect the problem the patient presents. *A score of 5 would require there being an* <u>explicit agreement</u> *from both the patient and the provider. If the provider asks the question "What do you think is your/the problem?" that would get a score of 4 or 5.*

3 = Medium is provider recognizes part of the problem stated by the patient, but the provider makes an assumption about what is the problem the patient wants to deal with without first testing the validity of said assumption.

1 = Low if they do not share a common understanding; patient and provider are expressing different interpretations of the problem or scenario presented by the patient; any initial verbal and non-verbal signals of agreement on the problem fail as the interpretation presented by the patient and the provider changes; provider gives no indication that he/she understands or is trying to understand the patient's problem.

One would be there is NO overlap at all in the way the patient and the provider see/interpret the problem(s). The provider is talking about X and the patient is talking/describing Y.

9. Elicits patient's understanding of the problem and/or his or her symptoms (4H, MA)

5 = High if the provider shows great interest in exploring the patient's understanding of a problem; provider directly asks patient what the symptoms/experiences mean to her; attempts to understand to what the patient attributes his/her symptoms/experiences; redirects the patient's question for the patient to answer her/himself;

NOTE: The patient and the provider don't have to agree on what the problem is. Even if they disagree on the problem, the provider could still obtain a high rating score if he or she elicits the patient to talk about how they perceive the problem/symptoms.

3 = Medium if the provider shows brief or superficial interest in exploring the patient's understanding of a problem; provider doesn't directly ask, but is interested when the patient explains her/his understanding; asks closed-ended questions to solicit the patient's understanding without allowing elaboration.

1 = Low if provider interrupts the patient when he/she is explaining her/his understanding of the problem; provider makes no attempt or shows no interest in understanding the patient's perspective; provider fails to elicit the patient's understanding of the his or her symptoms or problems

10. Provider uses patient's frame of reference when he/she explains the main problem (adapted from 4H)

5 = High if provider frames diagnostic and relevant information in ways that reflect the patient's initial presentation of concerns; provider uses the patient's frame of reference and/or actual words when presenting information; provider uses the patient's interpretation when speaking to them; provider uses the same words patients used to describe their problems.

NOTE: For patients who present somatic symptoms or talk about their behavioral/emotional circumstances in a metaphoric or physical matter, a high score would entail the provider talking about these 'somatic symptoms' using the same language that the patient mentioned (reflecting using the patient's words.)

For example: 'I think the anti-depressants will help you get some of the 'zip' back that you say you've lost.'

3 = Medium if provider makes cursory attempts to frame diagnostic and relevant information in terms of patient's concerns; provider minimally addressees the patient's concern(s) (possibly addressing the patient's concerns at the end of the visit while standing to exit the room); emphasizes an issue outside of patient's range of concern; provider asks follow up questions but changes the wording to one that doesn't matches the one used by the patients.

1 = Low if provider frames diagnostic and relevant information in terms that fit the provider's frame of reference rather than the patient's; provider does not address the patient's concern(s).

11. Gives hope to patient about recovery (MA) (Coder item)

This item only explores hope regarding recovery, it could either be long term recovery or recovery from a symptom/behavior the patient is experiencing. General encouragement about anything else is NOT coded in this item. This item is also NOT about providing comfort, only hope about things getting better

5 = High: Provider shows confidence that improvement is possible, without being overconfident or offering too much (without sounding fake/hollow); provider uses examples of other people who have overcome the same problem/diagnosis as the patient (good examples of recovery).

0 = Provider gives no hope to patient regarding recovery.

12. Offers explanations about treatment possibilities (Coder Item)

Note: For this item, first determine whether explanations were given for the possible treatments discussed. Then rate how thorough the explanation was.

5 = High if provider gives thorough explanations about the importance of the treatment possibilities being explored with the patient; examples of this include: the rationale/results of current, past, or future tests and treatments so that the patient understands the significance of these to diagnosis and treatment

1 = Provider offers/orders possible treatments/diagnoses/etc while giving little explanation for these; provider simply states that a treatment should be started or test/procedure done with little or poor explanation of why; provider provides rationale but it is brief and/or poorly done

0 = Provider gives NO explanation about the importance or relevance of possible treatments

N/A = No conversations of treatment possibilities took place

13. Explores barriers about treatment possibilities (Coder Item)

5 = High if provider fully explores barriers regarding the implementation of the discussed treatment options; initiates discussion of barriers to increase patient compliance

For example: provider thoroughly addresses a specific or unique problem that could prevent the patient from following through with recommendations;

1 = Low if provider responds only feebly or ineffectively to the barriers issue; provider offers a solution to barriers that might be producing its own barriers

0 = Provider does not address whether barriers exist for implementation of the treatment plan; provider fails to address hurdles to patient compliance to the treatment plan.

N/A = No treatment was discussed so no barriers can be assessed.

Day 2: Attribution Errors

14. Provider explores the patient's background in non-judgmental manners. (MA) (EXPANDED)

The background of the patient is to be considered broadly. It encompasses any information regarding the patient's life or past. This information helps the provider to view the patient as an individual rather than part of a group. It emphasizes the patient's individual life. Therefore, information regarding family dynamics, family history, personal history, or personal information, is considered to be about the patient's background.

This item explores HOW the provider asks questions about the patient's background. Asking or following up on background information IS NOT enough by itself to earn a high score. Notice that <u>assumptions can be can be embedded in the way the provider asks questions </u>about background.

5 = High is provider asks multiple exploring questions about how background experiences affect him/her personally; provider stays away from generalizations about particular backgrounds the patient belongs to; in the case the patient mentions events of a cultural nature the provider encourages patient to elaborate or clarify these particularly how he/she is personally affected by them;

3 = Medium is the provider makes some assumptions about the patient's background, but he or she is still inquiring about background information; This is a medium because while some information might have been assumed, the provider is still inquiring about background.

For example: *"African American families are very close with one another. Is that how it feels living with your mother?"*

1 =*Low is provider usually makes assumptions about the patient's background and doesn't ask more questions about it; provider ignores patient's attempts to make conversation about their background*; provider remains silent as patient talks about their background; provider's interpretation of the background experiences the patient is describing doesn't match the ones provided given by the patient; provider doesn't ask ANY follow up questions when patient talks about their background; provider doesn't give verbal and non-verbal encouragement when patients describe background/cultural/ethnic/religious experiences; provider appears dismissive towards references of background; provider ignores significant background statements.

For example: "I've been having fears about Heaven and Hell." "Most Catholics do."

15. Provider uses situational and external OUTSIDE-OF-CHARACTER explanations to describe the patient's behavior or symptoms (<u>Attributions that place guilt/responsibility outside of the patient's character</u>).

5 = High is provider often uses external/situational explanations when describing the patient's behavior. <u>These place the guilt/responsibility for the patient's behavior on factors outside of the patient's character.</u> The seldom/sporadic use an internal/inherent attributions is OK, as long as this is not the main type of attribution the provider uses. A high score implies that situational/external/outside-of-character attributions are the normal/most frequent approach used by the provider.

3 = Medium is a combination of situational/external/outside-of-character attributions with some inherent/character-based attributions. It could entail the provider not using external attribution as often.

2 = Using genetics as an attribution is an internal attribution and should be assigned a score of 2. Explaning how thought patterns explain behavior is another type of internal attribution scoring a 2.

1 = Low is provider makes comments that signal that the patient's inherent character, personality, etc is responsible for their behavior or symptoms; provider fails to attribute the patient's behavior or symptoms to situational or external (out of character) factors; provider attributes most of the patient's symptoms or behavior to inherent dispositions.

16. Provider collects enough information about symptoms or mental health problems. (MA)

5 = High is provider does an exceptional job collecting information of pertinent symptoms that are crucial to determining a diagnosis or to understand the full extent of a problem.

3 = Provider attempts to explore behavioral symptoms and problems, but only collects superficial details about these; provider inquires about new behaviors or actions, but in passing, or fails to ask about their clinical significance.

1 = Low is providers collects incomplete information about behavioral symptoms; provider hears acute symptoms and fails to inquire more; provider hears key behavioral information and fails to ask questions that would allow him or her to make appropriate diagnostic distinctions. This item can be scored based on both frequency of occurrence as well as severity of mishap. Provider misses information which can lead to attribution errors.

NOTE: It's hard to come up with examples of this behavior. You can use your clinical judgment to determine if enough information was collected by the provider given the problems the patient presented.

Day 3: Positive Patient Activation

17. Provider listens attentively (ALOS) (Gives patient time and space to present the problem, ALOS; Attentive silence, PCBI)

5 = High is provider gives the patient space to continue his/her story; provider does not does not interrupt the patient's narrative and on listens attentively; provider is not distracted either by external events (talking on phone, someone entering room) and does not behave in a distracted (uninvolved) manner.

Scoring on the low to high continuum depends on the quality/quantity of the listening-related silence. Listening attentively does not include back-channel responses (these are coded under nonverbal/verbal encouragement).

NOTE: Do not code silence during writing or typing or looking at the computer screen (if those actions can be ascertained from audio).

18. Provider is attentive and respectful when changing subjects with the patient (Adapted from PCBI) (Restructured)

5 = High is *provider is attentive and respectful when changing subjects with the patient; provider doesn't interrupt the patient at inappropriate times, or if he/she needs to interrupt this happens at justified times and in respectful matters*

1 = Low is provider ignores cues, and switches the topic; provider does not respond to the cues of the patient, but instead spends time on extraneous subjects when the patient wants to talk about something more serious, provider changes the subject from topics set by the patient. The low to high range of scores for this item is about the degree and severity of the provider's shifting topics without a clear rationale or explanation of why they are changing the topic.

19. Provider Assists with patient's self-management by providing illness management education (MA)

5 = High if provider educates the patient with useful information that is specifically relevant to the patient's motivation and ability to take care of him/herself; provider gives examples of ways the patient can self-manage his condition; provider gives everyday techniques to encourage treatment adherence.

If it's done well

3 = Medium is provider talks about the importance of doing everyday actions towards recovery but fails to provide concrete examples about how to do it; provider signals that recovery is long continuous process, but doesn't provide specific examples or assistance; provider is considerate and compassionate towards the patient's hardship in treatment implementation but doesn't provide ways to better implement treatment.

When this occurs at least once it would be 3.

1 = Low if provider appears dismissive towards hardship the patient is experiencing in treatment implementation; provider fails to mention any self-management tools or techniques as the patient talks about hardship with symptoms; provider misses a lot of opportunities to provide psycho-education

Missed opportunities

Notes: Empathizing with the patient's hardship does not count as providing self-management. Psycho-education and illness management are explicit processes to teach the patient about their illness and ways to management. If this is done in implicit manners it falls under psychotherapy and would NOT be considered psycho-education.

20. Provider helps patient to formulate questions (Coder Item)

5 = High if provider turns an incipient idea of the patient's into a question, or takes a vaguely formulated question and makes it clearer; provider reflects statements of concern in the form of a question; patient starts to ask something, but isn't able to finish. And then the provider helps the patient finish it

Do it well, and more than once then it's a 5

4 = Do it once well.

Examples

Or: 'It sounds like you have a question about this. What are you wondering?'

Or: 'I didn't know if you could help me with that.' 'Did you want to ask for my help with this?'

Or: "I don't know where this anxiety is coming from." "Are you wondering what's causing this anxiety?"

Or: "I don't know where this anxiety is coming from." "Did you want to ask me about possible sources for your anxiety?"

Or: 'I didn't know whether or not you could help me with that.' "Whether that's something we can work on here?"

Or: "The internet listed hair loss as one of the side effects.' "Are you wondering if that's a possible side effect?"

Or: "I don't know, maybe it's because of X." "So you're not sure if it's Med X that's causing it, is what you're saying?"

3 = You hear the question, and answer it. recognizes patient's concerns or hidden questions and answers it, or responds with a questions that helps the provider accurately answer.

Or: "I don't know where this anxiety is coming from." "Where do you think it might be coming from?

Or: "I don't know where this anxiety is coming from." "Well, there are many things that precipitate your anxiety, like blah blah"

1 = Low if provider acknowledges there is a concern or need for a question but changes the topic after a patient makes an incomplete question/ statement of concern

Day 3: Encourages Open Communication

21. Provider Offers Praise (Coder Item)

5 = High is Provider enthusiastically gives praise, compliments, or positive reinforcement for behavior intended for self-betterment; does NOT refer to compliments on appearance or other irrelevant matters.
To achieve a high score provider needs to connect the dots of why the behavior is good/worth being praised

4 = Making the connection of why the action was well done

3 = Using more generic forms of praise such as "good" or "that's great

2 = Backhanded praise, where an action is praised but also demands that more be done, such as "that's great, but we can do so much more" or "good, but that's not what we talked about doing".

1 : No praise or half-heartedly; disinterested tone; provider does not seem sincere; provider offers praise but qualifies it with a "but" or a retraction of some kind

22. Provider creates an open/inviting/non-judgmental atmosphere (Coder Item)

5 = High is Provider is accepting and welcoming of all the patient has to say and wishes to express; encourages the patient to speak freely and express herself/himself; responds positively to patient's expressions (emotional and verbal).

1 = Low: Provider is not very accepting or welcoming of what the patient has to say and wishes to expresses; provider shows moderate signs of discomfort in response to what the patient says but never explicitly states discomfort or criticizes the patient for speaking freely.

Other Questions

23. Provider has a biological focus to treatment (MA)

5 = High is provider uses biology to explain behavioral conditions; provider fails to explore social or psychological factors pertaining to behavior. This item focuses on conversations related to treatment, talking about medical procedures, physical pains or problems doesn't automatically grant a high value for this item. **All the coding for this item is only about conversations relating to the treatment, the diagnosis, the patient's (-) behavior. General conversation or questions about social or financial circumstances are considered social talk until the provider ties them directly to the behavior/diagnosis.**

3 = Medium is a provider who uses sporadic references to biological explanations; providers who use a mix of biological and other types of explanations to discuss behavior, such as psychological, social context, and situational circumstances; provider talks about biology as a result of psychological or social circumstances.

1 = Low if provider exclusively uses non biological explanations to discuss behavioral or substance abuse circumstances; provider redirects discussion of symptoms towards psychological, social, cultural, or situational factors.

Providers who talk about medication and symptoms could still have a low value if the discussion is focused on how psychological or social factors influence or affect these. Conversations surrounding housing/employment don't necessarily grant a low score for this item, only when they're used to explore/explain symptoms or behavior.

24. Can you, as a coder, tell what arm of the study the PROVIDER belongs to? (NEW)

0 = There is no indication of this.
    NOTE: The provider talking generally about the study's goals does NOT giving away whether they're receiving intervention or not.
1 = *Observed as being part of intervention group*

For example: 'One of the things I'm learning from this study is it might be helpful for us to establish an agenda at the beginning of every session'

Or: 'They're training us to encourage patients to ask more questions"

2 = *Observed as being part of control group*

For example: "Some of the other providers are learning about …"

25. Can you, as a coder, tell what arm of the study the PATIENT belongs to? This can be because the patient said something to indicating it, or because of things they did.(NEW)

0 = No indication of this,

1 = Observed being part of intervention group

This can happen because the patient uses phrases like 'workbook', 'DECIDE', 'planner', 'care manager', or says phrases like "I was told to ask you these questions' OR "after talking to Ana I wrote down some questions I wanted to ask you'

2 = Observed being part of control group

This will happen less often. For example: "You know, they mentioned something about meeting with a care manager, but those haven't happened, so I guess I won't be getting them."

26. Did the patient ask at least one question throughout the session?

WAI Coding Manual (WAI-Bond)

General Scoring Breakdown

1	2	3	4	5	6	7
Very Strong Evidence **Against**	Considerable Evidence **Against**	Some Evidence **Against**	No Evidence	Some Evidence	Considerable Evidence	Very Strong Evidence

1. The provider and the patient are *comfortable* with each other. (SCALE REVERSED on Nov 6th)

7 = Participants appear extremely comfortable in the session. The client approaches difficult topics very openly. The client and/or therapist may comment on how comfortable or relaxed the other is. Behavioral cues such as relaxed posture and smooth voice are evident.

6 = Client shows no apprehension toward topics in therapy. The client seems to approach and explore topics without hesitation, is not defensive, and appears to be relaxed during most of the session. Behavioral cues suggest that the client is comfortable.

5 = Client discusses difficult topics with limited hesitancy, and appears to be relaxed (e.g., relaxed, smooth speaking). The client may become hesitant during parts of the session, but the therapist and client work through it appropriately.

4 = No evidence or equal evidence regarding client comfort and/or discomfort.

3 = Client is fidgety (only near the beginning of the session) and is generally hesitant to discuss deeply personal topics in the session. The client appears to be unwilling to explore some specific content areas. The therapist may also show some physical signs of discomfort (e.g., shaky voice) toward the beginning of the session.

2 = Client and/or therapist show(s) physical signs of discomfort in the session. The client does not appear to become more comfortable as the session progresses and/or may seem defensive throughout. Communication between the client and therapist may seem forced or uneasy.

1 = Client seems uncomfortable throughout the session. The client appears extremely defensive and actively avoids difficult topics. Client may even state on multiple occasions that he/she is uncomfortable.

2. There is good understanding between the client and therapist.

7 = Therapist makes consistently empathic, insightful, and accurate reflections throughout the session. The client rarely/never asks for clarification. The client may comment that the therapist truly understands him/her.

6 = Participants generally have efficient and warm communication with each other. The therapist makes accurate reflections during the session.

5 = Therapist is generally warm toward the client. There are few/no inaccurate reflections by the therapist. The client answers the therapist's inquiries without much confusion. Understanding improves over the course of the session.

4 = No evidence or equal evidence regarding good and/or poor understanding.

3 = Therapist makes a few poor reflections. Occasionally, the therapist has a mechanical tone of voice. The client may ask for clarification of ideas on a few occasions.

2 = Therapist makes several inaccurate reflections, and the client must correct them and ask for clarification at several points in the session. The client appears to become mildly agitated as a result of the miscommunication.

1 = There is consistent need for clarification of ideas. The therapist makes inaccurate reflections and/or interpretations most of the time. The client becomes outwardly irritated or annoyed by the miscommunication. The tone of the therapist is very cold and mechanical. The therapist does not express warmth toward the client.

3. There is a mutual liking between the client and therapist.

7 = Therapist appears genuinely interested in the client's life, including hobbies and other outside interests. The therapist constantly reinforces positive behavior and displays positive regard for the client consistently during the session. The client may state "I really feel like you care about me" or something to that effect.

6 = Participants react warmly toward each other throughout the session. The therapist encourages healthy behavior and continually expresses what seems to be genuine concern for the client.

5 = Participants react with warmth toward each other for most of the session. The therapist is actively involved in exploration of emotions and is aware of important details of the client's life. The therapist's tone is empathic and encouraging for the most part.

4 = No evidence or equal evidence regarding mutual liking and/or disliking.

3 = Although not verbalized, there appear to be stresses in the relationship between the participants. In particular, the therapist rarely/never reacts warmly toward the client, nor does the therapist reinforce healthy outside behaviors very often. The relationship seems relatively cold and mechanical.

2 = Therapist fails to show concern for the client. This may be reflected in the therapist's forgetting of important details of the client's life. The client may question whether the therapist disapproves of him/her.

1 = There is open dislike between the participants. Overt hostility is apparent. Arguing and disparaging comments may be present. Neither participant displays concern for the other, and here is a noticeable coldness between them.

3. The client is aware that the therapist is genuinely concerned for his/her welfare.

7 = Client is confident that the therapist is genuinely concerned. The therapist is attentive, shows empathy using a variety of techniques, delivers statements in a warm and caring manner, and uses direct statements of concern.

6 = Client feels like therapist is concerned and invested in the therapy. The therapist is attentive and warm, demonstrates empathetic listening, and offers statements of concern.

5 = Client feels some concern from the therapist. The therapist is mostly attentive, shows some warmth using reflection, and may give a few statements of concern.

4 = No evidence or equal evidence regarding therapist concern and/or disinterest.

3 = Client feels like therapist is listening, but does not care. The therapist may pay attention, but only give some signs of emotion in response to the client.

2 = Client feels little concern from the therapist. The therapist may give a few statements of concern, but mostly acts in a mechanical and uncaring fashion, despite repeated attempts for responses from the client.

1 = No concern is shown in therapy. The therapist is non-attentive, cold, and statements are hostile and/or inappropriate. The client does not feel genuine concern from the therapist

5. The client and the therapist respect each other.

7 = Strong evidence that participants consistently and completely attend to the other's communications throughout the entire session. The client voices strong confidence in the therapist's competence in some way. The therapist voices some note of encouragement that indicates respect for what the client is trying to do.

6 = Participants show frequent signs that they are really paying attention to each other throughout the session, such as or other minimal encouragers, insightful reflections by the therapist, and active participation by the client.

5 = Participants show some evidence that they are really paying attention to each other. The therapist may exhibit some notable acceptance of client problems.

4 = No evidence or equal evidence regarding respect and/or disrespect.

3 = Participant actions include one or more of the following at times: interrupting each other, employing derogatory/supercilious statements or mechanical reflections, and/or not paying attention. This may cause an inaccurate therapist reflection and/ or the need to ask the client to repeat some content, or induce a client tendency to dismiss therapist ideas or persuasiveness.

2 = Participants show some disregard for each other, or one of the participants demonstrates a great amount of dislike, disdain, and/or spite for the other. One or both consistently interrupt and/or demonstrate a lack of effort in trying to understand the other, which could be exhibited by negative nonverbal behaviors. The therapist could end the session abruptly, without regard to the client's state.

1 = Participants show a great amount of dislike, disdain, and/or spite for each other.

6. The client feels that the therapist _is totally honest_ about his/her feelings toward her/him. (SCALE REVERSED)

7 = Client feels that the therapist is being completely honest toward him/her. The client may verbally acknowledge trust of therapist.

6 = Client is comfortable in disclosing intimate issues as a result of knowing the therapist's feelings towards him/her.

5 = Client shows some implicit satisfaction towards therapist response to interpersonal questions about feelings towards the client.

4 = No evidence or equal evidence regarding client feelings of therapist honesty and/or dishonesty.

3 = Client shows some implicit hesitancy in disclosing intimate details. The therapist may show some impatience in dealing with the client, and there may be some evidence that the client senses this.

2 = Client demonstrates hesitancy in disclosure and some distrust of therapist. Client may question therapist about his/her level of honesty. There may be considerable evidence of dislike of the therapist as a result, including negative voice tone.

1 = Client shows extreme distrust of the therapist, and/or accuses therapist of not being honest about his/her views of the client.

7. The client feels confident in the therapist's ability to help the client.

7 = Client consistently agrees with therapist reflections and interventions/guidance, while also discussing the virtues of the therapy and/or the therapist a few times during the session.

6 = Client believes in the therapist's competence level to a great extent, and this may be evident in the client's expressions about the usefulness of therapy or praise of the therapist.

5 = Client expresses some confidence in the therapist's ability, either by praise or an optimistic view about the outcome of the therapy as the result of a collaborative process (rather than thinking that the client him/herself is doing all of the work).

4 = No evidence or equal evidence regarding client confidence and/or doubt.

3 = Client expresses some doubts about the usefulness of therapy, in regards to the therapist, process, or outcome. The client may doubt that the therapist is truly understanding his/her problems or doubt the interventions/homework/etc. given during a problem-solving phase.

2 = Client expresses considerable doubts, frustration, and pessimism, and may question therapist directly about his/her qualifications or understanding of the client's experience.

1 = Client expresses extremely little or no hope for therapy outcome. The client questions the therapist's ability to a great extent. The client is resistant to therapist suggestions or attempts to help.

8. The client feels that the therapist appreciates him/her as a person.

7 = Client feels that the therapist likes him/her, and expresses gratitude for the relationship or compliments the therapist's ability to empathize.

6 = Some direct client acknowledgement of therapist warmth, acceptance, and/or understanding. The client feels concern/support from the therapist and is comfortable and at ease during most of the session.

5 = Therapist expresses some nonjudgmental acceptance, warmth, empathy, personal interest, and/or sensitivity to the client and his/her situation that the client responds to in some fashion.

4 = No evidence or equal evidence regarding client's feelings about therapist appreciation or disregard.

3 = Client expresses some doubts about whether the therapist cares for him/her by subtlety mentioning this to the therapist in passing during discussion of other topics. The client may show some nonverbal signs of withdrawal, displeasure, or frustration, in response to feeling unappreciated.

2 = Client perceives the therapist as mechanical, distant, and/or uncaring, by voicing these concerns to the therapist. Client may demonstrate some contempt.

1 = Client accuses the therapist of being uncaring, inconsiderate, and inattentive to his/her concerns several times.

9. There is mutual trust between the client and therapist.

7 = Participants have complete faith in each other. The client is very comfortable about disclosing extremely intimate details or problems, and the therapist feels extremely comfortable.

6 = Client is receptive to therapist reflections, challenges, and/or suggestions, and discloses a considerable amount of more intimate/relevant information regarding his/her problem(s). The therapist seems comfortable with the overall situation and is not defensive at all. The client may express confidence in the therapist.

5 = Some willingness by the client to disclose personal concerns and some therapist acceptance of the client's statements at face value. The therapist does not override or interrupt a client's train of thought by redirecting focus.

4 = No evidence or equal evidence regarding mutual trust between the participants.

3 = Participants are somewhat distrustful of each other. Client is a bit guarded in terms of content disclosed. Therapist may show a few signs of lack of comfort about the therapy situation.

2 = Participants are considerably distrustful of each other. The client is very guarded in disclosing any intimate content, while the therapist also shows a lack of comfort. Questions concerning trust may arise.

1 = Client states outright that he/she does not trust the therapist at all. The client does not openly discuss any significant issues. The therapist demonstrates a complete lack of confidence in the client's ability to discuss significant issues.

10. Both the client and therapist see their relationship as important to the client.

7 = Participants believe that this relationship and the process of therapy will bring about change. This client is highly invested in therapy, and it is evident that he/she spends considerable time working on therapy homework or contemplating therapy outside of the therapy hour. Any breaks in therapy would be taken seriously by the client and could cause discomfort.

6 = Client believes in the process and speaks freely about relevant topics. The client believes in therapist as the facilitator of change. The client looks forward to future sessions and may show concern about any breaks in therapy, such as a therapist or client vacation, etc.

5 = Client puts some effort into the relationship, task participation and speaking about relevant topics.

4 = No evidence or equal evidence regarding importance and/or unimportance.

3 = Client is not fully invested in the relationship. The client does not open up a great deal. The client may express a negative comment about the relationship.

2 = Client puts little effort into the relationship. The client does not fully participate and rarely opens up. If the client does open up, it may be with a negative comment (e.g., "I feel that I am not getting what I need from you"). The client has little respect for the therapist. The client may not respect the therapy hour, arriving late or missing sessions.

1 = Client does not respect the therapist. The therapist may make frequent interruptions or seem uninterested indicating that he/she is not fully invested in the relationship. The client may frequently make derisive remarks towards the therapist. If the client opens up at all it is most likely a negative comment (e.g., "I feel

that I am not getting what I need from you"). The client may be considering leaving therapy or is being forced to attend.

11. The patient is confident that the provider will be accepting of him/her no matter what information the patient reveals. (SCALE REVERSED)

7 = Client is forthcoming about all issues without fear of reprisal. The client shows that he/she is willing to discuss process concerns: displeasure with process, displeasure with outcome, lack of effort, and/or not doing homework. The client also expresses no fears.

6 = Client is forthcoming about most issues, but may hold back somewhat with certain items. The client does not seem to be very concerned with being judged.

5 = Client seems somewhat secure in relationship and is forthcoming about some issues.

4 = No evidence or equal evidence regarding client fears and/or comfort level.

3 = Client seems tentative to say some things. The client may be embarrassed and may express some concerns that he/she will be judged.

2 = Client openly talks about being judged or the therapist stopping working with him/her. The client may directly question whether the therapist is judging him/her. Also, the client may test this notion by revealing some past transgressions

1 = Client seems convinced that his/her comments will be judged harshly and/or that the therapist will stop working with him/her if the client says something of which the therapist disapproves. The client appears to be ashamed of his/her thoughts or feelings, and is extremely resistant to exploration

12. The client feels that the therapist respects and cares about the client, even when the client does things the therapist does not approve of. (SCALE REVERSED)

High: Is the patient comfortable talking about difficult topics. Like talking about having wanted to kill someone in their past

Low: Patient seems tentative or reserved while saying these things. For example "I know you don't approve that I hit my child, but I have no other way of disciplining it"

7 = Client feels very respected and cared for, allowing the client to open up. The client is comfortable enough to discuss certain topics of which the therapist might disapprove: problems in the therapy relationship, failures to do homework, lack of effort towards goals, canceling sessions, etc. The therapist contributes to the client's sense of comfort by acting in a warm and nonjudgmental manner.

6 = Client feels respected and cared for, allowing the client to speak freely. He/she probably feels comfortable enough to voice topics of which the therapist may disapprove. The therapist may contribute to the client's sense of comfort by acting in a warm and non-judgmental manner.

- Warm/Nonjudgmental behavior even when there isn't a disclosure of unacceptable behavior is a 6.

5 = Client feels some respect and caring from the therapist. While the client is able to converse freely, he/she is probably not comfortable enough to voice topics of which the therapist may disapprove.

4 = No evidence or equal evidence regarding respect and/or disrespect.

3 = Client shows some tentativeness due to the fact that he/she feels that respect and caring is sometimes lacking.

2 = Client withholds some information that the therapist may disapprove of because he/she feels that respect and caring are often lacking.

1 = Client states that he/she is unwilling to discuss certain topics or he/she displays nonverbal reluctance. The client does not feel respected and may openly challenge the therapist about the lack of caring and/or disrespectful attitude.

Shared Decision Making –OPTION

General Notes:

- **For any item that is exhibited highly at least in one instance, give it a higher than average score (above a 2)**
- **Since these actions are so rare, it's ok to not judge too harshly.**
- **Make sure to write examples of WHY a score was average or above (score of 2 or higher)**
- **For these items, only score explicit decisions. Don't score potential moments for decision making. For example, most problems a patient presents are an opportunity for making decision, but for this SDM Option scale only consider the explicit decisions.**
- **Something that the patient already made, should not be a decision**
- **Patients simply saying they're going to do something, but there wasn't no collaborative talk about it and decision making then it wouldn't be a decision.**

1. **The clinician draws attention to an identified problem as one that <u>requires a decision making process</u>.**

    0 = No attempt to draw attention to a need for a decision making process *(there is no clarity about problems, or at least no clarity about the decisions to be taken about the problem or problems identified)*.

    1 = Very brief or perfunctory attempts to draw attention to the need to embark on a decision making process.

    2 = Baseline skill level: Clinician draws attention to a problem that requires a decision making process.

    3 = Clinician puts emphasis on the decision making process required.

    4 = The skill is exhibited to a high standard *(e.g. supplementary explanations and evidence of patient recognizing the need to engage in the process of decision making)*.

2. **The clinician states that there is more than one way to deal with the identified problem ('*equipoise*').**

    0 = The clinician does not state that there is more than one way of managing problems.

    1 = Perfunctory attempt to convey the existence of more than one option.

    - Using external equipoise is a score of 1

2 = Baseline skill level: Clinician conveys the sense that the options are valid and need to be considered in more depth.

3 = Explains 'equipoise' in more detail and that options have pros and cons that need to be considered.

4 = The clinician also explains 'why' choices are available *(e.g. there is genuine professional uncertainly as to the 'best' way of managing the problem – clinical equipoise);* the skill is exhibited to a high standard.

3. **The clinician assesses patient's preferred approach to receiving information to assist decision making** *(e.g. discussion in consultations, read printed material, assess graphical data, use videotapes or other media).*
    0 = The behaviour is not observed.

    1 = A minimal attempt is made to exhibit the behaviour.

    2 = Baseline skill level: Clinician asks for patient's preferred method of receiving information.

    3 = Doing this behaviour well *(e.g. states that there are many ways in which information can be conveyed; provides reading for outside of consultation).*

    4 = Gives many examples of the types of information formats and media available for the patient, and then provides an opportunity for the patient to select their preferred method or methods.

4. <u>**The clinician lists 'options', which can include the choice of 'no action'.**</u>
    0 = The behaviour is not observed *(listing options is different from providing details about each option).*

    1 = Minimal or perfunctory attempt is made to list options.

    2 = Baseline skill level: Clinician lists options as distinct possibilities that are available (*e.g. using 'either / or' phrasing to describe the existence of options).*

    3 = Careful listing of all possible options, including the choice of taking no action, or deferring the decision.

    4 = Clinician exhibited this behaviour to a high standard.

5. **The clinician explains the pros and cons of options to the patient** *(taking 'no action' is an option).*
    0 = No explanation.

    1 = The clinician fails to provide information about more than one option (a*ccording to the extent that each option is described*).

    2 = Baseline skill level: The clinician provides details about the pros and cons of the options.

    3 = The behaviour is exhibited to a good standard.

    4 = The skill is exhibited to a high standard *(e.g. by description of options followed with discussion).*

6. **The clinician explores the patient's expectations** *(or ideas)* **about how the problem(s) are to be managed.**

   0 = No attempt to ascertain patient's views about their expectations.

   1 = Unskilled or perfunctory attempts to uncover patient's ideas or expectations about management.

   2 = Baseline skill level: The clinician explicitly asks the patient what they expected *(thought)* about the actions required to manage the problem(s). Skilled clinicians are able to explore these expectations and ideas *(using open ended questions, suggesting a range of common expectations, using pauses, being alert to verbal and physical cues and so on)*.

   3 = This behaviour is exhibited and leads to supplementary questions to clarify expectations or ideas *(e.g. exploration of expectations takes place)*. The behaviour is performed to a good standard.

   4 = The behaviour is achieved to high standards and patient's views are discussed and addressed.

7. **The clinician explores the patient's concerns** *(fears)* **about how problem(s) are to be managed.**

   0 = No attempt to ascertain patient's views about their fears or concerns.

   1= Unskilled or perfunctory attempts to uncover patient's fears or concerns about management.

   2 = Baseline skill level: Clinician explicitly asks the patient to voice their fears or concerns about the possible actions required to manage the problem(s). Skilled clinicians are able to explore these fears and ideas (*using open ended questions, suggesting a range of common fears, using pauses, being alert to verbal and physical cues and so on*).

   3 = Exhibits behaviour and leads to supplementary questions to clarify concerns.

   4 = Achieved to high standards where patient's fears/concerns discussed and addressed.

8. **The clinician checks that the patient has understood the information.**

   0 = No attempt to ascertain patient has understood the information.

   1 = Perfunctory attempt to check patient has understood relevant information.

   2 = Baseline skill level: Explicit question posed to the patient asking whether they had understood the information provided or obtained from other sources.

   3 = The clinician explores nature of the patients understanding by using statements like: "I'd like to check that you have understood the information about the possible options. Would you like to let me know what you now understand about this issue?"

   4 = The behaviour is observed and executed to a high standard.

9. **The clinician offers the patient <u>EXPLICIT opportunities</u> to ask questions during decision making process.**

   0 = No attempt to offer opportunities to ask questions.

   1 = Clinician provides pauses, or other opportunities for queries to be raised *(e.g. appropriate pace within the discourse)*.

2 = Baseline skill level: Clinician explicitly asks patient to voice a question *(e.g. "Do you have any questions?").*

3 = The clinician is more specific and asks the patient whether they have questions about the options and the management of the identified problem(s).

4 = The behaviour is observed and executed to a high standard. The clinician will allow time for the patient to respond and will check if there are any other or supplementary questions.

10. **The clinician elicits the patient's preferred level of involvement in decision making.**
    0 = No attempt made to clarify.

    1 = Perfunctory or rushed attempt to elicit the patient's preferred role (active or passive) in decision making.

    - Provider somewhat mentions that the option is up to the patient, but ends up making the decision for the patient.
    - "Well, there is option X, but you're not interested in that"
    "you know there's this other thing W, but you haven't been interested in this before"2 = Baseline skill level: Clinician explicitly asks patient about their preferred role.

    3 = Clinician provides further explanation and continues to assess patients role preference.

    4 = Clinician asks this question in a way that is easy for patient to understand and which signals that the clinician is sensitive to the decisional responsibility that is being expected of the patient.

11. **The clinician indicates <u>the need for a decision making *(or deferring)* stage</u>** (*how the decision is made is not evaluated –could be paternalistic. How the decision is made between the participants and who takes 'control' is not evaluated*).
    - This item can often occur at the end of the session, when last minute topics are brought up, or in the beginning as agenda is being set.
    0 = The clinician does not clearly indicate that a time has come where a decision *(or deferment)* is required.

    1 = Perfunctory or unclear attempt to indicate need for a decision making state.

    - Provider makes the decision, but asks in passing if that's what the patient wants.
    - "Maybe we should talk about this in the future?"
    - "I know this is important for you, we'll talk about it next time.
    2 = Baseline skill level: Clear statement such as, "Perhaps it's time now to make a decision about what should be done."

    - "Do you think we should talk about this now or next time?"
    3 = Exhibiting this behavior to a good standard.

    "Do you want to decide that today or next time?

    4 = Clinician that achieves this task to a high standard and will have signaled the transition from consideration of information and views to one of deliberation and closure.

12. **The clinician indicates <u>the need to review the decision</u> *(or deferment)*.**
    0 = No attempt to indicate a need to review or defer.
    1 = Perfunctory *(e.g. that the patient should be seen again)* or rushed attempt.

- "We'll keep talking about this"
- "" Let me know how it keeps going"

2 = Baseline skill level: Clinician indicates that the patient should be seen again to re-consider the decision.

- "We'll check in next week about how it goes"

3 = The behavior is performed to a good standard.

4 = The behavior is observed and executed to a high standard *(e.g. makes it very explicit and encourages this approach).*

eAppendix 3. Coaches' Wrap-up Call Guide

Part 3: Coaching Guidelines

Note: Part 3 calls should be 1 hour long and must be recorded. For Part 2 of the call, you should take notes on the provider's answers to each question. When you have completed the call, send Stephen and Andrea an email with the length of the call and your notes, and be sure to upload your recording to your coding folder.

General Comments
The part 3 coaching call is meant to be a chance to summarize and review each provider's progress throughout the workshops and coaching calls. It also allows the provider to give us feedback on the intervention.
- Coaches should highlight improvements they have noticed over time as well as areas that still need more attention.
- Together, the coach and provider should discuss concrete strategies that that they can continue to use to improve their communication on their own.
- Whenever possible, the coach should reinforce the core messages of the intervention:
  o Avoid attribution errors
  o Use cognitive empathy/perspective taking to better understand patient context
  o Explore barriers to treatment
  o Ask if patient has questions, help them formulate them – give them time to think
  o Recognize your own biases, possibly related to past negative experiences with similar patients
  o Pay attention to emotions – don't just rely on your intuition – confirm how the patient feels by asking them explicitly: "Do you feel ____?"
  o Encourage patients to ask questions and to take an active role in their own care

Structure of the Call
Part 3 calls should be 1 hour long and divided into two roughly equal segments:

Part 1 (30 minutes): Overall Feedback
 Give a general summary or synthesis of areas where the provider has performed well (15 minutes)
Before your call, review all the coding and putting feedback together sheets you drew up for the provider and look for positive trends. Write a paragraph that synthesizes your main points and then discuss each one in depth during your call.

- For each point you note, try to tie it to a specific example that shows *how* the provider did a good job
- Look at the coder's codes as well to see if there were other improvements you didn't notice in your own coding
- Review which strategies the provider used that worked well

Identify six areas that still need improvement
Write down these six points in the boxes provided on your part 3 coaching sheet. Then write down a specific example of how the provider could work on each area for improvement. Emphasize that even though the coaching sessions are over, the providers can continue to use the skills they learned to communicate more effectively.

Part 2 (30 minutes): Questions

The second half of the call should be devoted to getting feedback from the provider on the intervention. Ask each of the questions below. Feel free to probe and explore areas about which the provider has more to say. During this section, you should take detailed notes on the response to each question.

1. **What do you think helped the most from the coaching intervention? What worked the least? You can mention more than one thing.**

2. **Were there times that you purposefully deviated from the training? Could you give an example? If so for what reason?**

3. **Have you adjusted your interactions with your patients as a result of the coaching you got? If you adjusted your behavior as a result of the coaching, how hard was it to do so during a session with your patient?**

4. **How did you behave differently in taped sessions vs. sessions that were not taped?**

5. **Once you participated in the coaching, did you prepare before a clinical session (for example, reviewing the feedback that was previously given or looking at notes of the coaching)? If so what did you do to prepare? Did any particular preparation method help more than others?**

Part 3 – Follow up Evaluation - 1 Minute

- Mention that we'll be conducting a follow up evaluation in 1 Month.
- It will be conducted another person who is not their coach or Andrea

eAppendix 4. Coaching Call Feedback Sheet

DECIDE-PC Provider Coaching: Summary Feedback Sheet

Tape_____ Coach_____

	Strengths	*Average*	*Areas for Improvement*
Day 1 **Shared Decision Making**			
Perspective Taking			
Engagement			
Day 2 **Attribution Errors**			
Global Impressions			
Day 3 **Positive Patient Activation**			
Encouraging Open Communication			
General Comments			

eAppendix 5. DECIDE-PA (Patient Intervention) Training Materials

DECIDE-PA

Principal Investigator: Margarita Alegría, PhD

Co-Investigators: Nicholas Carson, MD, FRCPC and Antonio Polo, PhD

Version: April 2014

CARE MANAGER MANUAL
DECIDE-PA: A Participant Activation and Self-Management Intervention

D…Define the Problem or Decision

E…Explore Possible Questions

C…Closed- or Open-Ended Questions?

I… Identify the Who? How? and Why? of the Decision

D…Direct Your Questions

E…Explore Additional Resources

Care Manager Manual

Table of Contents

DECIDE
OVERVIEW

Rationale

The DECIDE program is designed to teach individuals to reflect on their care, consider their options, identify and ask key questions, all so they can actively participate in important decisions with mental health providers (e.g. psychologists, social workers, psychiatrists).

The DECIDE intervention provides support for individuals who feel they do not participate in their treatment and for those who lack knowledge about ways to take full advantage of mental health services.

History

The DECIDE intervention is based upon the educational strategy developed by the non-profit organization, the Right Question™ Institute (formerly, the Right Question Project). Since 1991, the Right Question Institute (www.rightquestion.org) has been developing and refining its innovative strategy for teaching question formulation and decision skills by learning from people in low-income communities around the country as they learned to advocate for their children's education, and advocated for themselves and their families in their ordinary encounters with social services, health care, housing agencies, job training and other programs. RIGHT QUESTION™, QUESTION FORMULATION TECHNIQUE™ and FRAMEWORK FOR ACCOUNTABLE DECISION-MAKING™ are trademarks owned by the Right Question Institute and are being used by the Cambridge Health Alliance with the Right Question Institute's permission.

This study is supported by Contract number CD-12-11-4187, funded by the Patient Centered Outcomes Research Institute (PCORI).

Materials

The DECIDE program includes this Care Manager Manual, Care Manager Materials, and a Participant Planner. All these materials are needed to effectively deliver the intervention.

How to Use this Manual

Guidelines for Success

This is the Care Manager (CM) manual for the DECIDE program. DECIDE is a structured intervention with the goal to increase the participant's voice in the clinical encounter. It includes a series of exercises to facilitate participant activation and self-management when interacting with mental health providers.

Suggested scripts will be boxed, bolded, and italicized, as follows:

> ***These boxes provide examples for presenting topics or exercises to participants. They can be paraphrased or delivered as written.***

Trainings can be delivered by telephone. This approach will require you to cue the participant to consult materials at home, indicated here by the "Phone Cue" icon in the margin. Here are some important tips for delivering phone trainings:

- At your first meeting, give the participant the DECIDE training materials that accompany the manual. Request several contact numbers for the participant (e.g., cell phone, home phone, work phone, email address). If the participant permits, phone numbers of family or other close contacts can be very helpful in reaching the participant.
- If you were not able to meet the participant in person, confirm that your participant has received any participant materials you mailed to them (e.g. DECIDE Planner and Care Manager Cards)
- Call to confirm the phone training a day before as a reminder.
- Once the phone training has begun, ask the participant to find a quiet space free from distraction (e.g. no television), and remind them of how long the call will take (usually 45-60 minutes).

The four trainings have specific tasks and suggested time frames for each section. However, do not let the pressure of having to go through every section impede a natural flow or prevent building rapport with participants. Each CM has his/her own personal style. Following a manualized intervention does not mean that you cannot blend that style into your interaction with participants. Being warm, attentive and a good listener will help participants learn the DECIDE skills and buy into self-efficacy in the clinical encounter. Your enthusiasm will be contagious!

Please schedule your trainings at times that are convenient for the participant, such as when they are in the clinic for a regular appointment. You will give participants a Planner that contains the exercises in this manual, which will help participants remember each training.

CMs can be a great support for participants. However, you should never think of yourself as a substitute therapist or case manager. Participants may want advice about their personal problems and, during disclosure, seek reassurance or guidance. It is crucial that you clarify your role explicitly. CMs are *not* trained to be therapists or case managers, and attempting "therapy" with participants will undermine the work being done by their actual providers. Instead, turn requests for advice into "teaching moments." You can speak with the DECIDE team for support with this. The goal is to help participants bring these requests back to their providers as new questions.

Training

1

TRAINING 1 – DECISIONS & AGENCY

Training 1 is the most didactic of the DECIDE sessions and lasts approximately 45 minutes. The main goals of the first training are to 1) increase participant awareness of their role in the interactions with their mental health providers; and 2) to teach skills for asking questions as a strategy to become involved in decisions about their mental healthcare. The DECIDE approach helps participants "find their voice" (we call this "activation"). Thus, the main rule for Care Managers (CMs) is not to train participants in the *CM's* voice but in the participants', *own* voices.

Help participants "find their voice"

It is not uncommon for participants to have a difficult time generating questions for their providers. Sometimes they are nervous about being put on the spot or afraid they will not ask the "correct" question. Others may understandably lack enthusiasm because of depression, anxiety, or other emotional problems.

You should not immediately feed participants questions. Instead, help them find their voice. Most participants will come up with very good questions if given some time. Fight the impulse to fill the silence.

If needed, refer to questions at the end of the participant Planner to help guide the conversation. Even in these cases, however, the participant should be given time to select their preferred questions among the others in that section.

In Training 1, participants are introduced to the Tips for Brainstorming Questions (*Ask as many questions as you can; do not stop to try to answer them; write down each and every question; change any statements into a question; choose the most important questions*) and to the first three components of the DECIDE acronym. This includes defining a problem or decision that matters to them, generating questions they want answered, and differentiating between closed- and open-ended questions. The role-play and practice assignments for this training are intended to help participants actively rehearse the strategies they have learned.

Activities	Time
A. Introduce Rationale and Goals of DECIDE	4 min
B. Confidentiality	2 min

A.   Rationale and Goals of the Trainings (4 minutes)

It's very nice to meet you. My name is＿＿＿＿＿＿＿＿＿＿and I will be your "Care Manager" for these trainings. We will have three trainings together, plus a fourth "booster" session if needed. We will do these trainings in person, or by phone if needed. I will teach you the "DECIDE" program. I am not a doctor or a therapist, so I am not able to answer questions about your mental health care. I do hope to be an excellent coach as you learn the DECIDE methods.

In our work, people have told us they often feel confused during their mental health appointments. They might not know what to expect from their care. They don't know what their diagnoses and treatment options are. They also don't know how to find information about their condition and the best treatments available.

This confusion can make it difficult to ask providers questions (a "provider" is a counselor, therapist, or psychiatrist). Some even decide to stop coming to appointments altogether. Many people have told us they wish they knew more about ways to get better, but aren't really sure what to ask. Perhaps you can relate to these people?

Over the next few months, we will share with you some tools you can use to collaborate with your provider. We will show you where you can ask your questions and get more information to make decisions about your care. Providers can be a great resource. However, it is up to you to get the most out of what they can offer. With some work and lots of practice, we expect that you will become an excellent manager of your own healthcare! Do you have any questions?

During our meetings, I will teach you strategies to help you participate in decisions about your care. We call this program "DECIDE." Each letter in DECIDE stands for something we will learn together. Here is a card that has the meaning of each letter. You do not have to memorize what DECIDE stands for. I just want you to see what we will cover in our trainings. [REVIEW DECIDE CARD AND BRIEFLY GO OVER EACH LETTER].

B. Confidentiality (2 minutes)

Take a moment to set the scene for the DECIDE trainings. Reassure the participant that their private health information will be kept in the strictest confidence. This is meant to help participants share their concerns about their providers in private. The only time you, as the Care Manager, should share participants' information with providers is with their written permission or in circumstances where you believe the participants may harm themselves or someone else. In this latter case, you will directly contact the participants' clinicians and the DECIDE project investigators for how best to proceed.

During our meetings, you and I will talk a lot about the mental health services you are receiving. I will often refer to the people that provide you with these services as "providers." These "providers" can be social workers, psychologists, or psychiatrists.

It's important that you know that the things we speak about are private. I will not share with your provider(s) what you have told me. I hope this makes you comfortable enough to tell me about your relationships with your providers. I will be discussing our work with my supervisors in private to make sure I'm providing you with the best training.

I will not contact your provider unless I believe you are at risk of harming yourself or someone else. Then I must tell your provider and the supervisors of this study, so they can get you help. Do you have any questions about this? Once more, let me reassure you that I will not talk with your provider about our meetings unless I believe you or others may be at risk for harm.

There may be times when you or I may need to stop a training early. I will do my best to finish the training with you at a later date. We also have the option of doing trainings by phone, though in person usually works best.

C. Rapport Building (3 minutes)

Spend some time getting to know the participant. Focus on how they are currently managing their mental health needs and how they are working with their provider to meet those needs. You should avoid discussing the details of participants' mental health histories, but try to convey that you care about who they are. Briefly, ask about what brought them to the clinic and get a sense of how their treatments are going. These answers will suggest where participants can apply their DECIDE skills.

Before we start our training, I'd like to get to know a little about you:

- ○ *When did you begin treatment at the clinic?*
- ○ *Who are the providers that work with you? How many do you see? How often do you meet with them? [WRITE DOWN THIS INFORMATION SINCE IT WILL BE HELPFUL ACROSS TRAININGS]*
- ○ *Do you ask questions during your appointments? (If not,) why not? How has that been working for you?*
- ○ *Do you have any goals for your mental health treatment?*

D. Using the DECIDE Planner (1 minute)

If literacy is not a problem, participants can use the Planner to write down their questions and reflections throughout the DECIDE program. The Planner matches the content in this manual and contains worksheets for use after the program is complete. For those participants who do not know how to read or write, offer to read and write for them if you sense this may be needed, when introducing the DECIDE Planner. You might also ask if it is possible to audio record content from the Planner on the participant's cellular phone for later review. It might also be possible that participants have family members, friends or neighbors who might be able to read for them.

I'd like to go over the DECIDE Planner. It's yours to keep, and I hope you bring it to our meetings and to every visit with your providers. The Planner has all the information I am going to teach you in our trainings together. You can use it to write down questions for your providers. It also has some worksheets you can use for appointments after our work is done.

We know that many of the participants we work with need help with reading or writing. I hope you will let me know if I can help you read the Planner or write down questions. I will do my best to help you understand our materials. For example, I can take notes for you and read these back to you. Please stop me at any point if you don't understand something, if you need me to repeat it, or if you feel we're going too fast.

Review the contents of the Planner. Have the participant write down any provider appointments they know about (e.g. psychiatrist, therapist, other service provider), and a date and time for their next DECIDE training with you.

E.   Hypothetical Provider Scenario (10 minutes)

This exercise demonstrates how participants can take more responsibility for their care. The emphasis is on convincing participants that providers prefer more engagement, and will change in response to participants' needs.

For each scenario, use the cards depicting the hypothetical patient-provider interactions to help participants imagine these situations.

<u>Scenario 1</u>

Ask participants to imagine that they have been meeting with Dr. Anna and sessions are going very well (hand participant the "Dr. Anna" picture):

Now we are ready to begin learning the DECIDE process. This first section will help you think about different ways to participate in treatment.

Imagine you have been meeting with a therapist named Dr. Anna. You have seen her for a couple of months and the meetings have been helpful to you.

Let me describe Dr. Anna:

- *She is encouraging and supportive*
- *She switches appointment times if they don't work for you*
- *You feel comfortable asking her questions*

Scenario 2

Now, imagine one day Dr. Anna tells you she is leaving the clinic. You are going to be switched to Dr. Beatrice. After a few weeks of meeting with Dr. Beatrice, things are not going well (hand participant the "Beatrice" picture):

Let me describe Dr. Beatrice:

- *She is not very supportive*
- *The appointment times are inconvenient for you (e.g., during work)*
- *You don't feel comfortable asking her questions*

Ask participants to list their options in the Dr. Beatrice situation:

What options would you consider? What could you do? Why are therapists like Dr. Anna or Dr. Beatrice?

Participants often point to the differences between the personalities, work ethic, or other unchangeable characteristics of the two therapists. Many participants think their only option is to stop treatment as a response to Dr. Beatrice. Take advantage of this "teaching moment" by inviting participants to consider other options, like asking Dr. Beatrice to be more flexible or responsive.

Does your relationship with your provider remind you of Dr. Anna or Dr. Beatrice, or maybe both?

The reason we did this exercise is to make sure that you consider other options instead of giving up on treatment. People sometimes tell us that they would stop coming to treatment if this happened to them. Being persistent until you feel comfortable is much better than stopping treatment.

There may be some things you like about your provider, and some things that need improvement. An important lesson in this program is that providers prefer it when patients ask questions and state their concerns!

In these trainings, we will coach you to tell your provider what you want from treatment. This helps providers do their job better and helps you participate in your healthcare.

Remember:

- *There are things __you__ can do to improve your relationship with your provider.*
- *By not doing anything, you are __still making decisions__!*
- *During your appointment, you can be more responsible for your health by letting providers know what you like and what helps you.*

F. The D in DECIDE (4 minutes)

DECIDE is the name of this program. It is also an acronym that will help you remember ways to work with your provider. Each letter stands for a part of the process (SHOW PARTICIPANT THE DECIDE ACRONYM):

     D…   Define the decision or problem E…
            Explore possible questions

     C…   Closed- or open-ended questions

     I…   Identify the Who (Role), How (Process), and Why (Reason) of the decision or problem

     D…   Direct your questions

     E…   Explore Additional Resources

You do not have to memorize DECIDE, but it may help you remember what you learn. Let's start with letter "D": define the problem or decision.

How would you describe what a decision is?

We see decisions "as a choice of one option among two or more options."

[ASK ONE QUESTION AT A TIME AND WAIT FOR THE RESPONSES].

What decisions do you make in your treatment?

What decision do others make for you about your treatment? For example: Who decided to make the initial appointment?

> *Who decided on the time and date for your appointments? Who decides what you talk about in your meetings?*

Often, some of these decisions were made by your provider, while others were made by you. In general, we believe that the best decisions are made when you and your provider work together and share information. This is one of the most important messages we hope you learn.

G.   The E and C in DECIDE (6 minutes)

You have now introduced the importance of agency and shared-decision making in mental health care. Now, the focus turns to learning tools to improve decision- making, such as asking good questions.

We now know it's important to work with our providers to get information, make our voices heard, and participate in decisions about our mental health treatment. An excellent way to accomplish all these things is to ask good questions. The "E" in DECIDE teaches us to Explore Possible Questions.

We've come up with some Tips for Brainstorming Questions to help you. [SHOW THE "TIPS FOR BRAINSTORMING" CARD; BRIEFLY EXPLAIN EACH TIP]:

- *Think of as many questions as you can*
- *Do not stop to try to answer them*
- *Write down each and every question*
- *Change any statement into a question*
- *Choose the most important questions*

Ask the participant to reflect on these tips and think of an example from their own lives where they have used brainstorming.

When you brainstorm, think of different <u>kinds</u> of questions. The "C" in DECIDE stands for Closed- or Open-Ended Questions. Open-ended questions require an explanation and can be answered in many ways. For example, "What is your neighborhood like?"

Closed-ended questions can be answered briefly and have limited ways of being answered. For example, "What is your favorite color?" Many closed- ended questions can be answered with "yes" or "no".

If you are not getting the information you want from your provider, try changing questions between closed- and open-ended. This can get you different kinds of information.

Can you give me an example of an open ended-question? How about a closed-ended question?

Provider Prescription Vignette

Let's practice asking questions. Imagine you have your first meeting with a new provider. He suggests you try a medication to help you feel better.

[SHOW PARTICIPANT THE PRESCRIBER CARD]

What would the problem or decision be here?

What questions come to mind if this was happening to you? What questions would you have about that decision?

Participants should use the Tips for Brainstorming questions, listed above. You should also write down their questions in your CM notes.

Let's review your questions and see if they are open- or closed-ended. Closed-ended questions provide concrete facts and save time. Open- ended questions give more information. Then we'll change some of the closed-ended questions into open-ended questions, and vice versa.

Do you notice any patterns in the questions you came up with?

Give participants the chance to label and change their questions as open- or closed-ended. If needed, give an

example of each, such as, "Do I have an appointment next week?" (Closed) "What are my medication options?" (Open). Help identify any patterns in their questions. Participants may not notice that most of their questions tend to be closed- or open-ended. Do not spend time changing each of the questions. Instead, help the participant identify any patterns (e.g., all their questions are closed-ended) and change one or two of the questions only (e.g., from closed-ended to open-ended).

Care Manager Tip: Stepping back to determine what is negotiable

In the Provider Prescription vignette, above, some participants will automatically accept the medication and ask questions about the *consequences* of taking the medication. Others will immediately decline the medication. Use this "teaching moment" to step back and teach that *all* aspects of a decision are negotiable.

Stress that participants can ask why the provider decided to recommend this medication. This might include asking about alternatives to the medication. Participants may feel uncomfortable or disrespectful questioning their providers' judgment. Suggest that politely asking about the provider's decisions can be both helpful and respectful. Participants may connect with their providers better, while learning more about their treatment options.

If they haven't done so already, help the participants articulate a question about alternatives to medication they would feel comfortable asking their providers.

> *You can have questions about the medication the provider recommended. Those could be very useful. You can also ask the provider about the reasons why s/he is recommending medication instead of another treatment. Also, you can ask if there are alternatives. This will allow you to learn why the provider made the decision to recommend medication.*

H.   Personalizing and Role-Playing (10 minutes)

At this point, the attention shifts back to customizing the training to meet the participants' current needs

> *Are there any decisions or problems you've been considering in your own mental health treatment?*
>
> *Think about decisions or problems that are important for you to discuss with your provider during your next mental health appointment. Choose topics that you are interested in discussing. Can you think of something you want to talk about? What decisions are important in your life or in your treatment that you want to talk about?*
>
> *Let's write them down in your planner.*

Ask the participant to select two or three decisions and help them reflect on each carefully. Then, select the one that the participant is most invested in discussing with his/her provider. This allows the participant to be more engaged since the first decision or topic is not always the most important for them. Write down these topics and decisions; they will be useful to bring up in future trainings. If the participant does not select decisions but only topics, ask him/her why the topic is important and, after probing, help him/her identify a decision.

Okay. Now that we have identified a few decisions or topics, let's pick one. Which of these do you think is the most important to explore with your provider? Let's circle it. Now let's brainstorm a list of questions related to this decision that you might ask in your next meeting with your provider. Write them in your Planner.

You should record these questions as well in your CM notes. Use the Tips for Brainstorming questions from Section G. Once several questions have been generated, help the participant identify whether they are open- or closed-ended questions. Make modifications if necessary (e.g., if all questions are closed- ended). Write questions down for the participants if they have trouble writing.

[Help the participant identify whether they are open- or closed-ended questions. Make modifications if necessary (e.g., if all questions are closed-ended)]

Now choose one question from your list that you believe is the most important to ask in your next appointment. Make sure it is a question that you feel comfortable asking your provider.

Care Manager Tip: Addressing Ambivalence

The following tip can help participants address their discomfort with asking questions. The key for the CM is to reinforce any confidence they show, even if it is a little. Ask the participants:

On a scale of one to ten, how confident are you that you will ask your question to your provider? One is 'not ready at all' and ten is 'completely ready.' (SHOW PARTICIPANT THE RATING SCALE)

If the participant gives any number greater than 1, follow up with,

That's great! What makes you feel that you are at a [Number] and not a 1 or 2? Why isn't it lower?

What might help move you from a [Number] to a [Two numbers higher]?

Encourage participants to articulate the reasons why they feel ready, even if it is just a little.

You've now practiced brainstorming and asking questions. At your next mental health appointment, I'd like you to practice asking your question to your provider. Bring your DECIDE Planner to remind you of the question and what you learned today. Afterwards, write down in your Planner how things went. Think about how it felt to ask the question and how your provider responded. You and I will go over what you wrote about this experience next time we meet.

If you will not see your provider before our next training, is there someone else who could take your question? If not, we will keep practicing your questions to prepare you for your next mental health visit.

4. Do not answer the question. Make it clear that the role-play has ended and begin debriefing.

A good way to start the role-play is to say,

(CM pretending to be provider) *"Hello_____[PARTICIPANT'S NAME]. It's good to see you. What's on your mind for today?"* (Pause to let the participant ask the question)

After the role-play, ask:

How did it feel to ask your question?

What kind of answers do you think your provider will give?

Suggestions for reviewing role-plays:

1. Once the role-play is over, first ask the participant to reflect on his/her performance. Ask them what they liked and disliked about their attempt.
2. Give feedback. Always start by being supportive. If s/he did not ask a question, point out good attempts at bringing up the topic. Give specific feedback about the wording of the question in the role-play relative to how it was written by them or agreed upon prior to the role-play. Participants may phrase the question as a statement or use a tone that is too soft or harsh. They may ask a very different question than was intended.
3. Give feedback about their delivery, including non-verbal communication. They may avoid eye contact or pull away when they ask the question.
4. Repeat the role-play as needed to build confidence and to incorporate feedback. If necessary, come up with an alternative question if that emerges as the most helpful outcome of the role-play.
5. For participants who are very shy or unsure of how their question will be perceived by the provider, you can use a "Reverse Role-Play." In this case, you play the role of the participant and the participant plays the role of the provider. Ask the question that the participant selected, and then ask the participant how it felt to hear his/her question out loud.

I.   Practice Assignment (2 minutes)

After the role-play exercise, a practice assignment is given to be completed before the next training.

Note which question the participants pick. Indicate the page in the DECIDE Planner where they can write down their questions for their next appointment. Remind participants to bring the Planner to every appointment with their provider.

Preparing Participants for Answers

Providers may not always be ready for participants' questions. It is helpful to prepare participants for a variety of responses:

> *Providers may not be expecting your questions. They might hesitate or seem surprised when you ask. They simply may not have an answer for you. Be persistent and your collaboration with your provider should improve. It might take some time for your provider to see you as an empowered patient.*

For Participants who have a hard time reading or writing, it might be helpful to:

- Ask them how they keep track of important items or appointments. They might already have a system that works for them (e.g. a family member reads/writes documents for them.) Be mindful that participants might not feel comfortable having others read about their mental health concerns.
- Voice messages: it might be possible for the participant to record a cellphone voice message with questions for their providers. You could also leave a message with the questions if they prefer.

- Ask if the participant wants to talk before the next appointment to review the material and be reminded of the practice assignment.

J.   Review and Reflection (3 minutes)

After every training, ask participants to summarize and reflect on what they have learned. **Allow them first to say as much as they can remember**. If they can't come up with anything, give them some hints to help them and give them some time to figure it out. Participants should touch on:
- the importance of asking questions and making shared decisions
- what the letters "D", "E", and "C" stand for
- the difference between closed- and open-ended questions

Clarify confusing points and correct misunderstandings as needed. Some participants will be able to remember the details (e.g., that they learned closed- and open-ended questions). Others will be better at telling you that they understood the big picture (e.g., that participating in their care is critical). Make sure that you touch on both the specifics and the big picture after they are given a chance to tell you what they remember learning. Connect it to their examples and the questions they generated as much as possible.

Remind the participants of their next appointment time and of their practice assignment. Before you end, make sure you have a time and date for your next training session!

We are almost finished with our meeting today. Can you tell me in your words what we learned today? Great! What else? Excellent! Why is this important?

Let's confirm the date and time of our next training.

Training

2

TRAINING 2 – THE WHO, HOW & WHY OF DECISIONS

T rainings 2 teaches additional skills for getting information for shared decision-making. Participants are introduced to the last three letters of the DEC<u>IDE</u> acronym: **I**nvestigating the Who, How, and Why of a decision; and **D**irecting your questions to a provider; and **E**xplore additional resources. The role-play and practice assignment for this training are intended to help participants rehearse the strategies they have learned.

Activities	Time
A. Review of Training 1	4 min
B. Practice Assignment Review or Troubleshooting	4 min
C. The "I" in DECIDE: Identify the Who, How, and Why of Decisions	15 min
D. The "D" and "E" in DECIDE	3 min
E. Personalize, Role-play, and Reflection	12 min
F. Practice Assignment	2 min
G. Review	5 min

A.   Review of Training 1 (4 minutes)

Spend a few minutes reviewing material from Training 1. Ask participants to reflect on what they learned in Training 1. Allow time to ask questions and clear up any confusion. As you review this with them, connect it to their decisions and generated questions as much as possible. Remind participants of the following:

- the importance of asking questions and making shared decisions
- what the letters "D", "E", and "C" stand for
- the difference between closed- and open-ended questions
- highlights of the role-play exercise
- questions they brainstormed for their providers

B.   Practice Assignment Review or Troubleshooting (4 minutes)

Ask whether the practice assignment was completed. Participants may be critical of their "performance," or feel disappointed in the answers they received from their providers. Others will have success stories. If the participant did not ask their provider a question, proceed to the Troubleshooting section, found below.

- *When you met with your provider, did you ask the question you selected in our first Training?*
- *What did you learn?*
- *How did it feel?*
- *Is there something you wish you had done that you didn't do?*

Be **positive** about even partial completion of the assignment, and give positive feedback for any of the following:

- reading the Planner
- bringing the Planner to the appointment
- raising concerns with providers, even if no questions were asked
- taking notes about the appointment
- asking questions to other people in the participants' lives

Troubleshooting:

Your participant may not have had a chance to ask their preferred question because there was no scheduled provider visit before this training. In this situation, see if they asked the question to someone else. You should also review their question so they can use it at the next mental health visit.

Some participants will report they did not complete the practice assignment and did not ask their questions. Some will have forgotten their questions or Planners, or become distracted in the moment. Some will feel too anxious. They may want to avoid talking about the fact that they forgot or for some other reason weren't able to complete the assignment. *Be supportive but don't skip going over the troubleshooting section. A discussion about ways to overcome these barriers is helpful at this point.* Examples of strategies other participants have successfully used to ask their questions include:

- reviewing their DECIDE Planner
- practicing their question with someone they trust
- mentally rehearsing the question before the appointment
- Use a respectful introduction to the question, e.g. "I really value your opinion, and so I am hoping you will answer a few questions I have…"

[If your participant doesn't complete their practice assignment]:

I understand you weren't able to complete the assignment. Asking questions can be difficult, and I want to support you to build your skills. Can we review what made it difficult to ask your question to your provider? What did you find challenging?

What do you think could help you overcome these barriers?

Care Manager Tip: Care Managers are not therapists

Remember, Care Managers are not therapists or case managers. If participants ask you for advice about their health or treatment, you can use this script:

> *I'm glad you trust me enough to ask for advice, but the best person to address these issues is your therapist or psychiatrist. I'm not trained to be a therapist, and I don't want to interfere with the important work you are doing with your providers. I can certainly help you ask questions to get the advice you want from your provider.*
>
> *The DECIDE trainings are short-term and I want to help you generate answers for yourself. Can I help you turn your concern into questions that you can bring to your next appointment?*

C. The "I" in DECIDE: Identify the Who, How, and Why of Decisions (12 minutes)

<u>OPTIONAL</u> Scenario:

This scenario is <u>optional</u>. If you think the participant may struggle learning Who, How, or Why questions, it may be helpful to start with this story about Carmen, who is an imaginary DECIDE participant. The goal of this scenario is to illustrate the benefits of asking questions about role, process, and reason with the help of a concrete example.

If you think participants would be able to understand role, process, and reason and would prefer to focus on their own mental health concerns, skip this section.

> *To introduce our next topic, I am going to read to you a scenario about an imaginary DECIDE participant. Her name is Carmen. I want you to put yourself in her shoes (SHOW PARTICIPANT THE CARMEN CARD):*
>
> *"Carmen thinks her therapist spends too much time talking about her child's problems. Carmen would like her therapist to spend more time on her problems instead of on her son's problems. Her therapist also talks on the phone during sessions and shortens her appointment time."*

> *Carmen is feeling uncomfortable about her situation and has a decision to make. She considers three options: a) leave treatment; b) do nothing and hope things get better with her provider on their own; or c) ask questions to help her understand the situation better.*
>
> *What options would consider if you were in her place? [Allow participant to answer] After participating in DECIDE, Carmen has chosen to ask questions to her therapist. She does not want to leave treatment and she knows that if she doesn't say anything, her provider won't know how to make the situation better.*

Here is a list of the questions she generated:

Teaching the Who (Role), How (Process), and Why (Reason) of decisions

This section works best if participants already have a decision in mind or are considering a specific problem. If your participant is having a hard time changing a problem or concern into a decision, ask them to imagine what they are thinking of **doing** about it. Participants should brainstorm questions about this decision or problem, because this will help them learn Who, How, and Why more effectively. As we did in Training 1, it is helpful to brainstorm several problems or decisions rather than choosing the first one the participant mentions. It helps to then ask the participant which one s/he is most interested in exploring further.

Now I'd like to teach you some useful ways to think about decisions. An important part of this training is to help you participate more in decisions about your mental health care.

For this next exercise, think of a decision or problem about your mental health care that is important to you. Try to focus on decisions or problems related to your treatment, your diagnosis, or your relationship with your mental health provider.

Have your providers given you a name or diagnosis for your mental health condition?

We like to emphasize that there are "two experts in the room." Your provider knows a lot about diagnosis and treatment, but <u>you</u> know yourself best! Do you have your own name for your condition? Or do you have other reasons for being in treatment?

Now let's think about your treatment for your (condition, diagnoses, or concerns). What have you been told are good treatments for your condition? [DISTINGUISH WHAT THEY HAVE BEEN TOLD FROM WHAT THEY BELIEVE]. Have you been given other options for treatments that interest you?

Finally, do you have any problems or decisions related to your relationship with your mental health provider?

(**If participant has difficulty thinking of a decision**): *You can think of new decisions to make by asking "What could I do about this problem? What do I want to talk to my provider about in my next appointment? Why is this issue important to me?"*

[If participants have multiple decisions or problems they're interested in exploring, help them find the most important one].

Next, let's brainstorm some questions about this decision or problem you have selected and write them down in your Planner. You can use the Tips for Brainstorming from Training 1 to help you come up with questions.]

Have you already asked these questions to your provider? How confident would you feel asking these questions?

If the participant is not confident about asking a question to their provider, help them problem solve the barriers that prevent them from asking.

Learning the Who, How and Why of decisions can be challenging for participants. Follow the guide below and feel free to creatively teach these concepts.

> *Now that you have a decision or problem in mind and several questions, it is time to learn the next letter in DECIDE. The "I" stands for "Identify the Who, How, and Why of a Decision." [SHOW PARTICIPANT THE DECIDE ACRONYM]. You already know it's important to ask good questions. These three types of questions will help you think of decisions in exciting new ways.*

An excellent way participants can achieve a shared decision-making process with their provider is by considering the **role**, **process**, and **reason** behind decisions. These can be made easier to understand as follows:

> *<u>Who</u> makes the decision? Or, what <u>Role</u> do you or your provider play? <u>How</u> is this decision made? Or, what <u>Process</u> is used?*
>
> *<u>Why</u> is this decision going to be made? Or, what is the <u>Reason</u> for it?*

Participants may have generated questions already that cover Who, How, and Why. Below is an explanation of each:

Introducing "Who?" Questions

Who (Role) Questions ask who contributes to making a decision.

> *Questions about "Who" is making decisions show how you can participate more in your care. For example, "Who decided I should take this medication?" Or, "What can I do to improve my health?"*
>
> *Now let's look at your decision and the questions you came up with earlier. Do any of your questions help you understand who has the responsibility for the decision or problem?*
>
> *Remember that Who questions help you find out what <u>you</u> can do to take a more active part in your care. They can start with "Who…" or with "What can I do…" [If needed:] Let's write a Role question in your Planner.*

Introducing "How?" Questions

How (Process) questions address the steps taken to reach a decision. Again, using the Planner, help participants generate their own examples or find examples of process questions to help them.

Questions about "how" decisions are made help you learn the steps in making a decision. For example, "How did you decide that a new medication is needed?" Or, "How do we decide what to talk about in my therapy session today?"

Do you have a "How" question already in your list? Can you come up with one and write it in your Planner?

Introducing "Why?" Questions

Why (Reason) questions address the reasons behind a decision.

Why (Reason) questions help you understand why a decision was made about your mental health treatment. For example, "Why do we focus on this problem?" "Why do I need to take this medicine?"

Do you have a "Why" question already in your list? Can you think of one and write it down in your Planner?

It is helpful to tell participants that Who (Role), How (Process), and Why (Reason) questions often **overlap**, and they can be addressed in **any order**. For example, it may be easier to ask why a decision needs to be made before considering how it was made, or who will make it. The emphasis should be on thinking through a decision from these three perspectives.

D. The Second "D" and "E" in DECIDE (3 minutes)

You have learned "D" is "Define a decision or problem," "E" is "Explore possible questions. "C" is for "Closed- or open-ended questions," and "I" is "Identify the Who, How, and Why of the decision."

We've come to the second "D" in DECIDE. It stands for "Direct your questions." The final "E" in DECIDE stands for "Explore Additional Resources." We will revisit these two letters in the next training, but for now you can see how you can use the DECIDE process to help you with your health care decisions! In the next section, we will practice directing questions to your provider.

E.   Personalizing, Role-playing, and Reflection (12 min)

This section helps the participant practice the Who, How, and Why questions from earlier in this training.

> *Let's review the Who/How/Why questions you just came up with. Which one do you think is most important to ask your provider?*
>
> *Now let's practice one of these questions. I will pretend to be your provider. This time I want you to use your Planner to guide your questions.*

Try to model some of the provider traits the participants describe.

> *So, how are things going for you? What is on your mind today? (After role-play is over)*
> *How did that feel?*

Follow the role-play suggestions from the first DECIDE Training, which are also outlined below.

Remember the suggestions about role-plays:

1. Identify the provider who you will be role-playing
2. Don't say much during the role-play
3. Keep it brief
4. Do not answer the participant's question
5. After the role-play is over, ask the participant to reflect on his performance
6. Give the participant concrete feedback about how they asked the question
7. Give feedback about non-verbal communication, as needed
8. Repeat the role-play at least once and change the question as needed
9. Use a "Reverse Role-Play, if needed.

> *On a scale of one to ten, how confident are you that you will ask your question to your provider? One is 'not ready at all' and ten is 'completely ready.' (SHOW PARTICIPANT THE RATING SCALE)*

If they answer any number greater than 1:

> *That's great! What makes you feel that you are at a [Number] and not a 1 or 2? Why isn't it lower? What might help move you from a [Number] to a [Two numbers higher]?*

Care Manager Tip: If Participants Hesitate to Ask Questions

Please stress that questions can help improve rapport with the provider. Emphasize how questions can show providers that the participants are truly invested in their mental health appointments. Emphasize the rewards of shared decision-making.

> *Asking questions can be difficult. It might feel like you are being disrespectful to your provider. You can ask your provider at the beginning of your appointment to save a few minutes for your questions. You can also thank your provider for taking the time to answer your questions.*

F.   Practice Assignment (2 minutes)

The practice assignment for Training 2 is to ask providers at least one question from their Planner. Encourage participants to have a second or third question ready if their first question is answered quickly or not answered at all. Remind them to read their Planner before their appointments and take some quick notes afterwards about their experience.

> *If you think it could be helpful, bring your DECIDE Planner to your next appointment. When will you be meeting with this provider? Which question would you like to ask during your next provider visit? Is it the one we practiced or is there another on your list? Write it down in your Planner. You might want to have a second or third question ready.*
>
> *Afterwards, write down in your Planner how things went. Reflect on how it felt to ask the question and how your provider reacted. Your Planner can help you remember what you learned from your provider. You and I will go over this experience next time we meet.*

<u>If the participant is not going to see a provider before the next training, ask if they can direct their question to another provider.</u>

> *If you will not see your provider before our next training, is there someone else who could take your question? If not, we will keep practicing your questions to prepare you for your next mental health visit.*

G.   Review (5 minutes)

Once again, ask participants to reflect on what they learned in the session, and thus far in the trainings. CMs should not simply summarize the session for the participant. Make sure in the review participants touch on:

- The importance of asking question and shared decision making
- All letters of the DECIDE acronym
- Closed- and Open-Ended Questions
- Who, How, and Why Questions
- The question they plan to ask their provider in the next session

Clarify confusing points and correct misunderstandings as needed. Make sure to spend some time on both the specifics and the big picture after they are given a chance to tell you what they remember learning. Connect it to

their examples and the questions they generated as much as possible.

Remind the participants of their next appointment time and of their practice assignment. You can use this moment to reflect on the work you've done together to prepare them for ending after Training 3. You should also start thinking about whether your participant will need a booster session, so that you are ready in Training 3 to make that decision. A booster session is offered when the participant has not completed any practice assignments and is unable to describe the DECIDE process even with the help of the Planner. Before you end, make sure you have a time and date for your next training session!

We are almost finished with our meeting today. Can you tell me in your words what we learned today and in our trainings, so far? …Great! What else? …Excellent! Why is this important?

Great work! We have just one more training to go in the DECIDE program. In our final training, we will think of new ways to find information about mental health and mental health treatment.

Training
3

TRAINING 3 – SELF-EFFICACY & CONSOLIDATION

Activities	Time
A. Overview	3 min
B. Practice Assignment Review	3 min
C. Self-efficacy and Your Mental Health	18 min
D. Booster Session	2 min
E. Practice Assignment	2 min
F. Barriers and Facilitators	2 min
G. Persistence and Catching Up	2 min
H. Tailoring	6 min
I. Extended Review and Wrap-Up	7 min

A.   Overview (3 minutes)

Since this may be the last training, it is important for CMs to review the past two trainings with the participant and provide feedback on the development and practice of new skills. As in previous trainings, ask participants to reflect on what has been done up to this point. **Let the participants speak first!** Then, make sure to cover:

- Asking questions
- Agency and shared decision making
- Who, How, and Why in formulating questions for their provider

It is important to review both the overall importance of being an active participant in care (e.g. Agency and shared decision making) and the specific steps to get there (e.g. Who, How, Why). Use this review to get a sense of what the participant will need in "Tailoring", Section G.

> *[IF NO BOOSTER NEEDED:] Today is our final training! You've done excellent work thus far. In this last meeting, we will review what we have learned together. We will also think of resources that can answer your questions in addition to your providers.*

First, can you tell me what we have covered so far? Anything you remember is helpful. Please use your Planner to remind you.

[IF RELEVANT, ADD:] How have these trainings helpful to you?

B.   Practice Assignment Review (3 minutes)

Ask participants to take out their Planner and report on their attempts to ask the questions they had chosen. Ideally, participants will have shared their questions or concerns with their providers and received some feedback. If they have not seen their provider since the last training, ask if they were able to direct their question to another provider or individual.

- *What was the question in your Planner that you wanted to ask during your last appointment? How did that go?*
- *What did you learn?*
- *How did it feel?*
- *Is there something you wish you had done that you didn't do?*

C.   Self-Efficacy and Your Mental Health (18 minutes)

This last session points uses the DECIDE skills to teach self-efficacy, where participants learn to identify resources to be more informed about their illness and mental health care and become more active participants.

Mental health care can be confusing, especially those with limited experience in navigating complex health settings. Participants may need help with developing new skills for seeking information about their mental health care. The following exercise is designed to help participants learn "what you have," "what you know," and "what you can do" to get information about mental health and quality treatment.

Present the following exercise to the participants:

By now, we've learned what the D-E-C-I-D letters in DECIDE mean. We have practiced how to identify problems and concerns, ask questions, and participate in treatment decisions.

Next, we will think of new sources of information about your mental health care. Our goal will be to discuss what you know and what you may want to find out.

Let's start by going over the issues or concerns you are working on in your treatment. We can check the list you came up with in our last training [REVIEW LIST OF PROBLEMS/DECISION FROM TRAINING 2].

Remember these could be related to your treatment, your diagnosis, or your relationship with your provider. You could also think of a new problem or decision that is important to you in your treatment.

Explore how participants think about and understand their own mental health care. Some may have a very clear idea of the overall goals they're trying to accomplish in treatment, while for others this may be a new idea. Help the participant find their own voice in defining their mental health condition or concerns.

The Second "D" and "E" in DECIDE

> *Great! In this training, we'll focus on the last two letters of DECIDE. As we learned already, the last __D__ in DECIDE stands for 'Direct your Questions'. You can direct your questions to your provider, to other people, and to other resources you find.*
>
> *The last __E__ in DECIDE stands for 'Explore Additional Resources'. Questions can often be answered by checking with individuals or resources other than your regular provider.*
>
> *Are there resources like this that you have already found helpful? Tell me about them!*
>
> *We have found that good resources for you can be:*
>
> - *People you trust (e.g. family, friends, other health care providers)*
> - *Places where you can get help (e.g., library, pharmacy)*
> - *Sources of information (e.g. on the internet)*
>
> *Now that we've learned all the letters in DECIDE, it's time to use them to explore your questions about your mental health or your treatment. Here's an example of how this can be done.*

D – Define the problem	e.g. "I would like to know more about depression."
E – Explore possible questions	e.g. "What is depression?" "How do you know that I have this diagnosis?"
C – Closed- or Open-Ended Question?	e.g. Open
I – Identify the Who/How/Why	e.g. "What can I do to learn more about depression?" "How can I help myself feel better?" "Why do I have depression?"
D – Direct questions to _____	e.g. Provider, Internet, Religious community, friend, family, pharmacy, etc.
E – Explore Additional Resources	

Helping Participants Identify Resources

You will now walk your participant through the same process shown in the table above. For the first D, determine if they want to focus on their condition, diagnosis, or their treatment. For E, have the participant brainstorm

questions related to that concern. For C, determine if their questions are closed or open- ended. For I, ask the participant if they have any Who? How? or Why? questions in their list. If not, encourage them to think of a few.

> *Next we will brainstorm some questions for a resource you choose. What problem or decision should we focus on?*
>
> *Let's brainstorm some questions and see if they are open or closed. Do you have any who, how, or why questions?*

If participants have a hard time coming up with questions about their diagnoses or treatments, you can refer them to the section in the Planner called "Important Questions You May Want to Ask Your Provider." A final option would be to return to the questions they brainstormed from prior trainings.

> *Let's focus on finding resources to one of the questions listed above. Which of the questions you listed do you consider the most important? Let's circle it.*
>
> *Now let's think of resources that might help you answer these questions. Remember the last D in DECIDE stands for Direct your Questions and the last E stands for Exploring Additional Resources. Can you think of other resources that can help you find the answers to your questions?*
>
> *Remember resources can be:*
>
> - *People you trust*
> - *Places where you can get help*
> - *Sources of information*
>
> *Let's write these potential new resources in your planner.*

Brainstorm what options they have for getting information. The most obvious sources of information would be the participants' providers. However, encourage participants to consider other sources: clinic staff, the Internet, the library, friends, colleagues, community groups, social services, religious organizations, pharmacy, etc.

Some participants will have reservations about asking this to their provider. Others will not have resources (i.e., no access to the Internet). Participants should be encouraged to search for information first and then discuss it with their providers. They can also ask for information (e.g. printed material, websites) from their providers. Any learning they do outside of the session can be shared with their providers to help participants ask better questions and make more informed decisions. CMs should emphasize this feedback loop.

D.   Barriers and Facilitators (5 minutes)

Once the participant has identified resources to answer his/her question, it can be helpful to think about what can help this process, and what might get in the way.

We want you to succeed in using [RESOURCES IDENTIFIED ABOVE] to answer your question. Can you think of anything that might make it hard for you to find or use these resources? [WRITE DOWN ANY BARRIERS]

What can you do about that? [WRITE DOWN ANY SOLUTIONS]

Can you think of anything else that can help you use this resource?

E.   Booster Session (2 minutes)

If participants have difficulty mastering the DECIDE approach, they may benefit from a "booster" session, which can be done in person or by telephone as Training 4. Participants will need a Booster Session if they meet these criteria:

1. They have not completed any Practice Assignments and do not feel confident asking questions
2. They cannot describe the DECIDE process even while consulting the Planner

If a booster session is needed: tell your participant, you would like to schedule one. Continue to Section E, but have participants direct a question to **a provider**, just as in Trainings 1 and 2. Then, complete sections F. and G. only, and end Training 3.

If a booster session is NOT needed: continue with the remaining Sections in this training as written.

F.   Practice Assignment (2 minutes)

You've come up with some new sources of information to help you answer questions about your mental health. Select one question from today's list that you would like to ask and a resource you will use to help you get an answer.

On a scale of one to ten, how ready are you to look for the information you want?

(If answer is >1) That's great! What makes you feel you're a [Number] and not a 1 or a 2? What might help you move from a [Number] to a [Two numbers higher] number?

The Practice Assignment for this training is to check with the resources you just named to find answers to your question. [MAKE SURE THAT THEY HAVE WRITTEN DOWN THE QUESTION AND RESOURCE IN THEIR PLANNER].

After you check with these resources, discuss what you found with your provider at your next appointment.

In the future, you can find resources and answer questions you have with the help of your provider. There are extra pages in your Planner to use on your own for future appointments [SHOW PARTICIPANT PAGES IN THEIR PLANNER].

G.   Persistence and Catching Up (2 minutes)

Some participants may feel discouraged because of unsuccessful attempts to ask questions with their providers. Some participants may even make incorrect conclusions (e.g., "I'll never remember this") based on limited experience with skill building. Providing support for these participants is crucial to their success. You can stress they have only had a few trainings and will have many opportunities to practice their new skills in the future. It may be helpful to role-play one more time, especially for participants that require a booster session.

I want to congratulate you on making it to this point in the trainings! It takes persistence to ask questions. It also takes a lot of practice.

H.   Tailoring (6 minutes)

Before beginning this section, CMs should already have an idea of the sections they might want to review with the participant, based on the participant's strengths and areas of need. Set up this exercise so that you let the participant know that you have something in mind but you want their opinion as well.

> *We have covered a lot together! For this next exercise, I want your help to figure out what we should review together [SHOW DECIDE ACRONYM].*
>
> *Which parts of the trainings would you like to go over?*
>
> *[IF THE PARTICIPANT HAS SPECIFIC IDEAS ABOUT WHAT TO REVIEW, PRIORITIZE THOSE. OTHERWISE, PRESENT YOUR SUGGESTIONS AND DECIDE TOGETHER]*

Some participants have difficulty with some of the skills, such as identifying whether a question addresses the Role, Process, or Reason (Who, How, Why) of a decision. Other participants may have had less success in writing down questions ahead of appointments. Participants may want to strengthen one or two skills they particularly like. In other words, do not spend too much time on one concept that is unlikely to be used by the participant.

I. Extended Review & Wrap-Up (7 minutes)

Handling Termination

The DECIDE program, although brief, can still produce a bond between CM and participant. This last session should end with a celebration of the work accomplished together. CMs might expect some of the feelings that termination brings, such as ambivalence and anxiety; or pride and optimism.

Participants may have similar feelings about ending, and recognizing such feelings is very appropriate. You can help the ending by reminding participants of ways in which they became more independent using their DECIDE skills. Emphasizing this can make participants feel more at ease. Ideally, participants will continue to work on the learned skills with the help of their providers.

Participants may ask to stay in touch with you after the trainings are complete. We discourage this because your role is strictly limited to the research trainings. Any contact outside of this role would put an undue burden on you, could interfere with the participant's mental health treatment, and could also affect the accurate measurement of the intervention's effect.

If you conducted all three trainings by phone, a participant may ask to meet you in person as a way of helping an effective closure to the trainings. In this rare case, it can be respectful to meet the patient briefly (e.g. in the clinic waiting room) to thank the participant for their involvement and wish them well.

> *We've finally come to the end of your trainings, and I'm grateful for the chance to have worked with you [NOTE ANY AREAS OF IMPROVEMENT]. I hope you bring your Planner to your appointments to remember everything we covered.*

Allow participants a chance to reflect on what they have learned, in their own words. Some helpful summary

questions are:

> *What has been most helpful about the trainings? Least helpful? How do you feel using the DECIDE program and your new skills?*

After participants finish reflecting on their trainings, note any changes you see in their attitudes and behaviors toward their mental health care. Concrete examples help participants realize their own progress. Be positive! Emphasize resources that participants identified in Training 3 to learn more about their conditions and about available treatments. End the trainings with best wishes for the future.

TRAINING 4 – BOOSTER SESSION

A.   Overview (4 minutes)

This training is for participants who have had difficulty mastering the DECIDE program, specifically those who were not able to complete the two practice assignments of Training 1 and 2, and those who cannot describe the DECIDE process, even with the help of the Planner. This session can be done in person or by telephone, whichever is preferred by the participant. Have the participant use their Planner during the booster session.

The goal of the booster session is to identify two or more DECIDE topics to review in some detail. Potential topics to review include:

- Understanding their role in mental health care (Training 1, page 8)
- Asking questions to participate in decisions about mental health care (Training 1, page 11)
- Open- vs. closed-ended questions (Training 1, page 11)
- Considering Who (Role), How (Process), and Why (Reason) (Training 2, page 20)
- Self-efficacy skills for mental health conditions and treatment (Training 3, page 28)

It may already be clear from the first three trainings which of the above should be reviewed.

B.   Practice Assignment (2 minutes)

Ask participants to take out their Planner and report on their attempts to find new resources and share what they found with their providers. Ideally, participants will have shared their questions or concerns with their providers and received some feedback.

What was the question that you wanted answered from our last Training? Do you remember the resource you were going to check for answers?

How did that go?

> *What did you learn?*
>
> *Did you discuss what you learned with your provider? How did it feel?*
>
> *Is there something you wish you had done that you didn't do?*

C.   Overcoming Barriers to Learning (10 minutes)

The booster session is meant to give participants more training in areas that were not mastered during the first three trainings. Take some time to identify why the participants are having difficulties. Here are some possible reasons, with potential solutions:

Problem: Participants cannot remember training content

Solutions: Ensure participant has Planner (provide another if the Planner was lost)
Review benefits of using Planner, including using tricks to increase use of Planner (keep in purse/car, review before going to bed at night, etc)

Problem: Participants have not asked questions to their providers
Solution: Review Tips for Brainstorming Questions Practice role-
play and reflection
Identify provider issues that make asking questions difficult; discuss how to overcome these barriers

Problem: Participants' mental conditions make learning difficult (anxiety, depression, psychosis, substance abuse)
Solution: Run through Training 3 Education activities to help identify ways participants can learn more about their conditions and treatment Practice role-play and reflection

After identifying these barriers to learning, review some of the suggested solutions. Then identify area(s) from the first three trainings where the participant mastered the DECIDE content. Remind the participant of these examples and use them to build confidence for the remaining work to be done.

D.   Tailoring (10 minutes)

With the participant, select two topics from the list above and return to their sections in prior trainings to review with participants. This is very similar to what was done in Training 3.

E.   Wrap-Up (10 minutes)

Handling Termination

The DECIDE program, although brief, may still produce a bond between CM and participant. This last session should end with a celebration of the work accomplished together. CMs might expect some of the feelings that termination brings, such as ambivalence and anxiety; or pride and optimism.

Participants may have similar feelings about ending, and recognizing such feelings is very appropriate. You can help the transition by reminding participants of ways in which they became more independent using their DECIDE skills. Emphasizing this can make participants feel more at ease. Ideally, participants will continue to work on the learned skills with the help of their providers.

As you end the booster session, it is especially helpful to allow participants a chance to reflect on their DECIDE experience in their own words. Begin the wrap-up process by asking participants to share what they have learned and what they believe has been most and least helpful about the trainings. Allow participants to say as much as they can.

> ***What has been most helpful about the trainings? Least helpful? How do you feel using the DECIDE program and new skills?***

Then, one final time, reinforce areas that were covered. It is critical here to reflect on the changes that have been seen in the participant's attitude, behavior, and outlook towards their providers and towards their mental health care in general. The use of concrete examples is central in helping participants reflect on their own progress. Emphasis is also placed on resources that participants can turn to in the future, including their providers, their identified supportive friends or family members, and themselves using the participant Planner.

Above all, end on a celebratory note and remember that our goal is to move participants towards feeling more capable of collaborating in decisions regarding their mental health care. Even if participants do not seem to have mastered all the details or even asked questions, it is possible that they will need these skills and try them out in the near or not so near future. Instill this hope and expectation as you wrap up

eMethods 1. Coder Training

Six coders were trained on the OPTION instrument by listening to audio recorded therapy sessions obtained from a previous study. Training was led by two master coders through discussion until any confusions with implementation were clarified amongst all coders. Training was considered complete when coders showed full comprehension of the coding rules as laid out in a formal coding guide, at which point, the six trained coders separately rated 10 new tapes that were set aside for reliability testing purposes. Inter-coder reliability was calculated across the 10 tapes using a conservative method, intra-class correlation (two-way mixed, absolute agreement). Due to low reliability, one coder was excluded, leaving 5 coders in total. After excluding the weak coder, reliability was good (ICC = .53). All coders were blind to experimental conditions. On average, coders rated 70 sessions each, with a total of 353 rated sessions. The average number of tapes coders coded were 70.6.

eMethods 2. Analytical Method: Data Preparation

In addition to the power analysis described in the main text, we also computed ex-post power for the intent-to-treat analysis using GPower.[37] We achieved a power of 74.2% (ICC=0.50) to 93.4% (ICC=0.2) for an effect size of d=0.3 and a total sample size of 68 providers with on average 4.6 patients. In the data, the intra-class-correlation (ICC) ranges from 0.21 for patient-reported SDM to 0.5 for provider-reported SDM.

Analysis was carried out with Stata version 14.2[38] and Mplus version 7.4.[39] To address missing data, we used multiple imputation,[40, 41] in Stata via the *mi impute chained* command. Multiple imputation consists of three steps: first, generate missing data and create multiple complete data sets that differ only in the previously missing observations; second, run analysis on the individual complete data sets; third, combine the individual estimates to arrive at the final estimates.

Our imputation was done via chained equations. A conditional model g_j for each variable was specified given the set of all other variables used in the imputation, comprising both incomplete ($x_1, \dots, x_m$)and complete variables (Z). Each variable x_j was iteratively estimated and in each iteration the variable x_j^t was then updated to x_j^{t+1} based on the conditional model. This updated variable was then used in the estimations of the other variables, following this conditional model specification: $x_j^{t+1} \sim g_j\left(x_j \middle| x_1^{t+1}, \dots, x_{j-1}^{t+1}, x_{j+1}^t, \dots Z, \phi_j\right), for\ j \in \{1..m\}$, where ϕ_j were parameters of the conditional model g_j. These steps were repeated for all variables $x_1, \dots, x_m$ and, after an initial burn-in phase, the procedure was stopped once convergence was reached.

Regarding the appropriateness of multiple imputation to address missingness, note that observations are missing from the study mainly due to patients not having enough time and/or not being interested in the study any longer, while providers often withdrew due to a lack of time. This suggests that missing assessments are unrelated to the intervention and, thus, missing at random (MAR) is satisfied, although we acknowledge that it is ultimately impossible to formally test the validity MAR.

As far as MAR versus missing completely at random (MCAR) is concerned, we find that patient education and provider language and income significantly differ between participants with and without missing assessments. This suggests that MCAR is likely violated in favor of MAR and thus multiple imputation seems more appropriate than list-wise deletion.

The variables used for imputation included outcome variables, their baseline ratings, patient and provider socio-demographics, and study design variables such as clinic and intervention variables. We used interval regressions to incorporate the theoretical bounds of the clinical outcome variables to increase the efficiency of the imputation procedure, e.g., we restricted the imputed values of SDM to lie within the 0 to 100 interval. Other conditional models were specified to be multiple linear regressions.

After running analysis on the 20 individual data sets we imputed via step 1, we combined these separate analyses on the different data sets[40] to arrive at our final estimates.

In what follows, we used the multiple imputed data sets unless otherwise noted.

eMethods 3. Analytical Method: Data Analysis

We described the missing variable patterns and determined whether the patterns varied by design, clinical or demographic features of the participants. We tested for differences in the demographics and clinical characteristics of patients and providers across intervention groups using Chi-square tests on the un-imputed data set. We also compared the distributions of patient socio-demographics, clinical characteristics, and outcome measures at baseline separated by whether the patient has missing data in any of the primary outcomes or dosage measures; we repeated this analysis for providers by comparing providers' socio-demographics, clinical characteristics, and outcome measures between providers with missing assessments and with no missing assessments. Differences were assessed using Chi-square tests on the un-imputed data.

We then ran multilevel mixed-effects models using the *mixed* command in Stata allowing for random effects at the provider level. The hierarchical nature of the models and robust standard errors would account for the non-independence of patients seeing the same provider. For example, let Y_{ij} denote the RA2 blind coder SDM score for the j-th patient who was seen by the i-th provider. We estimated the model:

(1) $Y_{ij} = \beta_{0i} + \beta_1(\text{DECIDE-PA})_j + \beta_2(\text{DECIDE-PC})_i + \beta_3(\text{DECIDE-PA+PC})_{ij} + \beta_4 X_{ij} + \epsilon_{ij}$

(2)   The provider-specific random intercept can be written as: $\beta_{0i} = \beta_{00} + \mu^*_{0i}$

where DECIDE-PA was assigned effect codes (-.5, +.5) with -.5 being assigned to patients in the control arm and +.5 being assigned to patients in the treatment arm. Similarly, DECIDE-PC was effect coded as well where -.5 was assigned to providers in the control group and +.5 was assigned to providers in the intervention group. DECIDE-PA+PC denotes the interaction term of the DECIDE-PA and DECIDE-PC. X_{ij} included baseline outcome measures to adjust for imbalance despite random assignment. The term μ^* denotes provider random effects and ϵ_{ij} is the individual error term. We ran sensitivity analyses allowing for random effects at the clinic level, but results suggested that random effects at clinic level were minimal, i.e., estimated to be close to zero.

Estimations of the model in (1) rendered the main effects of DECIDE-PA and PC intervention interpretable in the context of interactions. Effect-coded regressions allowed us to estimate how much the intervention changed the outcomes across all patients that were affected by the intervention, i.e., the marginal effect of the DECIDE-PA intervention (β_1), and to estimate how much the intervention changed the outcomes across all provides that received the intervention, i.e., the marginal effect of the DECIDE-PC intervention (β_2). An interaction term (β_3) significantly different from zero would suggest additional synergy or anti synergy from the combined DECIDE PA+PC treatment over and above the patient-level intervention DECIDE-PA. We also ran estimations of the model in (1) with the intervention indicators coded as 0 and 1 (instead of -0.5 and 0.5) but we only reported the results of the benchmark regressions.

Joint significance F-tests were used to test whether the estimated effect-coded provider intervention, patient intervention, and their interaction were equal to zero. This adjusts for multiple comparisons or multiplicity of tests. To account for the multiple imputation design, we used the standard Stata test command for multiply imputed data sets (mi test), which makes use of Li et al. (1991)'s study.[42]

The primary analysis used intent-to-treat principles and assigned all subjects to their randomly determined category, regardless of whether or not they actually received treatment. We ran a similar analysis using treatment dosage as the independent variable, where treatment dosage was defined as the number of coaching sessions that patients and/or providers received divided by the intended dosage (up to 3 for patients and up to 6 for providers). Thus, dosage was a continuous variable ranging from 0 (no dosage) to 1 (intended dosage or more). We centered dosages at their mean levels.

We also explored whether ethnic/racial or language matching between patients and providers moderated the effect of the interventions on the outcome variables. To do so, we modified the models used to evaluate the interventions effect by adding the main effects of patient and provider racial/ethnic groups (and in separate analyses, language preference), the main effect of racial/ethnic discordance, and the interaction terms of discordance with the provider intervention, the patient intervention, and the three-way interaction of discordance with both provider and patient interventions. The latter three coefficients are the coefficients of interest in this analysis.

We estimated effect sizes for categorical regressors using Cohen's d[43] by dividing the estimated coefficient by the between standard deviation of the outcome variable across all patients. After rescaling the dosage variable to be 0 for zero sessions, 1 for the recommended dosage, and in between values for an intermediate number of sessions, our effect sizes were then the estimated coefficients of this rescaled dosage variable divided by the between standard deviation of the outcome variables across all patients.

We assessed normality of level 1 residuals (patients-provider dyads) and random effects (providers) and analyzed the impact of influential observations and clusters for the intent-to-treat analyses with unimputed data. We used robust standard errors, thus accounting for possible heterogeneity of variance.

Level 1 residuals adhered quite closely to a normal distribution, while a couple observations had particularly large residuals. Excluding these observations had only minor effects on the results, with all significant coefficients still being significant and vice versa. Patient-reported SDM had slightly left-skewed residuals, which would imply that our estimates are conservative.

Estimated random effects looked normally distributed both overall and split by intervention group, except for control providers for blind-coded SDM, which looked slightly bimodal. Excluding clusters with particularly large random effects had minor effects on the significance of coefficients (some originally insignificant coefficients became significant, while all originally significant coefficients stayed significant). Patient-reported SDM had insignificant random effects and dropping the random intercept specification had virtually no effects on the results.

Dropping influential observations and clusters defined by large Cook's Ds[44] had again minor effects (some originally non-significant results became marginally significant).

Altogether, the estimates in these sensitivity analyses ranged from 5.13*(se=2.16) when excluding observations with large level-1 residuals to 5.60**(se=1.99) when excluding influential level-1 observations for the effect of the provider intervention on SDM Option, with 5.38* (se=2.14) as the original estimate in the unimputed data. For PoC, the estimates range from 1.96**(se=0.63) when excluding influential level-1 observations to 2.90**(se=0.76) when excluding influential level-2 clusters, with 2.93** (se=1.11) as the original estimate in the unimputed data.
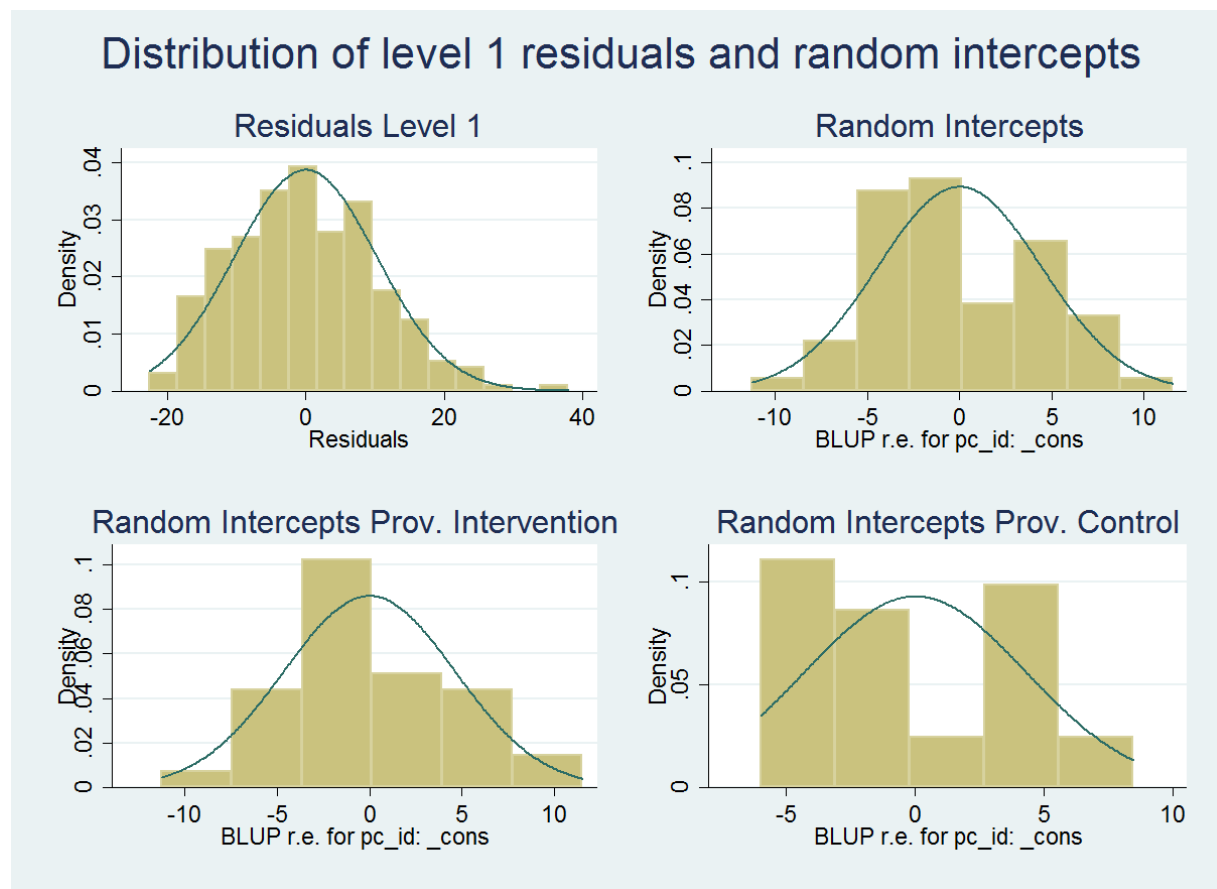
For the mediation analysis, we used the Baron & Kenny[45] three-step approach (or c and c' approach). We investigated whether a potential mediator mv_{ij} mediated the effect of an independent variable iv_{ij} , in our case the intervention or dosage variables, on an outcome variable Y_{ij}, for example global evaluation of care. We additionally included control variables cv_{ij} such as baseline ratings of the outcome variables and the other interventions, e.g., if iv_{ij} was the provider intervention, cv_{ij} would include both the patient intervention and the interaction term of the patient and provider interventions. In this model, we simultaneously estimated three independent regression equations:

1. $Y_{ij} = c \cdot iv_{ij} + \beta_1 cv_{ij} + \varepsilon_{1ij}$
2. $mv_{ij} = a \cdot iv_{ij} + \beta_2 cv_{ij} + \varepsilon_{2ij}$
3. $Y_{ij} = c' \cdot iv_{ij} + b \cdot mv_{ij} + \beta_3 cv_{ij} + \varepsilon_{3ij}$
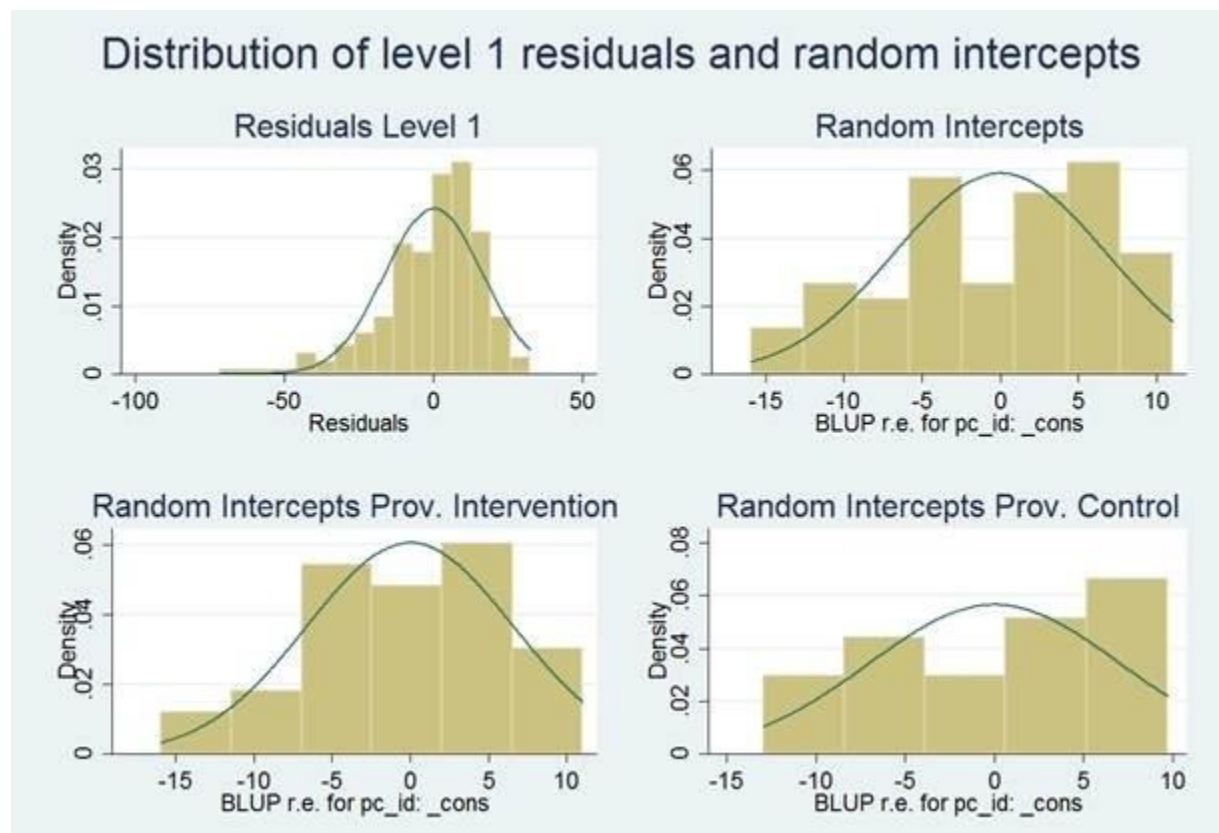
This provides us with estimates of c, c', a, and b. Given this, we estimated the mediation effect to be $a \cdot b$ (or equivalently $c - c'$ for the continuous outcomes). The coefficients $\beta_1, \dots, \beta_3$ were not of immediate interest to us.

When the independent variable varies at the patient-level, as is, for example, the case with the patient intervention, we computed standard errors of this procedure using the bootstrap method with clusters at the provider level to account for correlations between patients within providers. When the independent variable varies only at the provider level, as is the case with the provider intervention, we used the methods as in Preacher et al. (2010)[46] to address the hierarchical nature of the data. We used the non-imputed data sets and list-wise deletion to run the mediation analysis to avoid the computational demand implied by combining the bootstrap and multiple imputation methods.

eFigure 1. Distributions of Level 1 Residuals and Random Intercepts in Unimputed Intention-to-Treat Analysis for SDM Option (n = 240)

eFigure 2. Distributions of Level1 Residuals and Random Intercepts in Unimputed Intention-to-Treat Analysis for Patient-Reported SDM (n = 259)

eFigure 3. Distributions of Level 1 Residuals and Random Intercepts in Unimputed Intention-to-Treat Analysis for Provider-Reported SDM (n = 237)

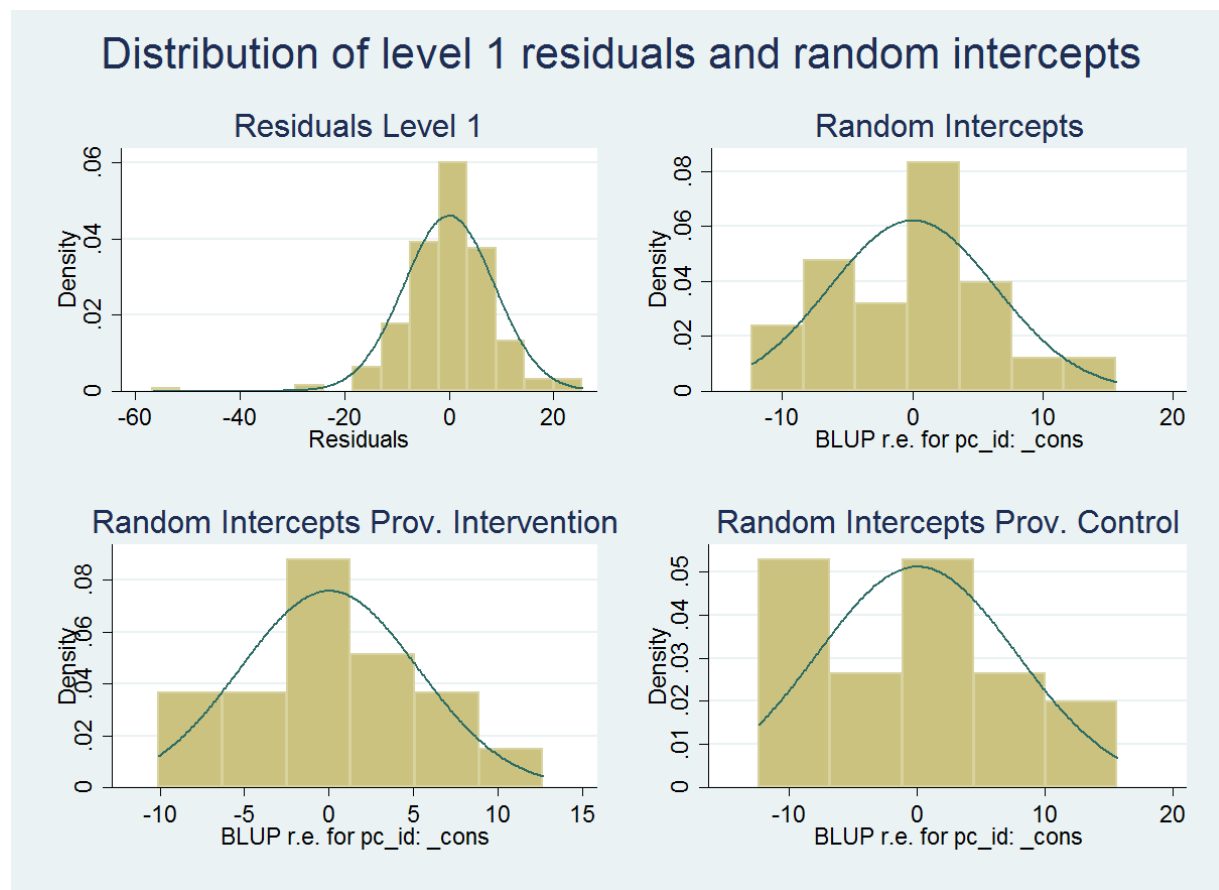
Distribution of level 1 residuals and random intercepts

eFigure 4. Distributions of Level 1 Residuals and Random Intercepts in Unimputed Intention-to-Treat Analysis for Perception of Care (n = 263)

Distribution of level 1 residuals and random intercepts

eFigure 5. Means of Blind-Coded SDM by the Number of Coaching Sessions Providers Had Received at Follow-up Assessment (n = 312)[a]

[a]This figure uses imputed data. The imputed Ns for each category vary due to imputation. In the unimputed data, the Ns for the dosage levels were (dosage: N): 0: 113, 1:75, 2:21, 3:13, 4:8, 5:9, 6+:3. There are 68 observations with missing data.

eFigure 6. The Effect of Patient Dosage on Patients' Perceived Global Evaluation of Care (n = 312)
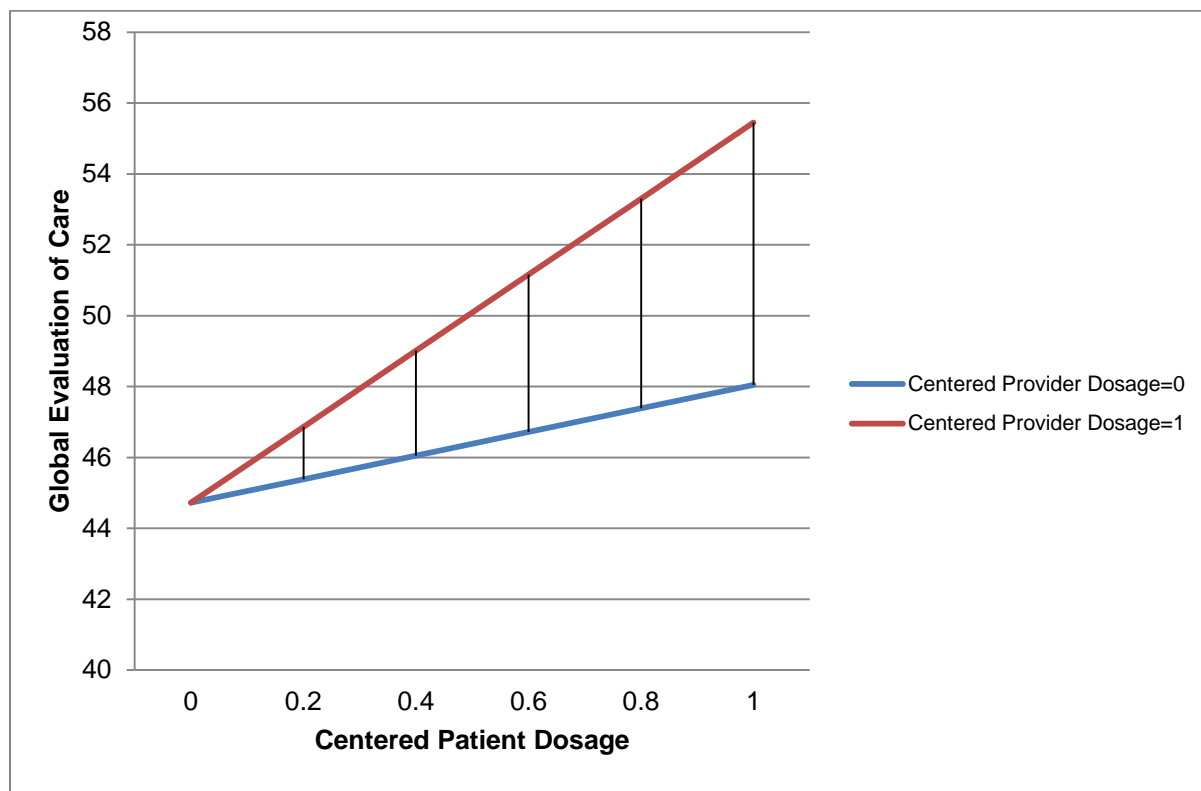
eTable 1. Comparison of Patient Baseline Characteristics With and Without Missing Data in Outcome Measures (n = 312)[a]

Patient Characteristics (%)	Total sample (n = 312)	No Missing Data (n = 215)	Missing Data (n = 97)	x^2 / t	P value
Patient Gender				0.25	0.62
Male	32.05	31.16	34.02		
Female	67.95	68.84	65.98		
Patient Age				3.40	0.33
Age 18-34	30.13	30.70	28.87		
Age 35-49	30.45	28.37	35.05		
Age 50-64	31.41	33.95	25.77		
Age 65+	8.01	6.98	10.31		
Patient Race				1.58	0.66
Non-Latino White	35.90	35.35	37.11		
Latinos	41.99	42.33	41.24		
Non-Latino Black	10.90	12.09	8.25		
Asian	11.22	10.23	13.40		
Patient Language				0.28	0.96
English	55.77	55.81	55.67		
Spanish	33.01	33.02	32.99		
Chinese	6.41	6.05	7.22		
Other	4.81	5.12	4.12		
Patient Origin				1.11	0.89
North America	56.73	56.74	56.70		
Central and South America	18.59	19.07	17.53		
Africa/Europe	2.88	3.26	2.06		
Asia/Pacific Islands	7.37	6.51	9.28		
Caribbean	14.42	14.42	14.43		

Patient Education				9.13	0.03
Schooling 0 to 6th grade	7.05	6.98	7.22		
Schooling 7th to 11th grade	17.31	13.49	25.77		
Schooling 12th grade	17.31	16.28	19.59		
Schooling More than 12th grade	58.33	63.26	47.42		
Patient Employment Status				0.52	0.47
Employed	64.10	62.79	67.01		
Unemployed	35.90	37.21	32.99		
Patient Personal Income				8.77	0.07
Income Below 12k	58.33	56.74	61.86		
Income Betw 12k and 30k	20.51	21.86	17.53		
Income Betw 30k and 75k	12.50	14.88	7.22		
Income Above 75k	4.81	4.19	6.19		
Missing	3.85	2.33	7.22		
Patient SDM Baseline				-0.25	0.80
Mean (SD, N)	76.48 (19.29, 307)	76.29 (19.71, 212)	76.89 (18.41, 95)		
PoC Baseline				0.41	0.68
Mean (SD, N)	89.67 (11.23, 310)	89.84 (10.37, 214)	89.27 (13.00, 96)		

[a] Distribution of socio-demographics, clinical characteristics, and patient-assessed outcome measures at baseline (n = 312), separated by whether patients have missing data in any of the primary outcomes or dosage.

eTable 2. Comparison of Provider Baseline Characteristics With and Without Missing Assessments (n = 74)[a]

Provider Characteristics (%)	Total sample (n = 74)	No missing data (n = 59)	Missing data (n = 15)	χ^2 / t	P value
Provider Gender				0.19	0.66
Male	24.32	25.42	20.00		
Female	75.68	74.58	80.00		
Provider Age				1.91	0.75
Age 18-34	48.65	49.15	46.67		
Age 35-49	24.32	22.03	33.33		
Age 50-64	20.27	20.34	20.00		
Age 65+	5.41	6.78	0.00		
Missing	1.35	1.69	0.00		
Provider Race				2.62	0.45
Non-Latino White	58.11	54.24	73.33		
Latinos	20.27	23.73	6.67		
Non-Latino Black	5.41	5.08	6.67		
Asian	16.22	16.95	13.33		
Provider Language				10.10	0.02
English	70.27	71.19	66.67		
Spanish	16.22	18.64	6.67		
Chinese	5.41	6.78	0.00		
Other	8.11	3.39	26.67		
Provider Origin				5.35	0.25
North America	60.81	59.32	66.67		
Central and South America	16.22	18.64	6.67		
Africa/Europe	8.11	5.08	20.00		

Asia/Pacific Islands	13.51	15.25	6.67		
Caribbean	1.35	1.69	0.00		
Provider Personal Income				19.21	0.00
Income Below 12k	10.81	3.39	40.00		
Income Betw 12k and 30k	10.81	10.17	13.33		
Income Betw 30k and 75k	48.65	54.24	26.67		
Income Above 75k	27.03	30.51	13.33		
Missing	2.70	1.69	6.67		
Provider Specialty				6.03	0.20
Psychiatrist	27.03	32.20	6.67		
Psychologist	21.62	20.34	26.67		
Social Worker	32.43	32.20	33.33		
Nurse	1.35	1.69	0.00		
Other Discipline	17.57	13.56	33.33		
Provider SDM Baseline				-0.21	0.83
Mean (SD, N)	72.48 (11.08,74)	72.34 (11.17, 59)	73.04 (11.11, 15)		

[a]Distribution of socio-demographics, clinical characteristics, and provider-assessed SDM at baseline (N = 74), separated by
whether providers have missing data in any of the assessments.

eTable 3. Dosage Analysis of DECIDE-PA and PC Intervention on Primary Outcomes With Covariates (n = 312)[a]

	Blind Coder SDM (SE; d)	Global Evaluation of Care (SE; d)	Patient-reported SDM (SE; d)	Provider-reported SDM (SE; d)
Patient Dosage	1.24 (1.93; 0.08)	3.19** (1.13; 0.27)	2.34 (2.07; 0.11)	2.52 (1.97; 0.17)
Provider Dosage	12.45** (3.86; 0.81)	-0.00 (2.65; -0.00)	-2.21(2.89; -0.11)	-0.32 (3.50; -0.02)
Patient Dosage X Provider Dosage	0.19 (9.02; 0.01)	7.88* (3.40; 0.66)	10.78+ (6.32; 0.52)	-12.63+ (7.37; -0.85)
Baseline Outcome Measures	0.05 (0.04)	0.50** (0.07)	0.45** (0.06)	0.50** (0.10)
Intercept	40.50** (6.05)	41.98** (7.92)	34.56** (7.55)	33.49** (8.84)
Random Effect at Provider Level	4.47** (1.34)	3.07** (0.87)	0.01 (0.19)	6.63** (0.98)
Intervention joint significance test	$F(3, 1696.3)=3.45$, $p<0.05$	$F(3, 5153.1)=8.66$, $p<0.01$	$F(3,2719.9) = 1.36$, $p=0.25$	$F(3,1405.1) = 1.59$, $p=0.19$
Between patient outcome SD	15.43	12.00	20.70	14.88

Abbreviations: All regressions control for patient race, gender, age, education; provider race, gender, age. Age, race, and education were coded in four categories. PA refers to patients, PC to providers, and CI to the 95% confidence interval. Between patient
outcome SD is the standard deviation of the outcome variable across all patients in the data. Patient-provider dyads with missing observations were analyzed via multiple imputation.
+ $p<0.10$, * $p<0.05$ and ** $p <0.01$.

[a] Robust empirical standard errors are in parentheses. Dosage variables are centered at their means.

eTable 4. Dosage Analysis of DECIDE-PA and PC Intervention on Primary Outcomes Without Using Recommended Dosage Cutoff Threshold (n = 312)[a]

	Blind Coder SDM (SE; d)	Patient-reported SDM (SE; d)	Provider-reported SDM (SE; d)	Global Evaluation of Care (SE; d)
Patient Dosage	1.33 (2.12; 0.09)	2.46 (2.19; 0.12)	2.80 (2.02; 0.19)	3.35** (1.17; 0.28)
Provider Dosage	12.21** (3.68; 0.79)	-2.75 (2.57; -0.13)	-0.48 (3.53; -0.03)	-0.09 (2.72; -0.01)
Patient Dosage X Provider Dosage	0.26 (9.87; 0.02)	10.63+ (6.22; 0.51)	-11.37 (7.39; -0.76)	7.25* (3.59; 0.60)
Baseline Outcome Measures	0.05 (0.04)	0.46** (0.06)	0.54** (0.11)	0.50** (0.07)
Intercept	28.90** (3.44)	40.85** (4.99)	30.27** (8.19)	44.70** (6.57)
Random Effect at Provider Level	6.05** (1.02)	0.52 (6.32)	7.66** (1.05)	3.58** (0.78)
Intervention joint significance test	$F(3,1726.0) = 3.65$, $p<0.05$	$F(3,3582.9) = 1.63$, $p=0.18$	$F(3,1440.7) = 1.38$, $p<0.25$	$F(3,5276.1) = 8.13$, $p<0.01$
Between patient outcome SD	15.43	20.70	14.88	12.00

Abbreviations: PA refers to patients, PC to providers, and CI to the 95% confidence interval. Between patient outcome SD is the standard deviation of the outcome variable across all patients in the data. Patient-provider dyads with missing observations were analyzed via multiple imputation.+ $p<0.10$, * $p<0.05$ and ** $p <0.01$.

[a] Robust empirical standard errors are in parentheses. Dosage variables are centered at their means.

eTable 5. Moderation Analysis of Racial and Linguistic Discordance on Patient and Provider Intervention on Primary Outcomes (n = 312)[a]

Discordance	Independent Coder SDM, coefficient (SE)		Global Evaluation of Care, coefficient (SE)		Patient-reported SDM, coefficient (SE)		Provider-reported SDM, coefficient (SE)	
	Racial/Ethnic	Linguistic	Racial/Ethnic	Linguistic	Racial/Ethnic	Linguistic	Racial/Ethnic	Linguistic
Patient Intervention	0.09 (1.64)	1.37 (1.84)	2.63* (1.27)	2.17+ (1.12)	2.13(2.29)	1.09(2.04)	0.91 (1.29)	1.11 (1.37)
Provider Intervention	5.47** (1.99)	3.11(2.44)	2.04 (1.45)	2.96* (1.37)	-0.72 (2.21)	-0.73 (2.04)	-0.36 (2.72)	0.23 (2.85)
Patient Intervention X Provider Intervention	2.88 (3.25)	3.90 (3.53)	1.9 (2.53)	2.30 (2.20)	3.45 (5.01)	3.96 (4.28)	-1.32 (2.52)	-3.34 (2.69)
Discordance Main Effect	-4.57* (1.87)	-1.28 (3.11)	-0.03 (1.45)	-1.47 (1.30)	-2.95 (2.17)	6.66* (3.18)	-1.20 (1.67)	-0.59 (1.72)
Discordance X Patient Intervention	0.04 (3.54)	4.69 (3.52)	2.20 (2.77)	0.40 (2.18)	4.42 (4.71)	-1.86 (4.38)	-0.24 (2.62)	-0.82 (2.96)
Discordance X Provider Intervention	3.94 (3.37)	-5.76 (4.64)	3.24 (2.43)	4.91* (2.38)	-1.09 (4.38)	1.12 (3.83)	0.87 (2.83)	-0.51 (3.77)
Discordance X Patient Intervention X Provider Intervention	4.84 (6.74)	6.23 (7.17)	-4.98 (5.76)	-1.31 (4.49)	-7.80 (9.69)	-3.70 (8.43)	6.85 (5.57)	-4.31 (5.67)
Baseline Outcome Measures	0.06 (0.04)	0.05 (0.04)	0.49** (0.07)	0.49** (0.07)	0.45** (0.06)	0.44** (0.06)	0.02 (0.04)	0.03 (0.04)
Intercept	26.71** (3.79)	27.04** (3.68)	45.96** (6.67)	45.47** (6.38)	41.05** (5.07)	45.22** (5.31)	67.15** (3.73)	65.62** (3.52)
Random Effect at Provider Level	5.53** (1.22)	5.50** (1.06)	3.23** (0.79)	2.91** (0.82)	0.18 (1.90)	0.00 (0.02)	9.13** (1.11)	8.44** (1.37)
Intervention joint significance of interactions involving the term Discordance	$F_{(3, 982.2)}=0.69$, $p=0.56$	$F_{(3,1373.6)}=1.13$, $p=0.34$	$F_{(3,3445.6)}=0.74$, $p=0.53$	$F_{(3,1732.7)}=1.39$, $p=0.25$	$F_{(3,5095.7)}=0.43$, $p=0.73$	$F_{(3,2823.4)}=0.19$, $p=0.91$	$F_{(3,846.1)}=0.58$, $p=0.63$	$F_{(3,737.4)}=0.25$, $p=0.87$
Between patients outcome SD	15.43	15.43	12.00	12.00	20.70	20.70	14.88	14.88

[a]Analyses controlled for patient and provider race/ethnicity. Robust empirical standard errors are in parentheses. Patient-provider dyads with missing observations were analyzed via multiple imputation. + $p<0.10$, * $p<0.05$ and **$p<0.01$

Dummy variables are effect-coded. Disc refers to discordance.

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