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Incorporating Shared Decision Making into Communication with Older Adults with Cancer and their Caregivers: Development and Evaluation of a Geriatric Shared Decision-Making Communication Skills Training Module

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Abstract

Objective: The purpose of this study was to evaluate a Communication Skills Training (CST) module for health care providers (HCPs) applying a shared decision-making approach to a meeting with an older adult with cancer and his/her family.

Methods: Ninety-nine HCPs from community-based centers, cancer centers, and hospitals in the Northeastern U.S. who worked primarily with older adult patients participated in a CST module entitled *Geriatric Shared Decision Making*. Participants completed pre- and post-training Standardized Patient Assessments (SPAs) and a survey on their confidence in and intent to utilize skills taught.

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Conflicts of Interest

No authors have conflicts of interest in the present manuscript or study.

Results: Results indicated high HCP satisfaction with the module, with over 95% of participants reporting high endorsement to all five evaluation items. HCPs' self-efficacy in utilizing communication skills related to geriatric shared decision making significantly increased pre- to post-training. In standardized patient assessments among a subset of providers (n=30), HCPs demonstrated improvements in three shared decision-making skills: declare agenda, invite agenda, and check preference.

Conclusion: A geriatric shared decision-making CST workshop for HCPs showed feasibility, acceptability, and improvement in self-efficacy as well as skill uptake.

Keywords

communication; geriatric; older adult; cancer; geriatric oncology; shared decision making

1. Introduction

Communicating with oncology patients around treatment and other forms of decision making is complex. The complexity is even greater when working with older adults who often suffer from cognitive impairments, multiple comorbidities, and other factors that influence the degree to which they can participate in clinical decision making.¹ Despite a vast research literature examining the complexity of communicating in the context of clinical decision making,²⁻⁴ little research has examined how to discuss treatment options and engage older adult patients and their loved ones in shared medical decision making.

The standard approach in western medicine tends to focus on the need for patient autonomy in the decision-making process,⁵ which has led to a shift from guided paternalistic models of decision making towards a model that involves active patient participation. Patient participation is viewed favorably by ethicists, health professionals, and patient advocacy groups.⁶ This approach, commonly referred to as *shared decision making*, is complex in that it requires patients to understand and process complex medical information and then be able to examine and evaluate all available options in order to make appropriate decisions. Shared decision making has become the gold standard decision-making approach in medicine. Not only does it promote patient autonomy, but it is associated with other benefits. For instance, shared decision making is associated with the following: alignment of medical care with patients' preferences and values, increased patient knowledge, less anxiety over the care and treatment process, improved outcomes, and often reductions in unwanted costs and care.⁵ Prior research has also found that being offered equal participation in the decision-making process is of more benefit to patients than being offered a choice between treatments.⁷⁻⁹ And yet, older adults are less likely than other age groups to participate in clinical decision making.¹

A shared decision making approach puts providers in the role of being a decision facilitator rather than a decision maker.¹⁰ Through this approach, providers are expected to present patients with available treatment options and then guide them to a path that will result in a treatment decision that is optimal for the patient. This can be a challenge for providers treating older adult patients, who may lack capacity to engage in this complex decision-

making process. Often, the provider is left feeling unsure as to how to operate as a decision facilitator rather than a decision maker.

In addition, prior research indicates that there is great variability in the degree to which patients prefer to be involved in making their treatment decisions.¹¹ Thus, providers must be sensitive to these potential individual preferences when negotiating proposed treatments with patients. They may also need to examine the preferred mode of decision making for their older adult patients, who tend to prefer less active involvement than younger patients.¹¹ In short, declaring a clear agenda and eliciting preferred decision-making style(s) is critical to improving provider-patient encounters and treatment decision making among older adults with cancer.

Another unique feature of shared decision making among the older adults with cancer population is the frequent need to involve patients' loved ones. Given this, research addressing shared decision making among providers and older adult patients has focused largely on a triadic model of shared decision making rather than a dyadic model.^{12–15} This research highlights the critical role that loved ones can play in aiding patients in decision making surrounding the patient's illness, treatment selection, and management. For instance, loved ones might play important roles such as the following: (1) information gatherer and/or interpreter; (2) coach (helping guide patient to ask questions); (3) negotiator (advocating for the patient); (4) advisor (advising the patient in which treatment option to select); or (5) caretaker (supporting or reinforcing the patient's treatment decision).¹²

Although these triadic relationships often aide patients in their medical decision making, problematic behaviors may be present as well. For instance, a systematic review indicated that caregivers' involvement sometimes raises challenges particularly when they engage in dominating or demanding behaviors.¹⁶ Thus, communication in these contexts requires a unique balance of assessing patients' preferred level of involvement and incorporation of loved ones' opinions while carefully guarding against potential abuse or dominating behaviors. It remains critically important to retain, when possible, older adult patients' autonomy while involving loved ones to the degree that the patient desires providing a therapeutic and supportive environment for the patient.^{17–19}

The Communication Skills Training and Research ("Comskil") Laboratory at Memorial Sloan Kettering Cancer Center (MSKCC) was created to train healthcare providers (HCPs) in communication skills to support the patient throughout the cancer disease trajectory. In response to a large need in the field to address the unique communication needs of older adults with cancer, and especially those with cognitive impairment, the Comskil Laboratory team in partnership with clinicians from geriatrics and psychiatry developed communication skills training (CST) modules targeting oncology providers working with the vulnerable population of older adults with cancer. The present study highlights the *Geriatric Shared Decision Making* module, which was developed, implemented, and evaluated by the Comskil team to train oncology providers on how to communicate with older adults with cancer and their loved ones in a way that promotes shared decision making. The aims of the present study are to describe the content of this module, assess HCPs satisfaction with the module, HCPs' uptake of communication skills, and their confidence in utilizing shared

decision-making approaches in communicating with older cancer patients and their loved ones present at the consultation.

2. Methods

2.1 Participants and Procedure

During 2017–2019, 99 HCPs working primarily with older adults with cancer were trained in small group formats of 12 to 15 participants per training day. Participants included the following provider types (data missing from 5 participants): 24 advance practice providers (including nurse practitioners and physician assistants; 24.2%); 23 nurses (23.2%), 14 social workers (14.1%), 13 physicians (13.1%), and 20 “other” HCPs (including occupational therapists, physical therapists, and psychologists; 20.2%). Participants ranged in age from 24 to 69 years ($M = 39.78$, $SD = 14.22$) and were predominantly female ($N = 83$, 83.8%) and self-reported as White ($N = 50$, 50.5%) with 20.2% Black, 11.1% Asian, 6.1% bi/multi-racial, and 12.1% others. All study procedures were reviewed and approved by MSKCC’s Institutional Review Board.

2.2 Development of Training Module

The Comskil Laboratory at MSKCC has traditionally focused on developing CST modules to support providers in communicating with a variety of oncology patients and their families throughout the cancer trajectory.²⁰ All of our CST modules in the Comskil Laboratory, including the module discussed in the present study, go through the following series of seven consecutive steps of development used in prior research:²¹ (1) systematic literature review, (2) consensus review meetings, (3) modular blueprint development, (4) training materials development, (5) scenario development, (6) making revisions and adaptations iteratively, and (7) assessment. The present, newly developed module was based on approaches used in prior module development in the Comskil Laboratory.²²

2.3 Modular Content

Each component of the module is operationally defined, as explained in the Comskil Conceptual Model.²³ Each interaction between the provider, patient, and family member(s) is guided by an overarching goal, which is achieved through the use of communication strategies, communication skills, and process tasks that are meant to be flexible in all interactions (see Table 1 for the Modular Blueprint). Providers are able to apply these skills in a way that is translatable across varying interactions with patients.

The overall communication goal in the *Geriatric Shared Decision Making* module is to apply a collaborative shared decision making approach to a meeting of an older adult with cancer and his or her family with a HCP. This module proposes eight strategies (i.e., a priori plans that direct communication behavior toward the successful realization of the communication goal), along with appropriate communication skills (i.e., a standalone utterance by which a physician can further the clinical dialogue, and thus achieve a strategy) and process tasks (i.e., sets of interactions or nonverbal behaviors that create an environment for effective communication that are key to achieving a strategy), which allow the provider to achieve the desired goals of the patient interaction outlined above. The strategies, communication skills,

and process tasks are summarized in Table 1. Those emphasized as important to shared decision making are skills and process tasks related to setting up the provider-patient-caregiver-team and ensuring a clear starting point by checking each members' understanding of the current medical situation and potential next treatment decisions. Examples of skills and process tasks specific to shared decision making include: "Introduce joint decision making" and "Elicit each person's perspective and summarize differences, if any."

2.4 Training Format

Training of this module consists of brief didactic teaching, followed by substantial time spent in experiential role play. Prior to training day, participants are sent a booklet entitled, *Geriatric Shared Decision Making*, which includes relevant background literature and the core communication strategies taught and utilized in this module.

The training includes a brief didactic teaching of strategies (30 minutes); presentation of exemplary videos modeling the key strategies, skills, and process tasks embedded within the didactic; and an experiential role play session to practice the skills taught in the didactic presentation (90 minutes). The small group role play sessions follow best practice principles in adult learning which is experiential, learner-centered, and centrally involves individualized feedback.²⁴ In the role play sessions, consisting of approximately three learners per group, participants engage in prepared scenarios in which an older cancer patient with a history of mild cognitive impairment needs to engage in substantial treatment related decisions with the help of the HCP and his/her adult children. The patient's experience and desires as well as family goals and values are designed to interplay in the process. During the role play sessions, participants practice the skills taught in the didactic presentation with standardized patients (SPs) as well as their standardized caregivers (SCs), followed by thorough, instantaneous feedback from peers, the facilitators, video feedback, as well as the SPs and SCs.

In an effort to standardize facilitation across all small groups, the module is taught and co-facilitated by a trained, experienced geriatrics and/or oncology HCP and a communication skills expert.²⁵ Prior to facilitating a small group, each facilitator participates in a three-hour training module focused on leading equitably structured, learner-centered, supportive role play sessions. A co-facilitation model allows each facilitator to bring different expertise to the group, which can improve learners' educational experience and ability to apply the skills learned. This training model also ensures that all important facilitation tasks are completed.

2.5 Evaluation of Training

All participants (n=99) completed pre- and post-training surveys immediately prior to and immediately after completion of the module. These surveys had two primary goals: (a) evaluation of the module and (b) assessment of self-efficacy. In addition, a subset of participants (n=30, 30.3%) were evaluated pre- and post-training by engaging in a 12-minute, video-recorded interaction with a standardized patient (Standardized Patient Assessment or SPA) on a given clinical scenario. These 30 patients were randomly selected to complete a training related to the Shared Decision Making content of the training (one of three modules). These SPAs occurred at the beginning of the day (prior to the training) and

end of the day (right after the training ended). Observed encounters with standardized patients are considered a high fidelity method when measuring the skills related to communication²⁶ and thus were utilized to assess skill uptake in the present study.

2.5.1 Module evaluation.—Evaluation of the module included five statements using five-point Likert-type scales (1 = “strongly disagree” and 5 = “strongly agree”) to assess participants’ levels of agreement or disagreement (see Table 2). These five statements focused on attitudes regarding the skills learned in the module and how providers could apply them to their clinical practices. In addition, participants evaluated different components of the training module (i.e., booklet, didactic teaching, exemplary video, and role play experience) using a three-point Likert-type scale (1 = “Did not aid my learning at all” and 3 = “Aided my learning a lot.”).

2.5.2 Self-efficacy.—Participants’ self-efficacy was measured by asking participants to determine if the module had provided them knowledge or ability to perform a skill. Specifically, pre- and post-training perception of self-efficacy was measured with five statements using a five-point Likert-type scale (1 = “strongly disagree” and 5 = “strongly agree”) (see Table 3).

2.5.3 Communication skills uptake.—SPAs were completed both pre- and post-training. Two trained coders coded all the SPA videos using the Comskil Coding System previously used in provider-patient CSTs²⁷ and adapted to geriatric cancer patient clinical scenarios. First, 10% of the video recordings were coded independently by two separate coders as an initial reliability test. For these 10% coded, the inter-coder reliability assessment demonstrated an average of 75.5% agreement between the two coders, and all disagreements were reconciled by a team member. After establishing acceptable reliability, the primary coder coded 40% of the video recordings. At the mid-coding state (after 50% of video recordings were coded), a second inter-reliability assessment was conducted, followed by the primary coder independently coding the remaining 40% of the video recordings.

2.6 Data Analysis

For module evaluation, a rating of agree or strongly agree was considered to be an indicator of satisfaction with the module. These evaluations were analyzed descriptively with means and standard deviations. Paired *t*-tests were used to assess perceptions of improvement in self-efficacy. Finally, to measure an increase in communication skills uptake using the SPAs, frequency of individual skills was used as the unit of measurement. Namely, each time a particular skill was utilized, the participant got counted as using that skill. As such, there could be 0 uses of a skill or more than 1 per encounter. Paired *t*-tests were used to examine if significant changes in skills uptake occurred from pre- to post-training.

3. Results

3.1 Module Evaluation

Participants rated the module favorably across all five statements. Specifically, over 95% of the participants indicated that they “agreed” or “strongly agreed” with all five evaluation

items (see Table 2). In addition, three out of four modular components were rated favorably, with over 90% of participants indicating that the respective component “aided their learning somewhat” or “aided their learning a lot” (see Table 2).

3.2 Improvements in Self-Efficacy

Participants’ overall self-efficacy to employ shared decision making in communicating with older cancer patient and their families significantly improved, $t(78) = 11.76$, $p < .001$ from pre- ($M = 3.47$, $SD = .76$) to post-module training ($M = 4.56$, $SD = .48$). Additionally, the self-efficacy for all individual items also improved significantly from pre- to post-module training (see Table 3).

3.3 Communication Skills Uptake

Results indicate that participants had a significant increase in overall skill use from pre to post-training. Specifically, participants demonstrated clear uptake of three individual skills - declare agenda, invite agenda, and check preference. Additionally, overall skill uptake increased in two skill categories - agenda setting and checking (see Table 4). Note that these changes in skill uptake represent the overall change in scores on each individual skill, which is represented as a count variable of the number of times this skill appeared in a single SPA.

4. Discussion and Conclusion

4.1 Discussion

Results from the present study indicated that a *Geriatric Shared Decision Making* communication module was rated favorably by participants, and was associated with improvements in the participating HCPs’ self-efficacy and skill uptake. Specifically, participants rated the training as highly favorable across five key module evaluation items and reported high levels of satisfaction and confidence in understanding the importance of and using the skills to facilitate family meetings and pivotal cancer care decisions.

Older adults have higher incidence of cognitive difficulties than the younger population, which may limit their ability to engage in clinical decision making.¹ As such, the present study addresses a critical gap in the research literature by developing and testing a CST module designed to train providers in how to best engage older adults with cancer and their loved ones in shared decision making effectively and ethically. This CST module accounts for the triadic relationship that is often present among older adult populations (patient, loved one, provider) compared to the more common dyadic patient-provider relationship present in younger patient populations.^{12–15} This shared decision making module helps train HCPs on how to talk “with” the older patients and not “about” them as well as how to engage patients’ loved ones while acknowledging and respecting the patient’s wishes. Unfortunately, ageism, or stereotyping people based on their age continues to be prevalent with harmful effects on the health of older adults.²⁸ Thus, language and communication style are crucial to ensuring patient-centered care among older adults.²⁹ Communicating in a way that promotes true shared decision making among older adults with cancer is even more important when facing critical treatment and end of life care decisions with older adults who may have cognitive decline.

It should be noted that skill uptake was significant in three distinct skills: declare agenda, invite agenda, and check preference. These key skills create a strong foundation for achieving clear and effective communication among all members of the triad. These three skills are particularly important for shared decision making because they emphasize an active (rather than passive) dialogue between the triad while respecting patient values and preferences. Importantly, with declaring agenda, the HCP is able to better structure the consultation and articulate what content will be covered. By inviting agenda, the provider emphasizes the value of patient-family member engagement in the medical consultation process and invites important issues that they want to discuss. Finally, with check preference, the provider ascertains that patient values are respected, encouraged, and elicited. Future work should examine how to improve uptake of other skills presented in this module and better understand why there was limited uptake for these additional skills. Key skills included in the training, such as “check each person’s understanding of the illness” and “education regarding risks, benefits, and alternatives,” are extremely important at the time of assessing decision-making capacity of the patient and working towards a shared decision among the provider-patient-family member triad. Improving this knowledge has the potential to empower older adults, who are commonly overlooked or talked down to in clinical situations,³⁰ and ensure that ethics are followed. Nevertheless, it must be noted that only three of the communication skills showed significant improvement. This is likely due to the small sample size (n=30) being underpowered to detect all significant effects and thus the present results may only highlight those skill uptake with large effect sizes or which were most impacted by the training. Future research should examine skill uptake in larger samples and assess the degree to which this training is effective at improving all skills as well as reasons as to why it may have a larger impact on certain skills.

This study has several strengths, but there are limitations that must be noted when interpreting results. First, the study was conducted at a single cancer center in the Northeast United States and within the Comskil Laboratory, limiting the generalizability of results to other cancer care contexts. It is critical to conduct future research to examine adaptations of this training for other settings and institutions. Second, results included here are limited to self-report and behavioral uptake in structured settings (e.g., SPAs). As such, these results may not translate to real-world, clinical settings. Future research should examine if the skill uptake demonstrated in the present study transfers to clinical settings as well as if the use of these skills influences patient and caregiver outcomes. Third, the pre/post study design prevents us from fully interpreting causality of the effects of the training on participants’ outcomes. Future research should examine the effects of this training in a randomized controlled trial (RCT) in order to determine if it is significantly more likely to increase uptake of skills compared to a control condition. Fourth, due to the pilot nature of the project, we did not employ conservative statistical tests (specifically, Bonferroni correction) to the paired t tests, as it may lead to a high rate of false negatives.³¹ Finally, the reliability of the video recording coding was acceptable but not high. Reliability may have been linked to clarity around the coding scheme used and/or clarity of when particular skills were being utilized. Future research should examine ways to improve this reliability between coders.

4.2 Conclusion

This study demonstrated the successful implementation of a CST on shared decision making between HCP-older adult with cancer-family member triad, as evidenced by favorable evaluations and significant uptake in several important skills. This increased skill uptake indicates that this training is not only feasible and acceptable among this provider population, but that it may be effectively improving their ability to communicate around shared decision making with older adults and their caregivers. Future research should focus both on how to disseminate and implement this training in various clinical settings as well as examine the degree to which it improves patient and caregiver outcomes.

4.3 Practice Implications

This *Geriatric Shared Decision-Making* CST module can serve as an easy-to-disseminate, effective intervention to improve collaborative shared decision making among providers, patients, and family members in the context of older adults with cancer. This critical training could reduce the amount of ageism and overlooked patient input among older adults with cancer and increase patient-centered and shared decision making among the older adult with cancer population.

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Highlights

- Shared decision making for older adults include patient, caregiver, and provider.
- There is a need for communication training for working with older adults.
- This intervention is acceptable, feasible, and potentially effective.

Practice Implications:

This *Geriatric Shared Decision-Making* CST module provides an intervention for improving provider-patient-family member communication in the context of cancer care for older adults.

Table 1.

Modular Blueprints for Geriatric Shared Decision Making

Strategies	Skills	Process Tasks
1. Welcome and set agenda collaboratively	<ul style="list-style-type: none"> • Declare Agenda • Invite Agenda • Negotiate Agenda (if appropriate) 	<ul style="list-style-type: none"> • Make introductions • Arrange seating, if needed • Sit at eye level
2. Establish the physician-patient-family team	<ul style="list-style-type: none"> • Endorse question asking • Check patient preference 	<ul style="list-style-type: none"> • Introduce joint decision making • Make partnership statements
3. Check each person's understanding of the illness /treatment/ prognosis so as to develop an accurate shared understanding	<ul style="list-style-type: none"> • Check understanding • Clarify • Restate • Invite questions • Check preference 	<ul style="list-style-type: none"> • Correct misunderstandings, if any • Elicit each person's perspective and summarize differences, if any
4. Educate regarding risks, benefits and alternatives	<ul style="list-style-type: none"> • Check understanding • Check preference • Preview • Summarize • Endorse question asking 	<ul style="list-style-type: none"> • Present treatment benefits, side effects and potential inconveniences • Present the source and strength of evidence for each treatment • Avoid jargon • Draw diagrams/write down information
5. Respond empathically to all members of the family group	<ul style="list-style-type: none"> • Encourage expression of feelings • Acknowledge (potential differences between viewpoints of family members) • Validate • Normalize • Praise efforts 	<ul style="list-style-type: none"> • Maintain eye contact • Allow time to integrate; use silence • Highlight positive and common intentions • Repeat as often as necessary
6. Discuss how family values and lifestyle factors may impact on the decision	<ul style="list-style-type: none"> • Ask open questions (to each individual) • Clarify • Validate 	<ul style="list-style-type: none"> • Draw on patients' social support • Identify family strengths and affirm their level of commitment and mutual support for each other • Address patient's needs, including palliative care preferences (symptom control, planning, and decision maker of care)

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Strategies	Skills	Process Tasks
7. Present a clear, guiding recommendation, as appropriate and invite patient/family choice to crystallize the decision	<ul style="list-style-type: none">• Summarize	<ul style="list-style-type: none">• Present treatment recommendation• Offer decision delay
8. Close meeting by final review of agreed goals of care and future plans	<ul style="list-style-type: none">• Check understanding• Invite questions• Endorse question asking• Review next steps	<ul style="list-style-type: none">• Arrange next appointment• Reinforce joint decision making

Table 2.

Participant Evaluation of Geriatric Shared Decision-Making Module (N = 99)

Module Evaluation Items ^a	Favorable Endorsement	
	M (SD)	N (%)
1. I feel confident that I will use the communication skills I learned today.	4.67 (.48)	96 (96.9%)
2. The skills I learned today will allow me to provide better geriatric patient care.	4.66 (.50)	95 (95.9%)
3. The workshop prompted me to critically evaluate my own communication skills.	4.74 (.44)	96 (96.9%)
4. The skills I learned were reinforced through the feedback I received in the small group.	4.74 (.44)	95 (95.9%)
5. The small group facilitators were effective.	4.77 (.45)	95 (95.9%)
Modular Component Evaluation Items^b		
6. Booklet	2.40 (.64)	81 (81.8%)
7. Didactic training	2.65 (.56)	92 (92.9%)
8. Exemplary video	2.78 (.49)	93 (93.9%)
9. Role play experience	2.91 (.33)	95 (95.9%)

Note.

^aThese five items were scored on a 5-point Likert scale with anchors at (1) Strongly disagree to (5) Strongly agree.^bThese four modular component items were rated on a 3-point Likert scale with anchors at (1) Did not aid my learning at all to (5) Aided my learning a lot.

Table 3.

Participant Self-Efficacy Regarding Geriatric Shared Decision-Making Module (N = 99)

Self-Efficacy	Pre-training	Post-training	
	M (SD)	M (SD)	t(df)
1. I feel confident in my understanding of the principles of shared decision making.	3.59 (.81)	4.57 (.52)	t(83) = -9.48 **
2. I feel confident in my understanding of the importance of family-centered care and the complexity of facilitating a family meeting, including the concept of the “third person.”	3.63 (.92)	4.57 (.54)	t(83) = -8.53 **
3. I feel confident in my understanding of the challenges of engaging and supporting the family in the care around pivotal cancer-care decisions.	3.49 (.89)	4.58 (.52)	t(82) = -10.37 **
4. I feel confident in my understanding of the core communication components of conducting a family meeting with a geriatric patient.	3.44 (.92)	4.54 (.55)	t(81) = -10.91 **
5. I feel confident in facilitating shared decision-making with an elderly cancer patient via a family meeting.	3.31 (.99)	4.48 (.60)	t(79) = -9.49 **
Overall Self-Efficacy	3.47 (.76)	4.56 (.48)	t(78) = -11.76 **

**
p < .001

Table 4.

Geriatric Shared Decision Making Module Communication Skill Uptake (SPA Skills Coding) (N = 30)

Skills	Pre-training	Post-training	<i>t</i> (df = 26)
	M (SD)	M (SD)	
Agenda setting	.30 (.47)	1.11 (.97)	-3.81 ***
Declare agenda	.30 (.47)	.70 (.47)	-3.05 **
Invite agenda	.00 (.00)	.33 (.56)	-3.12 **
Negotiate agenda	.00 (.00)	.07 (.27)	-1.44
Take stock	--	--	--
Checking	.67 (1.27)	1.18 (1.49)	-2.15 *
Check understanding	.56 (1.28)	.67 (1.07)	-.55
Check preference	.11 (.32)	.52 (.70)	-3.05 **
Questioning	5.93 (3.39)	6.48 (3.60)	-.96
Ask open questions	4.67 (2.56)	4.41 (2.62)	.50
Clarify	.59 (.84)	.78 (.97)	-.96
Restate	.52 (1.19)	.89 (1.05)	-1.63
Endorse question asking	.11 (.32)	.22 (.51)	-1.14
Invite questions	.15 (.46)	.41 (.57)	-1.89 ^
Information organization	.44 (.80)	.59 (.89)	-.70
Preview	.00 (.00)	.04 (.19)	-1.00
Summarize	.04 (.19)	.11 (.32)	-1.00
Transition	.19 (.48)	.15 (.36)	.44
Review next steps	.22 (.51)	.30 (.67)	-.44
Empathic communication	2.89 (2.33)	3.59 (2.52)	-1.08
Encourage expression of feelings	.85 (1.06)	1.07 (1.21)	-.86
Acknowledge	.59 (.84)	.85 (1.06)	-.88
Validate	1.11 (.97)	1.15 (1.20)	-.14
Normalize	.11 (.32)	.15 (.60)	-.30
Praise patient efforts	.22 (.51)	.37 (.74)	-1.07
All skills	10.22 (4.53)	12.96 (5.64)	-2.43 *

^
p < .10,*
p < .05,**
p < .01,***
p < .001

Note: Means above reflect the total count of a single skill present, on average, across participants.