Handout to accompany workshop

From Cacophony to Consensus—A Case Study: Creating Primary Care Behavioral Health Competencies in Colorado

North American Primary Care Research Group (NAPCRG)
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When and why do you need consensus?

**General answer:** To act in concert as a field rather than as separate individuals or “shops”.

1. **Cacophony—in the room:** Everyone with a different definition, different version, looking at a different part of the elephant, or talking in different dialects. Symptoms can be:
   - “We don’t mean the same thing by that…”
   - “We have our own version of it”
   - “We know what that means here”
   - “We can’t get through a phone call without stopping frequently to negotiate what the subject matter really is or fight over whose version, definition, or measure to use”

**Audience “clicker” data** from presentation at 2010 AHRQ Annual Meeting (Miller & Peek):

“To what extent can you relate to the experience of being on phone calls and meetings that get stuck on concepts, language and what is essential in a subject matter?”

1. This happens all the time
2. Happens enough to be a problem
3. Happens enough to be a problem, but quickly resolved
4. Rarely happens

2. **Research—the pre-empirical:**

   **Principle:** Settle what everyone will mean by the subject matter in order to study it together.

   All mature scientific or technical fields have systems of concepts for their subject matter developed well enough to allow collaborative and geographically distributed scientific, engineering, or applications work to take place.

   Agreement on these basics has an esteemed place in the history of mature fields with empirical triumphs that we now take for granted, e.g., electrical engineering, physics, and software development.

   Emerging fields require shared concepts for their subject matter adequate to the work.

**Lesson from history—electrical research:**

Emerging fields require shared conceptual systems adequate to the work

**Before 1881:** 12 different units of electromotive force, 10 units of current, 15 units of resistance.

“The International Electrical Congress of 1881 has borne good fruit... a rapprochement between electricians of all countries... and the adoption of an international system of measurement which will be in universal use”.

*Nature 30, 26-27; 8 May 1884.*

**After 1881:** Volt, Ohm, and Ampere all defined as one conceptual system—as in a mature field

**Audience “clicker” data** from presentation at 2010 AHRQ Annual Meeting (Miller & Peek):

“In what kinds of situations would clarified concepts & terms be most helpful to you?”

1. Explaining or providing clinical care
2. Provider education and training
3. Forming a program evaluation or research agenda
4. Committee work on practice development and model of care
3. Implementation—of what exactly?

*Principle:* Get good enough agreement on what we have to build. *And “who says?”*

Common confusions or conflicts:
- “We already do that”—”no I don’t think so”
- “You don’t really need that part”—”yes you do”
- “That’s part of fidelity”—no that’s local tailoring”
- “Who says? That’s just your opinion”

Agreement on these kinds of things goes a long way to make consistent implementation possible

### What do we mean by “consensus”?

**Definition:** “A good majority agree, and everyone can live with it?” (A.O. Putman)

**Standard:** “Good enough to go with, knowing it will evolve” (inspired by complexity science)

**NOT:**
- Unanimity—everyone agrees with every single thing
- It stands for all time
- “It is expressed in my own dialect”
- It’s done being wordsmithed: “I wouldn’t change a syllable”

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**Consensus method using the Colorado case example**

**Method (Step 1):** Establish a shared view of the context of need (and practical use) for consensus

*Principle:* Consensus is hard—know clearly why you need it and what you are going to do with it

**Colorado example:**

**Big environmental context:** Colorado to mainstream integrated behavioral health in hundreds of practices via CMS SIM grant and other efforts early in 2016.

**Context of need for consensus:** For quality, consistency, public understanding, and future certification:

The Eugene S. Farley Jr. Health Policy Center of UC Denver Family Medicine Dept. (with 5 Foundations and the Colorado SIM) to establish common competencies across training programs & delivery settings via a Colorado Consensus project in 2015.

***Consensus conference participants***: BH providers, primary care providers, BH health educators, Foundation representatives plus state agency representative, practice facilitator, specialty care health educator, researcher, consultant, project coordinator, academic institution, administrator

<table>
<thead>
<tr>
<th><strong>Foundation partners:</strong></th>
<th><strong>Project planning committee</strong></th>
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<tbody>
<tr>
<td>The Colorado Health Foundation</td>
<td>Benjamin Miller, PsyD</td>
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<tr>
<td>Caring for Colorado Foundation</td>
<td>Emma Gilchrist, MPH</td>
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<td>The Ben and Lucy Ana Walton Fund of the Walton Family Foundation</td>
<td>Linda Niebauer</td>
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<td>Rose Community Foundation</td>
<td>Shale Wong, MD</td>
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<td>The Piton Foundation at Gary Community Investments</td>
<td>Larry Green, MD</td>
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</tbody>
</table>

**Other partner:**

- Colorado State Innovation Model (SIM)

- C.J. Peek, PhD; U of MN Family Medicine
The consensus product: What the licensed BH workforce will be able to do in primary care—regardless of discipline or target population. It’s practical uses:

- For use by the many training programs in the state: Anchor curricula & learning experiences for BH providers aiming to practice in PC
- Supply criteria for funding or RFP’s for clinician education
- Help practices select BH providers and set expectations for them
- Specify integrated BH capabilities for health plans creating practice networks (and providers)
- Better target policy actions needed to support these capabilities
- Increase confidence of supporting foundations and SIM by reducing cacophony across clinician groups

Context—what is particularly tricky about “competencies” as a consensus task

- Different concepts for what a competency is
- Different discipline, specialty, or population competencies
- Different altitudes (mom and apple pie to granular operations)
- Different participant preferences for lumping and splitting
  - **Lumping**: Combining elements of full competent functioning. But then hard to define observable elements to make a judgment that is not subjective
  - **Splitting**: Specifics broken out to always be observable. But such a list gets very long. The actions become a-contextual and judgment of *when* to do *what* is invisible
- Individual competency vs. organizational / team competencies
- Different geographical areas and “dialects”.

Method (Step 2): Literature synthesis—make use of good work already done

*Principle*: Don’t start with a blank sheet unless you have to.

*Colorado example:*

**Synthesize best existing articles and sources on BH competencies in PC**

*Method*: Read everything, then “Drop the details and record the pattern that remains” (PG Ossorio)

**Articles and sources identified for synthesis**

- AHRQ competencies for integrated BH lit review (2015)
- McDaniel et al competencies for psychology in PC (2014)
- Strosahl training BH and PC providers (2005)
- SAMHSA-HRSA Core competencies for integrated BH & PC (2014)

**Show multiple “altitudes” in the synthesis**: Span global to granular and “lumpers & splitters”

- Competency name w 1-2 sentence description (the global, lumped—mom & apple pie)
- Bullet-point list with headings “unpacks” global description (the global—split up)
- Examples: what you see in action—concrete & practical; “to do” (hard observables)
Method (Step 3): Online feedback / survey on the synthesis

*Principle:* Find out where you are already close (and way off).

*Colorado example:*
Test agreement with synthesis among those invited to a subsequent face-to-face consensus conference.

**Online survey** (same question for each competency):

*Is this competency good enough to use in Colorado?*
- “Yes—Just fine as written” (informed by the concrete examples)
- “Yes—but needs to be sharpened up first” [Type in your suggestions in the free text field]
- “No—not salvageable at all” [Type in why not, and what to do differently instead]

**What the collated online feedback looked like** (just part of the feedback on one competency)

<table>
<thead>
<tr>
<th>Competency #1</th>
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<tbody>
<tr>
<td>Yes, just fine as written: 11</td>
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<tr>
<td>Yes but needs to be sharpened: 24</td>
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<td>No, not salvageable: 0</td>
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**Feedback to sharpen competency**
- Compound competencies are very difficult to measure. This is really at least 3 competencies lumped together. Split them apart to make clearer and cleaner.
- Need to better define what is meant by blending in with PC. What does this mean. It would be helpful to have this go both ways, BH needs identified by BH and the PC provider
- There is no mention of trauma. Also I’m not sure about a BHP diagnosing ADHD. Seems like we need to have a psychologist or psychiatrist diagnose
- Expand D (or add another component) to include a two-generation approach to care. Providers who identify a BH concern in a child should then 'treat' the entire family. Also, if a BH concern is identified in an adult, providers should ask if there are children in the home and treat accordingly.
- In pediatric primary care, an emphasis on a whole family approach that views the child as embedded in their family unit. Also screening and assessment tools for children, mothers and families to identify psychosocial risk factors and environmental stressors in addition to developmental and learning concerns.
- Consider adding behavioral difficulties/ behavioral parent training
- Include the words 'diagnose the full spectrum of mental health disorders when they are present'. And, 'provide appropriate patient education and referral when a mental health condition is present. Educate patients about the differences between receiving care in a primary care vs. a tertiary care setting.
- Should there be any language around screening tools?
- The language is vague in terms of common (relatively not complex) medical problems that often have behavioral components to them. The first example from Susan McDaniel is good but does not fit into A-D above but it should.

**Approximately 25 other suggestions for just this competency**
Method (Step 4): Rewrite and redistribute for use at the all-day consensus conference

**Principle:** Use the feedback to create the face-to-face work agenda—identify specifically what will require face-to-face interaction

*Colorado example:*

Lots and lots of feedback on the 8 competencies—hundreds of suggestions, dozens on each one. **What to do with it all?**

- Make the obvious non-controversial improvements (editorial and obvious convergent opinion)
  
  Show those edits via highlight so changes are transparent, and list the verbatim feedback that gave rise to those changes.

- Designate the substantive disagreement areas (divergent opinions and options) for face-to-face resolution.
  
  Turn those areas into meeting worksheets.

**What the face-to-face meeting materials looked like.** *(Example is just the first competency)*

Note that the changes made based on the online survey appear in blue text, and the verbatim suggestions that gave rise to the blue are at the bottom (see next illustration)

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**The Eight Revised Competencies with Details and Examples**

1. Identify and assess behavioral health needs in primary care settings

   BH providers apply knowledge of cognitive, emotional, biological, behavioral, and social aspects of health and medical conditions across the lifespan; diagnosing BH disorders and incorporating into an *overall team-based* PC assessment that could include identifying:

   A. Mental illnesses, substance use disorders, and adverse health behaviors commonly encountered by PC—and ways these often present in PC practice

   B. Physical health problems requiring psychosocial interventions blended into the care plan, e.g., mental health (MH) and substance abuse (SA) or trauma contributors to common chronic illnesses and medically unexplained or stress-related physical symptoms.

   C. Complex or high-risk situations with behavioral health and social factors intertwined with medical care and/or barriers to care and patient self-management. *Use PCP knowledge of patient history plus review of the medical record to ensure efficient but complete evaluation.*

   D. In primary care clinics working with children, adolescents and families, identify children with, or at risk for, psychosocial problems, *regard the child as embedded in a family unit,* and further assess:

   • Developmental problems and milestones;
   • Potentially difficult situations in childcare, including bedtime, toileting, and feeding;
   • Learning difficulties and attention deficit hyperactivity disorder;
   • Psychosocial and environmental risk factors and stressors, including parent mental health, family systems problems and adverse childhood experiences
   • BH or medical problems involving children, adolescents and families (A-D above)
   • How family, guardians, or caregivers can be part of overall care or health for children or families, including potential parent training or coaching.

   E. Appropriate triage of severe or complex BH problems that require the assistance of specialized BH providers or services, or community-based resources as part of the approach to care.

**Specific examples or behaviors (drawn from all 4 source articles)**
Method (Step 5): Facilitate face-to-face time to resolve the specific substantive issues in small groups assigned to a competency(s).

Principle: Create small groups with specific charges and worksheets—to work on behalf of the larger group

Colorado example:
First, verify shared understanding of need, purpose/flow of the day

Round 1: small groups each take on the substantive issues in a competency(s) and report back.

Then ask the large group: What’s your reaction to this table’s work?
 • Do a good majority agree? Can everyone live with it?
 • Is it now good enough to go with? What would it take to answer “yes”?

This is testing for consensus. If not, look for a resolution right then. If not, it goes to Round 2

Round 2: small groups, differently configured, finish the job based on large group fb on round 1

Again, ask large group: Is it now good enough to go with?

What would it take to answer “yes”? Discover where consensus starts and ends, even if not as deep as you were hoping.

At the close: Individual feedback form—to assess confidence in the day’s results
Selected questions from: Individual feedback summary: BH Competencies Conference 11/17/15

1. How fully did you **participate** in today’s conversations?

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<td>If you held back, what would have made it easier to <strong>fully participate</strong>?</td>
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2. To what extent **were you clear** about the purpose and desired product—why this & why now?

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<td><strong>Suggestions for being more clear on why this and why now:</strong></td>
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3. To what extent did the **initial synthesis of published competencies** give us a good start for the meeting?

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<td><strong>What would have improved the way published competencies were synthesized in that booklet?</strong></td>
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4. To what extent did the **on-line survey** help you identify which competencies needed work at the meeting?

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<td>Just a useless distraction</td>
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<td><strong>What would increase the practical value of such a survey?</strong></td>
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5. To what extent are the **resulting competencies** good enough to start using, knowing they will evolve?

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<td><strong>What would increase the practical usability?</strong></td>
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6. To what extent was this meeting **well designed and run**?

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<tbody>
<tr>
<td>Don’t ever do it this way again!</td>
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<td><strong>Keep it up!</strong></td>
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**Advice for running a productive meeting of this kind in Colorado in the future:**
Method (Step 6): Rewrite based on face-to-face meeting and test it again

*Principle:* Keep your consensus group with you by not only revising the product according to their work, but testing it again to confirm they are behind it.

_Colorado example:_

**A. Rewrite based on the face-to-face work**
- From notes and table worksheets turned in at the meeting
- Again show the edits in highlight (for transparency)
- Write the clarifying preamble requested*

**B. Test again via similar online survey**
- Yes, just fine as written
- Close but still needs these tweaks: (written out)
- No, needs to be rewritten; missing major themes (what?)

Look at the overall results of this final survey—
Can we now go with it? Does it satisfy our definition of consensus?

* The face-to-face group requested a preamble containing perspective on the competencies achieved at the face-to-face meeting (outline below). This was drafted from meeting notes and part of the version submitted to conference participants for the final online survey test.

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**Preamble to the competencies**

1. **Target of the competencies:** AHRQ General definition of integrated BH
2. **Cross-cutting themes** for the 8 competencies (not repeated for each one)
   - Across prevention and wellness to illness care
   - Across the lifespan
   - Across the generations
   - Across a biopsychosocial continuum
   - Person-centered and culturally sensitive
3. **Competencies not written for any one model** or type of integration
4. **Competencies specific to BH practice in PC,** not all possible BH compet.
5. **How to read the competencies at 3 “altitudes”**
   - They can seem general, non-specific, or redundant—until you unpack them in detail:
     - Competency name with 1-2 sentence description (global lumped—mom & apple pie)
     - Bullet-point list with headings “unpacks” the global description (the global split up)
     - Examples: what you see in action—concrete and practical; “to do” (hard observable)
6. **Competencies are expected to evolve over time**
   (and picked up elsewhere for local adaptation)
Survey results on the final version of the competencies.
In the end, the survey results were regarded as satisfying the requirements of being a consensus statement.

<table>
<thead>
<tr>
<th>Final Survey Results on resulting competencies</th>
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<tbody>
<tr>
<td>Distribution of surveyed participants; N=35</td>
</tr>
<tr>
<td>Behavioral Health Providers</td>
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<tr>
<td>Primary Care Providers</td>
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<tr>
<td>Behavioral Health Educators</td>
</tr>
<tr>
<td>Foundation Representatives</td>
</tr>
<tr>
<td>Other: Policy, state agency rep, practice facilitator, specialty care educator, researcher, consultant, project coordinator, academic, administration</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Final Survey Results</th>
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<tbody>
<tr>
<td>Is this competency good enough to use in Colorado?</td>
</tr>
<tr>
<td>35 respondents x 8 responses = 280 total</td>
</tr>
<tr>
<td>Yes, just fine as written</td>
</tr>
<tr>
<td>Yes, but needs to be sharpened</td>
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<tr>
<td>[Many of these tweaks were then made]</td>
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<tr>
<td>No, not salvageable</td>
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<tr>
<td><strong>Yes just fine + Yes with tweaks</strong></td>
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Method (Step 7): Write, post, and use the final report

Principles: 1) Use the final survey “tweak” feedback to further improve it before posting
2) Get it into circulation and use quickly so people begin to experience the benefit.

Use: To date, the competencies have been used by the Farley Center or others with Colorado SIM and practice transformation work, collaborative learning session, e-learning for teams, a resource document for organizations and foundations, has been cited in 3 journal articles, was discussed with NCQA, and has been subject of conversations with foundations to scale up.