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Supporting shared decision making beyond consumer-prescriber interactions: Initial development of the CommonGround fidelity scale

Sadaaki Fukui, PhD.,

Director of Research, Center for Mental Health Research and Innovation, University of Kansas School of Social Welfare, 1315 Wakarusa Dr., Lawrence, KS 66049, U.S.A; TEL: 785-864-5874; FAX: 785-864-5277

Michelle P. Salyers, Ph.D.,

Professor of Psychology and Director of the Clinical Psychology Program, Indiana University Purdue University Indianapolis (IUPUI); Co-Director of the ACT Center of Indiana, U.S.A. TEL: 317-274-2904

Charlie Rapp, Ph.D.,

Research Professor, Center for Mental Health Research and Innovation, University of Kansas School of Social Welfare, 1315 Wakarusa Dr., Lawrence, KS 66049, U.S.A TEL: 843-388-7842

Rick Goscha, Ph.D.,

Director, Center for Mental Health Research and Innovation, University of Kansas School of Social Welfare, 1315 Wakarusa Dr., Lawrence, KS 66049, U.S.A, Tel: 785-864-0149

Leslie Young, LCSW, and

Project Manager, Center for Mental Health Research and Innovation, University of Kansas School of Social Welfare, 1315 Wakarusa Dr., Lawrence, KS 66049, U.S.A, Tel: 785-864-9005

Ally Mabry, LMSW

EBP Coordinator, Center for Mental Health Research and Innovation, University of Kansas School of Social Welfare, 1315 Wakarusa Dr., Lawrence, KS 66049, U.S.A, Tel: 785-864-8037

Abstract

Shared decision-making has become a central tenet of recovery-oriented, person-centered mental health care, yet the practice is not always transferred to the routine psychiatric visit. Supporting the practice at the system level, beyond the interactions of consumers and medication prescribers, is needed for successful adoption of shared decision-making. CommonGround is a systemic approach, intended to be part of a larger integration of shared decision-making tools and practices at the system level. We discuss the organizational components that CommonGround uses to facilitate shared decision-making, and we present a fidelity scale to assess how well the system is being implemented.

Introduction

Shared decision-making is not a new concept in health care, yet the application is still nascent in mental health, particularly for psychiatric medication management. Shared decision-making is a collaborative communication process in which health decisions are made jointly by health care providers and consumers (Légaré et al., 2012). The core practices involve encouraging consumers to take an active role in the decision-making process and equally valuing both providers' scientific/clinically-based knowledge and consumers' preferences about treatment options (Fukui, Matthias, & Salyers, 2014). This collaborative effort should optimize the probability of agreement with the final decision of a treatment chosen among the available options and should lead to better adherence to the decision.

Research in shared decision-making in mental health has consistently identified that: 1) concerns about time constraints (Torrey & Drake, 2010) and decisional capacity of consumers (Drake, Cimpean, & Torrey, 2009; Hamann, Mendel, Reiter, et al., 2011) could be barriers for some providers, but these barriers are not always evident (Fukui, Matthias, et al., 2014); 2) consumers are interested in decision-making involvement (Adams, Drake, & Wolford, 2007; Drake et al., 2009; Hamann et al., 2008); 3) shared decision-making is ethically favorable and practically feasible for consumers with severe mental illness (Carpenter et al., 2000; Hamann, Mendel, Meier, et al., 2011; Patel, Bakken, & Ruland, 2008; Stroup et al., 2005); and 4) consumer empowerment and activation may be linked to shared decision-making (Alegría, Sribney, Perez, Laderman, & Keefe, 2009; Salyers et al., 2009). However, implementation barriers are repeatedly discussed in mental health research. Despite calls for shared decision-making, core practices are not always transferred to the routine clinical office visit (Beitinger, Kissling, & Hamann, 2014; Hamann & Heres, 2014). For example, audiotaped medication management visits often do not demonstrate active shared decision-making in mental health (Salyers et al., 2012).

In order to improve the process and outcomes of shared decision-making for treatment options, three primary approaches have been identified in the general healthcare field: 1) training for providers; 2) training for consumers; and 3) using decision aids (Beitinger et al., 2014). Training providers may be particularly important given the intent to balance power between providers and consumers in sharing treatment decisions (Beitinger et al., 2014; Charles, Gafni, & Whelan, 1997). Indeed, there is a plethora of training methods to enhance shared decision-making communication for providers in the medical area. For example, Légaré et al (2012) identified 54 training programs for health care providers. However, not many of these training methods have been adopted in mental health, and when providers have been trained, the effect on mental health consumers has been small (Duncan, Best, & Hagen, 2010). Further, implementation barriers at the provider level need to be alleviated along with training. For example, Hamann and Heres (2014) discussed psychiatrists' reluctance to use shared decision-making in critical situations (e.g., those that may get worse depending on the decision) or based on the characteristics of consumers (e.g., impaired decisional capacity). Despite understanding the benefit of shared decision-making, psychiatrists may value beneficence (a decision thought to be in the best interest of a consumer) over autonomy if the decision might worsen symptoms.

Training for consumers to enhance involvement in treatment decisions has a longer history in general healthcare (Greenfield, Kaplan, & Ware, 1985). In psychiatric settings, research shows the importance of consumer initiation of conversations during a psychiatric visit to facilitate shared decision-making (Fukui, Salyers, et al., 2014), and some interventions target better consumer communication. For example, Hamann et al (Hamann et al., 2013; Hamann, Mendel, Meier, et al., 2011) developed a coaching method to increase consumers' communication competencies. Similarly, Alegría and colleagues (Alegría et al., 2014; Alegría et al., 2008; Polo, Alegría, & Sirkin, 2012) have developed and tested educational strategies that teach consumers how to ask questions in order to facilitate collaborative decision-making and improve activation and self-management. However, as shared decision-making is a collaborative effort between a consumer and provider, coaching consumers alone appears to have minimal effect in the broader healthcare literature (Cegala, Marinelli, & Post, 2000; Harrington, Noble, & Newman, 2004).

Decision aids have also been used to facilitate communication about available treatment options, including information on pros and cons and relevant outcomes (Stacey et al., 2011). Because decision aids require up-to-date scientific information, internet/web-based tools have gained momentum (O Connor, Llewellyn-Thomas, & Flood, 2004). There are some electronic decision support aids specifically for mental health. For example, Woltman et al. (2011) examined whether an electronic decision support system for people with psychiatric disabilities facilitates shared decision-making and improves consumer satisfaction with the process. The study showed that the system facilitated shared decision-making processes (e.g., improved providers' awareness of consumers' concerns, improved consumers' awareness of goals and services in their care plan), but not consumer satisfaction with the process. Van der Krieke et al. (2012) tested the usability of a web-based system that provided personalized functioning information to consumers with a mental illness. The system was well accepted, feasible to implement, and showed potential to improve practice. While decision aids can be useful in shared decision-making, simple dissemination does not guarantee the quality of shared decision-making (Légaré & Thompson-Leduc, 2014; O Connor et al., 2004), thus a supportive environment and effective system at the organizational level are needed to facilitate a quality shared decision-making practice (Deegan, Rapp, Holter, & Riefer, 2008).

Components of the CommonGround Approach

CommonGround, developed by Pat Deegan (Deegan, 2010; Deegan et al., 2008; Drake, Deegan, & Rapp, 2010), is a systemic approach to shared decision-making that integrates all three targets of intervention, providing decision aids as well as training for providers and consumers. CommonGround includes a computerized decision support system equipped with an interactive touch screen. Typically the CommonGround software is loaded on a kiosk that is located in a Decision Support Center, a room staffed by trained peers who provide coaching to consumers in community programs for people with psychiatric disabilities (often a community mental health center). Key features include: 1) a comfortable environment with peer workers' assistance prior to a medication appointment; 2) a user-friendly platform for those who have low literacy and/or computer skills to access up-to-date information on medication and symptom management and recovery stories; 3) a one page

health report that displays consumers' goals, current treatment (including personal wellness strategies and medications), symptoms, and concerns to discuss with the provider, highlighting the area that the consumer most wants to discuss given the limited consultation time. The one page health report will be printed for consumers to take into their visit with the provider and will also be available online for care providers to view. These features help consumers to organize their thoughts prior to seeing the provider and to bring consumer voices and goals to the center of treatment.

In order to optimize the effectiveness of the CommonGround program in promoting shared decision-making between consumers and providers, as well as adherence to the decisions, system level support is embedded within the CommonGround approach. Training is provided to peer supporters, medication prescribers, and direct service staff (e.g., case managers and supervisors) to effectively use the CommonGround program as well as to facilitate understanding about the role of medications and personal wellness strategies for consumer recovery. The CommonGround training is delivered through a workshop format "focusing on the practical, lived experience of learning to use medications in the recovery process and to work in empowered partnership with staff around medication decision making" (Deegan, 2006, p. 7). Peer supporters in particular facilitate consumers' awareness about recovery, wellness strategies, and medication preferences using the CommonGround program. Peer supporters also work closely with medication prescribers and direct service staff to integrate wellness strategies and medication preferences into a treatment plan.

Early evaluations of CommonGround have shown promising results (American Psychiatric Association, 2013; Campbell, Holter, Manthey, & Rapp, 2014; Deegan et al., 2008; Drake, Deegan, Woltmann et al., 2010; Goscha & Rapp, 2014; MacDonald-Willson, Deegan, Hutchison, Parrotta, & Schuster, 2013; Stein et al., 2013). However, the organizational components necessary to facilitate CommonGround integration into psychiatric treatment have yet to be detailed. Supporting the macro level integrity of a program (e.g., the structural aspect of a program, location of services, and integration of treatment) beyond specific practitioner behaviors is critical in psychiatric care (Bond et al., 2000).

We discuss the organizational components we have found critical for implementing CommonGround -- to facilitate shared decision-making in the medication consultation as well as following through with those decisions outside of the consultation room. We describe the structure, process, peer support, direct service staff integration, and supervision used in CommonGround. We then describe a fidelity scale developed to assess how well the system is being implemented.

Structure

Structure ("the framework for service delivery"; Mowbray, Holter, Teague, & Bybee, 2003) to support systematic implementation is imperative for evidence-based practice (Houser & Oman, 2010). The structure of CommonGround revolves around an onsite Decision Support Center, with close proximity to the medication clinic (or offices where medication consultations take place). The Decision Support Center hosts the computer and peer support staff to assist consumers. Consumers visit the Decision Support Center prior to psychiatric appointments, but can visit the center at other times as well. The Decision Support Center

should be welcoming to consumers and create an atmosphere that inspires hope and recovery. The importance of housing and structuring the Decision Support Center as part of the medication clinic is two-fold: the center facilitates the consumers' continued awareness and encouragement of the shared decision-making practice with providers; and it increases the providers' use of collaborative medication management practice through shared decision-making.

Given that medication and symptom management is ongoing and occurs primarily in community settings where consumers live, CommonGround goes beyond a decision aid that assists consumers with shared decisions in the medication consultation room. CommonGround takes a systemic perspective to support the process outside the room as well, with training and resources for peer supporters and other providers involved in direct care (e.g., case managers). These providers are essential to help consumers identify and use personal wellness strategies and medications in the community. This structured and integrative approach is also important to facilitate a strong relationship with the medication prescriber based on consumer values and goals.

Process

Process ("the way in which services are delivered"; Mowbray et al., 2003) is also critical. When consumers visit the Decision Support Center, they can access a variety of up-to-date information about medication and topics related to broader recovery. The intent is to stimulate a change in perspectives concerning medication from "taking as directed" to "using medications to support the consumer's defined recovery" (Baker et al., 2013). In addition, these resources can increase readiness for consumers to take an active role in the shared decision-making process with their prescriber. The CommonGround program produces a one-page health report that can be discussed with the prescriber during the medication appointment. It includes "Power Statements" (i.e., reflecting the person's overarching goals for using psychiatric medication), "Personal Medicines" (i.e., self-initiated, non-pharmaceutical self-care activities), current use of medication, psychiatric symptoms, concerns about medications, and questions for the prescriber (Deegan, 2005, 2007). Peer support workers and direct service staff help consumers complete these sections, and supervisors oversee the work. Understanding the consumer's goals for medication and the active ingredients driving the person toward recovery should facilitate more effective decision-making. Thus, a core function of the CommonGround program corresponds to a critical feature of shared decision-making – integrating consumers' preferences and values related to medication and symptom management.

Altogether, CommonGround facilitates consumer-centered medication management at the agency level. CommonGround helps consumers identify values and goals around medication management, facilitates sharing decisions about treatment options, clarifies treatment plans, encourages support to follow through with plans, test and adjust them in the community, and provides feedback to further integrate consumer voices in the shared decision-making process (See Figure 1).

Peer Support

Although the comparative effectiveness of peer support needs to be further examined (Davidson, Chinman, Sells, & Rowe, 2006), peer support is considered a critical element in recovery models (SAMHSA, 2011; Slade et al., 2014). Frequently cited roles for peer support include advocator for consumers' self-determination and personal responsibility, facilitator for treatment engagement, and coach to help consumers communicate with providers (Chinman et al., 2014), all of which are crucial to facilitate shared decision-making in CommonGround. Peer support workers assist consumers to identify and review each of the elements in the health report (e.g., power statements, personal medicines) and can help the consumer follow through after the medication consult by, for example, helping them locate and complete work sheets (Deegan, 2006). Peer support workers also model recovery and may be a source of inspiration and hope (Chinman et al., 2014). In the CommonGround approach, peer supporters not only provide tangible assistance, but also model being an empowered consumer who takes an active role in managing their mental illness.

Direct Service Staff Integration

Direct care providers are vital to supporting symptom and medication management in the community, especially for consumers who do not have a strong informal support network (e.g., family, friends). Discussions about optimal treatment typically involve complex processes and courses of action that go beyond the people in the room making a treatment decision (Matthias, Salyers, Rollins, & Frankel, 2012). In addition, decisions about medication and symptom management occur repetitively in community settings. For example, if a medication causes drowsiness, a consumer may adjust the timing of medication according to their desired activities or lifestyle. Thus, it is important for other providers involved in direct care (e.g., case managers) to work with the consumers to identify effective use of medications in the community. El-Mallakh, et al. (2014) also discussed the importance of multiple providers sharing a common focus in medication management, including administrative staff, direct care providers, and support staff. In CommonGround, direct care staff may review health reports as they are updated (typically following a medication consultation appointment), review consumers' goals around medication management, and reevaluate care plans based on the reports.

Supervision

Quality of supervision is often a determinant of the quality of services and clinical practice of direct care providers [e.g., case managers] (Fukui, Rapp, Goscha, Marty, & Ezell, 2014; McHugo et al., 2007; Rapp, Goscha, & Fukui, 2014). Supervisors' roles include providing training, feedback on work performance, and leadership for direct care workers. Within the realm of CommonGround, supervisors play a critical role in guiding direct care workers who often do not have professional training in symptom management or shared decision-making. Supervisors encourage direct care workers to use decision-making tools in CommonGround (e.g., video and worksheets). Supervisors review health reports on a regular basis to ensure that the consumer's power statements, personal medicine, and pill medicine are up to date and integrated with other areas of treatment. Supervisors are often the most experienced staff

on the team and can communicate across different levels (e.g., administrators, prescribers, direct care workers, etc.). Supervisor leadership to maintain the integrity of shared decision-making practice at the organizational levels is imperative in CommonGround.

Initial Development of the CommonGround Fidelity Scale

Developers and evaluators of CommonGround with experience in fidelity scale development identified critical elements of the program based on the first pilot test of CommonGround (Deegan, et al., 2008) and experience implementing the approach in other community mental health settings in Kansas. We identified 13 essential ingredients within five domains to promote the effectiveness of CommonGround: 1) structure (2 items); 2) process (6 items); 3) peer support (2 items); 4) direct service staff integration (2 items); and 5) supervision (1 item) [Scale available by contacting the first author]. We followed guidelines for fidelity scale development and evaluation in mental health, such as identifying essential ingredients of the program model and creating comprehensive lists to assess treatment integrity and differentiation (e.g., structural, clinical intervention, supervision components) that predict better consumer outcomes (e.g., Mowbray et al., 2003; Bond et al., 2000; Torrey, et al., 2012). We refined the scale through a series of pilot fidelity assessments (7 sites in 4 states in the U.S.), followed by consensus meetings of raters and developers. Two fidelity reviewers who are experts in CommonGround independently rated fidelity, discussed the reviews with our fidelity development team, and evaluated the face validity, clarity, and utility of each item. The fidelity reviews were conducted through a multimodal approach, including chart review, observation, interviews of key staff and consumers as recommended by Bond et al. (2000). Following standard conventions for other evidence-based practice fidelity scales (McHugo et al., 2007), each item score ranges from 1 to 5, with higher scores indicating better implementation (Table 1).

Although the core of each fidelity item remained constant, each pilot yielded refinement (clarification and specification) of the 13 items. For example, a shared decision should be included in a health report (item 7). Pilot tests clarified that writing the decision with the consumer present was important for quality, and so that item was adapted to include presence of the consumer. Thus, ratings made during the pilot testing were not directly comparable to later ratings.

The structural component includes having peer support workers available when consumers need to use CommonGround and integrating a Decision Support Center within the medication clinic (i.e., close proximity to offices where medication consultations happen, concurrent appointments between the Decision Support Center and prescriber, collaboration between medication prescribers and peer support workers). The process component includes evidence of completing a health report within the same day of a medication appointment, the presence of power statements that meet specific criteria (e.g., unique to the individuals), integration of power statements within goals of treatment plans, the presence of personal medicines, shared decisions that are written with the consumer present, and decisions that meet certain criteria (e.g., specific and unique to the individuals). The peer support component includes support for consumers for completing a health report and offering coaching prior to the medication consultation. The direct service staff component includes

staff reviewing a consumer's health report and the regular use of a variety of decision aids/self-help tools from the CommonGround program to support consumers' medication management. The supervisor component includes reviewing health reports and providing direct service staff feedback, support, and training.

We formed several impressions from the pilot testing. In general, because of the emphasis of CommonGround as a peer-based shared decision-making support system, peer workers' involvement/activities were relatively well documented (e.g., items 1, 9, 10) at the CommonGround implementation sites. Through the effort of peer workers helping consumers complete health reports, consumers are encouraged to report personal medicines and power statements (e.g., items 4 and 6). On the other hand, item 2 ("the Decision Support Center is part of the medication clinic") tends to reveal more variations between sites. This item may indicate or determine the extent to which CommonGround is embedded within the routine office visit structure. For example, sites with lower scores might not be able to smoothly transfer the collaborative effort between peer workers and consumers to the ensuing medication consultation with the providers.

Prescribers at the pilot fidelity review sites were not likely to fully utilize the health report during the medication consultation. In particular, shared decisions often failed to be written with the consumer present (item 7) and include the consumer's own voice (item 8). The health report also failed to be completed within the same day of the appointment with the prescriber (item 3). The health report intends to amplify consumers' voices. However, if reports are not used collaboratively with medication prescribers, potential adverse effects may arise, such as an impression of "difficult consumers". For example, assertive consumers who question clinical advice could negatively affect some (less-receptive) providers (Alegría et al., 2014; Hamann, Mendel, Meier, et al., 2011). Finally, the involvement of direct service staff and supervisor (items 5, 11, 12, 13) were less frequently documented. As described above, direct service staff and supervisors have critical roles in promoting on-going support for quality shared decision-making and following through on treatment decisions outside of the medication consultation office visit.

The fidelity scale is currently used in CommonGround implementation sites in Kansas, Indiana, and Pennsylvania. The scale requires a wider dissemination and long-term evaluation with consumer outcomes to test predictive validity. However, key informant interviews recently conducted at a CommonGround implementation site independent of a fidelity visit confirmed the face validity. Interviews revealed implementation barriers and effective strategies that were aligned with the critical elements identified in the fidelity scale (e.g., structure of core programming, CommonGround scheduling and coordination, direct staff investment, location of Decision Support Center, Decision Support Center atmosphere). We are currently planning a study to test the predictive validity of the scale across multiple sites.

Conclusion

Optimal treatment involves complex processes and courses of action that go beyond the people in the room making the decision. CommonGround takes a systemic perspective and

incorporates training and resources for peer supporters, psychiatric prescribers, supervisors, and other providers involved in direct care. Based on our experience implementing CommonGround, we identified five critical domains necessary to support shared decision-making at the system level. We used current methods in shared decision-making and guidelines for fidelity scale development in mental health to construct a fidelity scale and we refined the scale through pilot testing in different sites and states. As a program that integrates shared decision-making tools at multiple levels (consumers, prescribers, direct care providers, and supervisors), CommonGround provides structure and process to help implement shared decision-making more thoroughly in a system of care. The organizational components discussed in this article are specific to CommonGround and might not generalize to other shared decision-making models. However, given that the mental health field does not yet have good consensus about shared decision-making models, this paper attempts to highlight a practical approach that could be useful. We focus attention on considerations for supporting shared decision-making beyond interactions between consumers and medication prescribers and provide a tool that could be used to document this work. Further testing of the scale to assure psychometric rigor, including inter-rater reliability and predictive validity for consumer outcomes will be important next steps.

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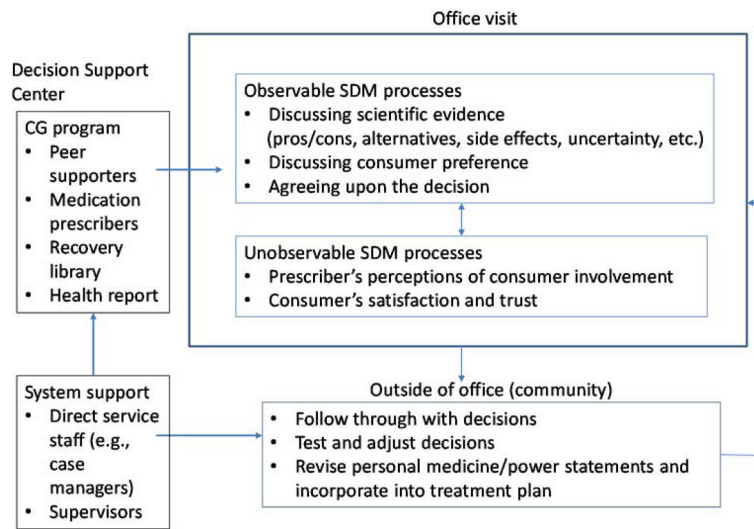


Figure 1.
CommonGround based shared decision-making support system

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Table 1

CommonGround Fidelity Scale Items

Domains	Items	Example of the highest fidelity	
Structure	Item 1.	Peer support specialists and/or peer support coordinator are available to support clients in their use of CommonGround whenever there are scheduled psychiatric appointments.	90 – 100% of the time peer support specialists are available to support clients in the DSC before and after their psychiatric appointments. Clients are free to stop by the DSC in between appointments to use resources found in the CommonGround program.
	Item 2.	The Decision Support Center is part of the medication clinic: located in close proximity to the medication clinic; the DSC and medication clinic appointments are scheduled as one appointment time or concurrent appointments; prescribers and peer support specialists collaborate to provide an integrated service for the client.	All of the three criteria were met.
	Item 3.	___% of clients who attend an appointment with their prescriber have completed a Health Report within the same day of their appointment with the prescriber.	90–100% of the clients completed a health report within the same day of their appointment with the prescriber.
	Item 4.	___% of clients who use CommonGround have Power Statements that meet criteria entered into the program.	90–100% of the reports reviewed contained well-written Power Statements
	Item 5.	Information from the client’s Power Statement is included within goals and/or objectives of their treatment plan.	90–100% of treatment plans reviewed appeared to contain information from the Power Statement.
Process	Item 6.	___% of clients who use CommonGround have Personal Medicines that meet criteria entered into the program.	90–100% of reports reviewed contained Personal Medicine statements which are unique to the individual and help clients feel better.
	Item 7.	___% of completed Health Reports have a Shared Decision that was written with client present.	90–100% of completed Health Reports have a Shared Decision that was written with client present.
	Item 8.	___% have a shared decision that meets criteria: The Shared Decision is written in the client’s own voice and is unique to the client being served.	90–100% had a shared decision which integrated information from the Power Statement and indicated what specific/ concrete action the client would take before their next medical appointment.
Peer Support	Item 9.	Peer specialists offer to do the following things with clients prior to completing the Health Report: introducing homepage and pointing out new information; reviewing and updating personal medicines, power statements, psychiatric medications; and explaining options for completing report and offering assistance.	Peer specialists did all of the activities listed with most of the clients who came in to do a Health Report.
	Item 10.	After clients have completed their Health Reports, Peer Specialists offer to do the following activities prior to the client meeting with their prescriber: reviewing the areas of concern (i.e., How I Am Doing Scale, Common Concerns about Medications, My Wellness); assisting clients in identifying a goal for the appointment with their prescriber and typing in any specific questions or comments into the goal section; reviewing CommonGround tools; and inviting the client to return to the DSC following their prescriber visit.	Peer specialists did all of the activities listed with most of the clients prior to the client meeting with the prescriber.
Direct Service Staff Integration	Item 11.	Direct service staff review a client’s Health Report (i.e., How I Am Doing Scale, Common Concerns about Medications, Shared Decision, Power Statements, and Personal Medicines) 48 hours after it is completed and respond to areas of concern and action needed prior to the next appointment.	Direct service staff met this criteria for 90–100% of the clients on their caseload using CommonGround.
	Item 12.	Direct service staff regularly use a variety of decision aids/self-help tools from the CommonGround program to help clients with a specific goal, barrier, or challenge related to medications.	All direct service staff regularly used a variety of Common Ground tools to help clients with a specific goal, barrier, or challenge related to medications
Supervision	Item 13.	Supervisors review Health Reports each week -- prompt direct service staff to follow up with clients on their Health Reports; provide field mentoring to model, observe, and prompt use of CommonGround related skills; provide feedback to direct service	Supervisor did all four activities each week.

Domains	Items	Example of the highest fidelity
	staff on CommonGround skills and performance; and Health Reports are used in clinical meetings, case presentations, etc.	

Note: DSC (Decision Support Center)

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