Achieving consensus

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Am J Health-Syst Pharm. 2011; 68:e40-1

Consensus for the Pharmacy Practice Model Summit was achieved using an a priori iterative process modeled after a modified Delphi technique. In advance of the summit, a 164-item survey was distributed to 107 previously appointed voting participants and the ASHP membership-at-large via the Internet-based Qualtrics survey tool. Along with individual and institutional demographic data, questions were categorized in five domains: (1) overarching principles for pharmacy practice model change, (2) specific services, (3) technology, (4) technicians, and (5) implementing change and responding to challenges. Options for responses to questions in these domains, depending on item type, were (1) strongly agree, agree, neutral/undecided, disagree, or strongly disagree, or (2) high priority, medium priority, or low priority. Respondents could also provide free-text comments after each of the five survey domains. Voting participants were provided with a three-week time frame to complete the survey and two reminders were sent to noncompleters. The voting member survey closed after three weeks, and the membership-at-large survey was closed after six weeks. Data were downloaded from Qualtrics to Excel 2007 (Microsoft Corporation, Redmond, WA) for analysis. For ease of analysis, those items that had response options of strongly agree, agree, neutral/undecided, disagree, and strongly disagree, were collapsed into three groups: (1) agree/strongly agree, (2) neutral/undecided, and (3) disagree/strongly disagree. The response rate for voting participants was 95.3% (102 of 107), and 1087 ASHP members completed the survey.

In advance of the summit, voting participants were required to participate in a live webinar review or a Web-archived version review of the small- and large-group consensus voting processes. For the presummit survey, consensus on an item was defined as at least 80% of voting participants (± 3%) indicating that they agreed or strongly agreed with an item or at least 40% of voting participants (± 3%) indicating that they disagreed or strongly disagreed with the item. For 51.8% of the items (85 of 164) at least 80% of voting participants (± 3%) indicated agreement/strong agreement, and these items were included as summit recommendations or observations and were not discussed further during the summit. For 4.3% of the items (7 of 164), at least 40% of voting participants (± 3%) indicated disagreement/strong disagreement, and these items were automatically excluded as summit recommendations or observations. The remaining 72 items were included for small-group discussion at the summit. ASHP Research and Education Foundation staff, with the assistance of a pharmacy student, reviewed the free-text comments and identified 16 additional items for discussion at the summit. A total of 88 items were scheduled for small-group discussion.

Small-group discussions. The summit participants were divided into seven small groups and participated in five small-group discussion sessions. Efforts were made to balance the small groups by participants’ years of professional experience, practice role, geographic location, and gender. Each small group discussed items listed under the following domains: (1) overarching principles for pharmacy practice model change, (2) services, and (3) implementing change and responding to challenges. Technicians were discussed by four of the small groups. The other three small groups concurrently discussed technology.
Each small-group discussion was facilitated by an ASHP member who had received three hours of facilitator training, and an ASHP staff member served as the group secretary. Small-group participants were instructed to discuss each of the items for which consensus was not achieved during the presummit survey and the additional items that were identified in the free-text review. For those items for which at least six or more of the small groups agreed to include as a recommendation or observation ($n = 31$), consensus was reached, and the item was not discussed further at the summit. Items for which fewer than six of the small groups agreed on their inclusion as a recommendation or observation ($n = 57$), were discussed by the 106 voting participants during large-group consensus-building sessions that followed each small-group session. New items identified during the small-group sessions or recommended by individual voting participants during the large-group consensus session ($n = 27$) were also discussed and voted on in the large-group sessions.

**Large-group sessions.** During the large-group sessions, revisions to the items were allowed, and an electronic audience response system (Turning Point 2008, Turning Technologies, LLC, Youngstown, OH) was used to collect participants’ votes. In the large-group sessions, at least 80% of the participants had to vote “yes” to include an item as a recommendation or observation from the summit. Sixty-two percent of the items discussed in the large-group consensus-building session (32 of 52) resulted in approval as a summit recommendation or observation.

Twenty-seven items related to the provision of pharmacist care to specific populations (Master Record items 66–92) were not included in the summit recommendations, as these were replaced by a voting participant recommendation (Master Record item 183) to prioritize pharmacist-provided drug therapy management using a patient medication acuity index.

**Reference**