

**This team building tool** was developed based on experience helping more than 500 organizations adapt, implement, and sustain evidence-based collaborative care for common mental disorders. Our experience has taught us that for integrated care programs to succeed, clinics need to clearly define the roles of all team members and create an effective shared workflow that makes optimal use of existing staff resources and meets the behavioral health needs of the unique patient population served by each clinic.

There are 5 steps in the team building process:

- 1 Individual Team Members Complete a Staff Self-assessment
- 2 Identify Gaps, Duplication of Services, and Training Needs
- 3 Create a Customized Integrated Behavioral Health Care Workflow for your Practice
- 4 Generate an Implementation Plan and Timeline Tailored to Your Practice
- 5 Track Program Outcomes and Adjust as Necessary

There are 3 worksheets to support this team building process:

- 1 Team Member Self Assessment
- 2 Task Summary by Team Member
- 3 Summary & Change Plan

## Facilitation of Integrated Care Team Building Process

**First, 1 or 2 team member(s) should be identified to facilitate the team building process:**

- 1 Tailor worksheets based on relevant collaborative care tasks
- 2 Distribute and collect completed Step 1 Worksheets for each team member\*
- 3 Tabulate all team member responses by completing the Task Summary by Staff Worksheet
- 4 Facilitate a follow-up meeting after Team Building Worksheets are completed and tabulated, and document—during or after the meeting—the current status and change plans in the Summary & Change Plan Worksheet
- 5 Create an implementation plan and timeline
- 6 Regularly revisit the Summary & Change Plan with the team to review progress and adjust roles as necessary

*\*For the purpose of team building, define the integrated care team broadly: include all clinical staff who are involved (including primary care providers) and administrative staff (e.g., clinic manager)*

## STEP 1: Individual Team Members Complete a Staff Self-assessment

### Identify relevant collaborative care tasks and who is currently performing each task.

- First, the team member(s) facilitating the team building process will identify all relevant collaborative care tasks—based on target patient populations, clinical conditions, etc—and will tailor the worksheets accordingly.
- Each member of the team will **complete the Staff Self-assessment Worksheet** individually.
- The worksheet lists several collaborative care tasks—for each task, individuals will answer:
  - ❶ Is the task part of the individual's role now?
  - ❷ If not part of the individual's role now, whose role is it?
  - ❸ What is the organization's capacity with regards to this task?
  - ❹ What is the individual's comfort level with this task? (respondents should answer even if they are not currently doing this task)
  - ❺ Would the individual like training to learn or improve their capacity to perform this task?
  - ❻ Are there other important tasks that should be on this list?

## STEP 2: Identify Gaps, Duplication of Services, and Training Needs

### Map out the current team structure and activities, based on responses to the individual Staff Self-assessment Worksheets to identify gaps, duplication, and opportunities for streamlining and/or more collaboration.

- The team member(s) facilitating the team building process will **complete the Task Summary by Staff Worksheet** by:
  - Writing in the staff member's role/title and/or name at the top of each column marked "Staff 1", "Staff 2", etc.
  - For each of the collaborative care tasks, mark the cell for each staff member currently performing a task.
  - If a task is completed via a partner agency or a referral, mark that cell (this information will not be on the Staff Self-assessment Worksheets; the team member leading this process will have to find out if s/he does not already know).
- Identify gaps and duplications in tasks by examining the completed worksheet. Identify opportunities to make the processes more efficient. Think about ways to collaborate effectively and discuss critical communication and 'handoff' steps.
- Think about if and where changes are needed.

## STEP 3: Create a Customized Integrated Behavioral Health Care Workflow for your Practice

### Systematically review—as a team—the results from the Staff Self-assessment Worksheets and the Task Summary by Staff Worksheet, in order to plan for implementation changes and document these plans.

- First, discuss the completed forms as a team. This discussion should be facilitated by the team member(s) taking the lead for this process.
  - Discuss gaps—which cells are blank?
  - Discuss duplication—which tasks are currently being performed by more people than necessary?
  - Discuss any tasks that individuals are not currently performing, but would like to start, and discuss what training or other changes are needed to facilitate this.
  - Discuss any tasks that individuals are currently performing, but would not like to continue doing and discuss possible alternative task re-assignments.

- Second, discuss the “practical ideal” you are striving for in your organization to provide the most effective care for your patients.
- Third, systematically review the list of collaborative care tasks on the Summary & Change Plan Worksheet. **For each task—or set of tasks as shown in the worksheet—document who, how, when, and where the task will be completed as part of your implementation plan. This worksheet documents your current situation plus your plans for change.**
  - ➔ Write in the individual(s) names who will perform each task.
  - ➔ Document how the task will be changed / accomplished. Include plans for smooth hand-offs and communication methods.
  - ➔ Document when a task is completed, in terms of patient flow (e.g., intake, initial assessment). If a task will be constrained by certain days of the week (e.g., a prescriber is only available on a certain day, or data will be entered into a registry only on certain days), indicate this.
  - ➔ Document where the task will be completed. At the clinic? At a partner agency? Through an external referral?
  - ➔ For each main category of collaborative care tasks (e.g., Identify/ Screen/ Diagnose Depression, Anxiety, & Substance Abuse), consider if there are organizational-level changes necessary for these plans. Staff training needs? Staff hires? Other needs? Additional supervision?
  - ➔ What is the implementation timeline for each of the main categories of collaborative care tasks? Note any relevant information in the appropriate section.

#### STEP 4: Generate an Implementation Plan and Timeline Tailored to Your Practice

- Create a quality improvement action plan with designated champions / sponsors, process owners, and a detailed timeline.
- Create materials to introduce the Integrated Care Team to patients.
- Create clinic-specific protocols for:
  - ➔ Psychiatric Emergencies (e.g., what to do if a suicidal patient presents in clinic).
  - ➔ Communication among team members (e.g., how will you ensure that recommendations from psychiatric consultants are effectively communicated to the primary care provider).
- Identify gaps and duplication in tasks by examining the completed worksheet. Identify opportunities to make processes more efficient. Think about ways to collaborate effectively and discuss critical communication and ‘handoff’ steps.
- Think about if and where changes are needed.

#### STEP 5: Track Program Outcomes and Adjust as Necessary

Revisit the Summary & Change Plan regularly (e.g., monthly) to review progress and make adjustments in the program as needed to achieve desired results. Focus reviews on:

- ➔ Number of clients served in the integrated program.
- ➔ Number and percent of clients who show clinical improvement as measured at the client level.
- ➔ Number and proportion of clients who receive initial assessments, follow-up assessments, and psychiatric consultation if they are not improving as expected.