Integrated Behavioral Health Care Team Building Process

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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:

1. Is the task part of the individual's role now?
2. If not part of the individual's role now, whose role is it?
3. What is the organization's capacity with regards to this task?
4. What is the individual's comfort level with this task? (respondents should answer even if they are not currently doing this task)
5. Would the individual like training to learn or improve their capacity to perform this task?
6. 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.**

STEP 1: Staff Self-assesment

Conditions for which you plan to provide clinical care (select all that apply)

☐ Depression
☐ Anxiety (e.g. PTSD)
☐ Substance Abuse
☐ Other Mental Disorders
_____

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Integrated Care Tasks

Integrated Care Tasks	Is This Your Role Now?		If No, Whose Role?	Your Organization's Capacity with This Task?		Your Level of Comfort with This Task		Would You Like Training to Perform This Task?	
Identify and Engage Patients	**Yes**	**No**	**Write in position title**	**High**	**Med/Low**	**High**	**Med/Low**	**Yes**	**No**
Identify People Who May Need Help	☐	☐		☐	☐	☐	☐	☐	☐
Screen for Behavioral Health Problems Using Valid Measures	☐	☐		☐	☐	☐	☐	☐	☐
Diagnose Behavioral Health Disorders	☐	☐		☐	☐	☐	☐	☐	☐
Engage Patient in Integrated Care Program	☐	☐		☐	☐	☐	☐	☐	☐
Initiate and Provide Treatment	**Yes**	**No**		**High**	**Med/Low**	**High**	**Med/Low**	**Yes**	**No**
Perform Behavioral Health Assessment	☐	☐		☐	☐	☐	☐	☐	☐
Develop & Update Behavioral Health Treatment Plan	☐	☐		☐	☐	☐	☐	☐	☐
Patient Education about Symptoms & Treatment Options	☐	☐		☐	☐	☐	☐	☐	☐
Prescribe Psychotropic Medications	☐	☐		☐	☐	☐	☐	☐	☐
Patient Education about Medications & Side Effects	☐	☐		☐	☐	☐	☐	☐	☐
Brief Counseling, Activity Scheduling, Behavioral Activation	☐	☐		☐	☐	☐	☐	☐	☐
Evidence-based Psychotherapy (e.g., PST, CBT, IPT)	☐	☐		☐	☐	☐	☐	☐	☐
Identify & Treat Coexisting Medical Conditions	☐	☐		☐	☐	☐	☐	☐	☐
Facilitate Referral to Specialty Care or Social Services	☐	☐		☐	☐	☐	☐	☐	☐
Create & Support Relapse Prevention Plan	☐	☐		☐	☐	☐	☐	☐	☐
Track Treatment Outcomes	**Yes**	**No**		**High**	**Med/Low**	**High**	**Med/Low**	**Yes**	**No**
Track Treatment Engagement & Adherence using Registry	☐	☐		☐	☐	☐	☐	☐	☐
Reach out to Patients who are Non-adherent or Disengaged	☐	☐		☐	☐	☐	☐	☐	☐
Track Patients' Symptoms with Measurement Tool (e.g., PHQ-9)	☐	☐		☐	☐	☐	☐	☐	☐
Track Medication Side Effects & Concerns	☐	☐		☐	☐	☐	☐	☐	☐
Track Outcome of Referrals & Other Treatments	☐	☐		☐	☐	☐	☐	☐	☐
Proactively Adjust Treatment if Patients are Not Responding	**Yes**	**No**		**High**	**Med/Low**	**High**	**Med/Low**	**Yes**	**No**
Assess Need for Changes in Treatment	☐	☐		☐	☐	☐	☐	☐	☐
Facilitate Changes in Treatment / Treatment Plan	☐	☐		☐	☐	☐	☐	☐	☐
Provide Caseload-Focused Psychiatric Consultation	☐	☐		☐	☐	☐	☐	☐	☐
Provide In-Person Psychiatric Assessment of Challenging Patients	☐	☐		☐	☐	☐	☐	☐	☐
Other Tasks Important for Our Program (add tasks as needed)	**Yes**	**No**		**High**	**Med/Low**	**High**	**Med/Low**	**Yes**	**No**
Coordinate Communication Among Team Members / Providers	☐	☐		☐	☐	☐	☐	☐	☐
Administrative Support for Program (e.g., Scheduling, Resources)	☐	☐		☐	☐	☐	☐	☐	☐
Clinical Supervision for Program	☐	☐		☐	☐	☐	☐	☐	☐
Training of Team Members in Behavioral Health	☐	☐		☐	☐	☐	☐	☐	☐

STEP 2: AIMS TEAM BUILDING Task Summary by Staff

INTEGRATED CARE TASKS PLEASE MARK AN X BELOW WHERE APPROPRIATE	STAFF 1	STAFF 2	STAFF 3	STAFF 4	STAFF 5	STAFF 6	STAFF 7	PARTNER AGENCY	REFERRAL	TOTAL #	CHANGES NEEDED
NAME:											
ROLE/TITLE:											
Identify and Engage Patients											
Identify People Who May Need Help	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Screen for Behavioral Health Problems Using Valid Measures	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Diagnose Behavioral Health Disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Engage Patient in Integrated Care Program	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Initiate and Provide Treatment											
Perform Behavioral Health Assessment	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Develop & Update Behavioral Health Treatment Plan	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Patient Education about Symptoms & Treatment Options	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Prescribe Psychotropic Medications	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Patient Education about Medications & Side Effects	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Brief Counseling, Activity Scheduling, Behavioral Activation	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Evidence-based Psychotherapy (e.g., PST, CBT, IPT)	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Identify & Treat Coexisting Medical Conditions	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Facilitate Referral to Specialty Care or Social Services	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Create & Support Relapse Prevention Plan	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Track Treatment Outcomes											
Track Treatment Engagement & Adherence using Registry	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Reach out to Patients who are Non-adherent or Disengaged	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Track Patients' Symptoms with Measurement Tool (e.g., PHQ-9)	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Track Medication Side Effects & Concerns	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Track Outcome of Referrals & Other Treatments	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Proactively Adjust Treatment if Patients are Not Responding											
Assess Need for Changes in Treatment	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Facilitate Changes in Treatment / Treatment Plan	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Provide Caseload-Focused Psychiatric Consultation	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Provide In-Person Psychiatric Assessment of Challenging Patients	☐	☐	☐	☐	☐	☐	☐	☐	☐		

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INTEGRATED CARE TASKS PLEASE MARK AN X BELOW WHERE APPROPRIATE	STAFF 1	STAFF 2	STAFF 3	STAFF 4	STAFF 5	STAFF 6	STAFF 7	PARTNER AGENCY	REFERRAL	TOTAL #	CHANGES NEEDED
NAME:											
ROLE/TITLE:											
Other Tasks Important for Our Program (add as needed)											
Coordinate Communication Among Team Members / Providers	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Administrative Support for Program (e.g., Scheduling, Resources)	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Clinical Supervision for Program	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Training of Team Members in Behavioral Health	☐	☐	☐	☐	☐	☐	☐	☐	☐		
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	☐	☐	☐	☐	☐	☐	☐	☐	☐		
	☐	☐	☐	☐	☐	☐	☐	☐	☐		
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	☐	☐	☐	☐	☐	☐	☐	☐	☐		

Notes for Discussion

STEP 3: AIMS TEAM BUILDING Summary & Change Plan

IDENTIFY AND ENGAGE PATIENTS				
INTEGRATED CARE TASKS	**WHO** Name / Discipline	**HOW** Process (Including Hand-offs) & Communication Methods (e.g., telephone, mail)	**WHEN**	**WHERE**
Identify People Who May Need Help				
Screen for Behavioral Health Problems Using Valid Measures				
Diagnose Behavioral Health Disorders				
Engage Patient in Integrated Care Program				
Needs for Implementation ☐ Staff Hires ☐ Staff Training ☐ Clinical Supervision ☐ Administrative Supervision ☐ Other Resources needed	Notes:			
Timeline:				

INITIATE AND PROVIDE TREATMENT				
INTEGRATED CARE TASKS	**WHO** Name / Discipline	**HOW** Process (Including Hand-offs) & Communication Methods (e.g., telephone, mail)	**WHEN**	**WHERE**
Perform Behavioral Health Assessment				
Develop & Update Behavioral Health Treatment Plan				
Patient Education about Symptoms & Treatment Options				
Prescribe Psychotropic Medications				
Patient Education about Medications & Side Effects				
Brief Counseling, Activity Scheduling, Behavioral Activation				
Needs for Implementation ☐ Staff Hires ☐ Staff Training ☐ Clinical Supervision ☐ Administrative Supervision ☐ Other Resources needed	Notes:			
Timeline:				

INITIATE AND PROVIDE TREATMENT (Continued)				
INTEGRATED CARE TASKS	**WHO** Name / Discipline	**HOW** Process (Including Hand-offs) & Communication Methods (e.g., telephone, mail)	**WHEN**	**WHERE**
Evidence-based Psychotherapy (e.g., PST, CBT, IPT)				
Identify & Treat Coexisting Medical Conditions				
Facilitate Referral to Specialty Care or Social Services				
Create & Support Relapse Prevention Plan				
Needs for Implementation ☐ Staff Hires ☐ Staff Training ☐ Clinical Supervision ☐ Administrative Supervision ☐ Other Resources needed	Notes:			
Timeline:				

TRACK TREATMENT OUTCOMES				
INTEGRATED CARE TASKS	**WHO** Name / Discipline	**HOW** Process (Including Hand-offs) & Communication Methods (e.g., telephone, mail)	**WHEN**	**WHERE**
Track Treatment Engagement & Adherence using Registry				
Reach out to Patients who are Non-adherent or Disengaged				
Track Patients' Symptoms with Measurement Tool (e.g., PHQ-9)				
Track Medication Side Effects & Concerns				
Track Outcome of Referrals & Other Treatments				
Needs for Implementation ☐ Staff Hires ☐ Staff Training ☐ Clinical Supervision ☐ Administrative Supervision ☐ Other Resources needed	Notes:			
Timeline:				

PROACTIVELY ADJUST TREATMENT IF PATIENTS ARE NOT RESPONDING				
INTEGRATED CARE TASKS	**WHO** Name / Discipline	**HOW** Process (Including Hand-offs) & Communication Methods (e.g., telephone, mail)	**WHEN**	**WHERE**
Assess Need for Changes in Treatment				
Facilitate Changes in Treatment / Treatment Plan				
Provide Caseload-Focused Psychiatric Consultation				
Provide In-Person Psychiatric Assessment of Challenging Patients				
Needs for Implementation ☐ Staff Hires ☐ Staff Training ☐ Clinical Supervision ☐ Administrative Supervision ☐ Other Resources needed	Notes:			
Timeline:				

OTHER TASKS IMPORTANT FOR OUR PROGRAM (ADD AS NEEDED)				
INTEGRATED CARE TASKS	**WHO** Name / Discipline	**HOW** Process (Including Hand-offs) & Communication Methods (e.g., telephone, mail)	**WHEN**	**WHERE**
Coordinate Communication Among Team Members / Providers				
Administrative Support for Program (e.g., Scheduling, Resources)				
Clinical Supervision for Program				
Training of Team Members in Behavioral Health				
Needs for Implementation ☐ Staff Hires ☐ Staff Training ☐ Clinical Supervision ☐ Administrative Supervision ☐ Other Resources needed	Notes:			
Timeline:				

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Introducing the Care Management Team and the Integrated Care Model

This is a template that you can use to introduce your integrated care team to patients. You may combine this with other educational pieces you regularly distribute to patients, or you may create a single document that meets all your needs.

The template includes placeholders for photographs of your team members and their contact information.

We recommend that you customize this template to meet your clinic's needs. Below are some suggestions:

- **Add other staff as appropriate to your clinical operation (e.g., case managers, clinical psychologists).**
- **Add team members' names and pictures.**
- **Include a brief overview of the approach your clinic uses for behavioral health care.**

Your Integrated Care Team

You

What is the patient's role?

You are the most important person on the team! You will get the best care if you participate actively with your primary care provider (PCP) and your care manager (CM). Tell them what is working for you and what is not. Work with your team to track your progress using a simple checklist. Let them know if you have questions or concerns about your care. If you take medication, know what it is and take it as prescribed.

[photo here]

First Name, Last Name, MD

What is the primary care provider's role?

The Primary Care Provider oversees all aspects of your care at the clinic.

He or she will work closely with the other members of the care team to make sure you get the best care possible. The PCP will make and / or confirm your diagnosis and may write or refill prescriptions for medications. The PCP works closely with your care manager to stay informed about your treatment progress. The PCP may also consult with the team psychiatrist if there are questions about the best treatments for you.

[photo here]

First Name, Last Name
206.555.1212
name@domain.com

What is the care manager's role?

The CM (care manager) works closely with you and the PCP to implement a treatment plan. The CM answers questions about your treatment. He or she will check-in with you to keep track of your treatment progress and can help identify side effects if you are taking medications. The PCP and the CM work together with you if a change in your treatment is needed. The CM may also provide counseling or refer you for counseling if that is part of your treatment plan.

[photo here]

First Name, Last Name, MD

What is the psychiatric consultant's role?

The psychiatric consultant is an expert consultant to the PCP and the CM. The team psychiatrist is available to advise your care team about diagnostic questions or treatment options, especially if you don't improve with your initial treatment. The CM meets and consults regularly with the consultant to talk about the progress of patients in the program and to think about treatment options. With your permission, the psychiatric consultant may meet with you in person or via telemedicine to help inform your care.