SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

Building High Performing Multi-Disciplinary Teams

SAMHSA MAI CoC Grantee Virtual Meeting
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Objectives

• Assess the main characteristics of high-performing teams for HIV Primary Care
  
  • Establish quality improvement strategies for practice-based learning.
  
  • Define collaborative care planning and coordination.
  
  • Describe ways to implement collaboration and teamwork for integrated care.

  • Review factors that inhibit and enhance interpersonal communication.

• **Bonus!** Learn about adaptive change for team success
What is a High-Performing Team?
Four Core Competencies for Integrated Teams

1. Practice-Based Learning & Quality Improvement
2. Care Planning & Coordination
3. Collaboration & Teamwork
4. Interpersonal Communication

www.integration.samhsa.gov/workforce/core-competencies-for-integrated-care
1. Practice-Based Learning and Quality Improvement

- Vision
- Goals
- Small tests of change
- Policies & procedures
- Sustainability

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Setting the Vision

• A mission and/or vision are critical, especially in times of change

• Leaders may set the vision, but soon the team members should integrate – work for shift in culture

• All members should resonate with mission/vision

• Work backwards and align goals with organizational mission but also with model that ensures sustainability
Defining Team Goals

• Develop a team dashboard that includes measurable, and meaningful/relevant goals
• The goals must relate to broader organizational goals
• Tie the goals to a quality improvement/PDSA process
• Incorporate discussion of the goals into every meeting
1. What are we trying to accomplish?

2. How will we know that a change is an improvement?

3. What change can we make that will result in improvement?
Engagement & retention in care

- HIV care
- MH
- SUD
- Hepatitis screening and referral
2. Care Planning & Coordination

- Type & intensity of services matched to needs
- Linked services between HIV, SUD, MH
- Information exchange
- Integrated care plans
- Warm handoffs
- Prioritized treatment goals - who decides?
The Four Quadrant Clinical Integration Model

**Quadrant II**
BH ↑  PH ↓
- BH Case Manager w/ responsibility for coordination w/ PCP
- PCP (with standard screening tools and BH practice guidelines)
- Specialty BH
- Residential BH
- Crisis/ER
- Behavioral Health IP
- Other community supports

**Quadrant IV**
BH ↑  PH ↑
- PCP (with standard screening tools and BH practice guidelines)
- BH Case Manager w/ responsibility for coordination w/ PCP and Disease Mgr
- Care/Disease Manager
- Specialty medical/surgical
- Specialty BH
- Residential BH
- Crisis/ER
- BH and medical/surgical IP
- Other community supports

**Quadrant I**
BH ↓  PH ↓
- PCP (with standard screening tools and BH practice guidelines)
- PCP-based BH*

**Quadrant III**
BH ↓  PH ↑
- PCP (with standard screening tools and BH practice guidelines)
- Care/Disease Manager
- Specialty medical/surgical
- PCP-based BH (or in specific specialties)*
- ER
- Medical/surgical IP
- SNF/home based care
- Other community supports

*PCP-based BH provider might work for the PCP organization, a specialty BH provider, or as an individual practitioner, is competent in both MH and SA assessment and treatment.

Stable SMI would be served in either setting. Plan for and deliver services based upon the needs of the individual, consumer choice and the specifics of the community and collaboration.
# Standard Framework for Integration

<table>
<thead>
<tr>
<th>Referral</th>
<th>Co-Located</th>
<th>Integrated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key Element:</strong> Communication</td>
<td><strong>Key Element:</strong> Physical Proximity</td>
<td><strong>Key Element:</strong> Practice Change</td>
</tr>
<tr>
<td><strong>Level 1</strong> Minimal Collaboration</td>
<td><strong>Level 3</strong> Basic Collaboration On-Site</td>
<td><strong>Level 5</strong> Close Collaboration Approaching an Integrated Practice</td>
</tr>
<tr>
<td><strong>Level 2</strong> Basic Collaboration at a Distance</td>
<td><strong>Level 4</strong> Close Collaboration On-Site with Some System Integration</td>
<td><strong>Level 6</strong> Full Collaboration in a Transformed/Merged Integrated Practice</td>
</tr>
</tbody>
</table>

**Behavioral health, primary care and others work:**

- In separate facilities.
- In separate facilities.
- In same facility not necessarily same offices.
- In same space within the same facility.
- In same space within the same facility (some shared space).
- In same space within the same facility, sharing all practice space.
# Poll Question

How would you rate your agency’s current level of integration?

<table>
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3. Collaboration & Teamwork

- Clarity of roles/tasks
- Huddles
- Handoffs
- Shared-decision making
Clear Role Expectations

- The more complex the task the clearer roles must be.
- Role ambiguity and conflict should be discussed right away.
- Routinely, clearly state who “owns” or is “responsible” for a task to help foster this thinking.
# Worksheet Example

<table>
<thead>
<tr>
<th>Your role?</th>
<th>Who’s role?</th>
<th>Training and/or support needs for role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening for substance use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication reconciliation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using motivational Interviewing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other tasks…</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Success Strategies

- Cross-train
- Periodically readjust / revise
- Planning meetings vs. “work” meetings
- Create redundancy
- Create contingency plans

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4. Interpersonal Communication

- Trust
- Shared understanding and accountability
- Decision making
A team is a problem-solving, decision-making mechanism. This is not to imply that an entire group must always make all decisions as a group.

The issue is one of relevance and appropriateness; who has the relevant information and who will have to implement the decision.
Teams can choose from a range of decision-making mechanisms, including:

1. Decision by default (lack of group response)
2. Unilateral decision (authority rule)
3. Majority vote
4. Consensus
5. Unanimity
Bonus!

Technical vs. Adaptive Change

- Problem is well defined
- Answer can be found within present structure
- Implementation is clear
- Mechanic = Fix

- Challenge is complex
- Need to address deeply held beliefs and values
- Loss is inherent part of the process
- Organic = Grow
Teams with greater occupational diversity reported higher overall effectiveness and the innovations introduced by these teams were more radical and had significantly more impact both on the organization and on patient care.

PCMH Teams & Adaptive Reserve

“Transformation occurs not at a steady & predictable pace, but in fits & starts.”

Adaptive Reserve: A practice’s ability to make and sustain change.

- Shared vision of how care teams affect the patient experience
- Requires shifts in the ways people think about and understand their roles
- Requires individuals or groups to adopt different mental models of their work

Theory U
Otto Sharmer, PhD, MIT, 2007

Problem

Focus

Broadening

Deepening

Solution

Creativity, New structures

Creativity, New processes

Creativity, new thinking

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Team Care & Persistence

- Recognize teams are dynamic, emotion laden, and need constant attention and reassurance
- Hardwire rewards into the work flows
- Be careful to hire team members, not positions
- Get in the habit of monitoring and responding to changes in morale/trust
Questions? Comments!

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