ESSENTIAL ELEMENTS OF EFFECTIVE INTEGRATED PRIMARY CARE AND BEHAVIORAL HEALTH TEAMS

SAMHSA-HRSA CENTER FOR INTEGRATED HEALTH SOLUTIONS

The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings. CIHS is the first "national home" for information, experts, and other resources dedicated to bidirectional integration of behavioral health and primary care.

Jointly funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA), and run by the National Council for Behavioral Health, CIHS provides training and technical assistance to community behavioral health organizations that received SAMHSA Primary and Behavioral Health Care Integration grants, as well as to community health centers and other primary care and behavioral health organizations.

CIHS' wide array of training and technical assistance helps improve the effectiveness, efficiency, and sustainability of integrated services, which ultimately improves the health and wellness of individuals living with behavioral health disorders.

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EXECUTIVE SUMMARY

As a result of the Affordable Care Act and a focus on achieving the triple aim of improved health, improved healthcare, and lower costs, healthcare is experiencing a paradigm shift from individual to team-based care focused on the patient. The integration of primary care and behavioral health is exemplary of this kind of innovative team approach. Fostering successful collaboration that leads to a shared treatment approach is complex due to the cultural and clinical differences between primary and behavioral health providers. Collaboration among these providers and a team approach to care has proven powerful. A wide variety of professionals comprises an effective integrated behavioral health and primary care team. These include, but are not limited to, psychiatrists, physicians, nurse practitioners, social workers, psychologists, addiction counselors, care managers, community health workers, peers, medical assistants, nurse aides, and representatives from community agencies who participate either in person or via remote technology. Developing a strong, effective integrated behavioral health and primary care team is vital and requires a clear understanding of the essential elements of integrated care team development.

This review is an initial exploration of team development within effective integrated primary and behavioral healthcare teams. Six integrated teams in safety net primary care settings were interviewed on the development of the clinical team. The study identifies four essential elements for effective integrated behavioral health and primary care teams and provides a roadmap for organizations designing their own teams, using examples from these best practices.

Leadership and Organizational Commitment: Integrated teams describe the vital importance of senior leadership and organizational commitment to the philosophy of integrated care. The clear vision and commitment to an innovative model of care was foundational for the development of the team. Specific leadership qualities noted by teams include the ability to span boundaries, buffer teams from stressors, take risks, create clear vision, and focus on providing the right care at the right time.

Team Development

The real work of fostering a strong integrated team is done through both formal and informal team development. The initial stages of integrated behavioral health and primary care team development include creating a shared vision and developing team values such as embracing a nonhierarchical team structure. Formal team development addresses concepts such as fostering strong team relationships, hiring the right providers, creating clear roles and responsibilities, and cross-training providers. Because primary care and behavioral health still have separate funding systems, regulations, and standards, another central area of team development unique to integrated care is developing the systems and providing operational support for integrated treatment.

Team Process

One of the most essential aspects of team-based care is effective communication among providers. Integrated care teams describe using three types of communication: clinical case review, day-to-day operational communication, and process communication. In addition, the teams describe the importance of continued reassessment of their team-based care process. The act of stepping back and making sure that the care and process are occurring as designed is an important aspect of delivering team-based treatment and maintaining a team.

Team Outcomes

Effective integrated care teams identify clear patient outcomes that they work to achieve. Teams identify outcomes as key to guiding a shared treatment approach as well as reducing conflict among providers.

INTRODUCTION TO PROJECT

The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) is a collaborative partnership designed to promote the development of bi-directional integrated primary and behavioral healthcare services. CIHS is funded jointly by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA), and managed by the National Council for Behavioral Health. CIHS provides training and technical assistance to organizations implementing and delivering integrated care, including the Primary and Behavioral Health Care Integration (PBHCI) grantees and HRSA-funded community health centers.

HRSA has a long-standing commitment to multidisciplinary team capacity and development; this project was a natural extension of this commitment. There is broad recognition of the importance of the team in this model of care. However, there is minimal information on how to develop effective behavioral health and primary care teams or what is needed for organizations starting teams. The goal of this project was to provide an initial identification of the essential elements of integrated care teams.

The interviews concentrated on HRSA safety net providers and included two federally qualified health centers, two Ryan White clinics, and two rural health clinics. Teams were selected for their outstanding performance in integrated care or for specific lessons learned in implementing behavioral health and primary care integrated care teams. Providers also shared barriers they encountered in trying to initiate an effective integrated multidisciplinary team.

Integrated Primary and Behavioral Healthcare Defined

A 2013 report from the Agency for Healthcare Research and Quality (AHRQ) describes integrated care as, "the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population."[1] These multidisciplinary teams may include: physicians, physician assistants, nurse practitioners, nurses, medical assistants, licensed clinical social workers, psychologists, and other bachelor-level providers. The exact combination of providers depends on the healthcare setting, the model design, and the desired functions of team members. In integrated primary and behavioral healthcare, the function of the provider is often more important than the discipline. For example, both a nurse and a case manager can function as a care coordinator. However, all of these teams include the integration of primary care and behavioral health professionals.

The setting for integrated primary care and behavioral health can vary from a private practice primary care clinic to a publically funded safety net provider. The model is designed to improve care for a number of populations. Patients typically seen in primary care settings benefit from behavioral health providers' expertise in behavior change to address chronic disease management, as well as the treatment of co-occurring behavioral health disorders such as depression, anxiety, and substance use. Patients with more significant behavioral health disorders benefit from an integrated and well-coordinated treatment approach that includes physical health, which can balance co-occurring and often co-morbid physical and behavioral health disorders.

Throughout this document, "integrated care" is used to describe teams integrating primary care and behavioral health through a collaborative team approach. These teams can be situated in a primary care setting, a behavioral health setting or they can be virtual teams tied together using technology such as telemedicine.

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[1] Peek CJ and the National Integration Academy Council. Lexicon for behavioral health and primary care integration: concepts and definitions developed by expert consensus. AHRQ Publication No.13-IP001-EF. Rockville, MD: *Agency for Healthcare Research and Quality.* 2013. Available at: http://integrationacademy.ahrq. gov/sites/default/files/Lexicon.pdf.

This document shares these providers' valuable insights, knowledge, and lessons learned with those looking to create or further develop integrated behavioral health and primary care teams, as well as to help identify barriers to effective team development. Site-specific information is included to provide rich examples of how integrated care teams address barriers to the model and implement practical solutions. Therefore, the primary focus remains on lessons shared by the integrated teams included in this project and the overarching themes that emerged, suggesting the essential elements of a collaborative care team. Although relevant research on team effectiveness is included to connect case studies to the evidence base, the purpose of this paper is not an exhaustive review of the extensive literature on team development. *The purpose is to identify the essential elements that have helped organizations successfully integrate behavioral health and primary care.*

The organizations interviewed include:

Federally Qualified Health Centers
Cherry Street Health Services — Grand Rapids, Michigan
Marana Health Center — Tucson, Arizona

Ryan White Clinics
University of Florida Center for HIV/AIDS, Research, Education and Service (UF CARES) — Jacksonville, Florida
Tri-County Community Health Council Inc., dba CommWell Health — Dunn, North Carolina

Rural Health Clinics[2]
California
North Carolina

Some of these teams are new, while others are well established and have worked on their team development for years. Although many of these sites integrated behavioral health into primary care, there are examples of effective teams in which primary care is integrated into behavioral health within the same organization. While specific differences may exist in implementation of collaborative care depending on the "direction" of integration, this project indicates that the process of team development is largely the same across collaborative care models. Case studies and examples are included throughout the document.

[2]Both rural health clinics chose to remain anonymous due to the challenges they described. Although the two sites with challenges were both from the same type of clinic, there is no reason to believe that this means integrated care is less successful in rural health clinics.

IMPORTANCE OF TEAM-BASED HEALTHCARE

The focus on team-based care in healthcare is beginning to change not simply the practice, but the conceptualization of healthcare, including educational models. As noted in a report from the Interprofessional Education Collaborative, "The time is right. Our resources are limited, and it's our obligation to determine and apply our health resources as effectively and robustly as possible in ways that produce better care outcomes for patients. As the health care community is looking for new strategies, and new ways of organizing to optimize our efforts — teamwork is fundamental to the conversation."[3] In addition, the Affordable Care Act encourages coordinated and collaborative models of treatment with greater emphasis on prevention and early intervention. Increased collaboration between multidisciplinary providers is viewed as essential to improved outcomes, improved quality, cost efficiency, treatment adherence, reduction of errors in healthcare and improved patient experience.

This kind of collaboration requires significant changes to how providers practice, interact, and perceive their relationships to other healthcare providers. In a recent paper, the Institute of Medicine (IOM) described the concept of transdisciplinary professionalism as "an approach to creating and carrying out a shared social contract that ensures multiple health disciplines, working in concert, are worthy of the trust of patients and the public."[4] This highlights the need for providers to change their focus from a "sole provider" mentality to being team members with a team-based approach to care.

On the frontlines of health delivery, this collaboration is occurring largely through team-based care: "The high-performing team is now widely recognized as an essential tool for constructing a more patient-centered, coordinated, and effective health care delivery system."[5] Increasing evidence indicates this model of care is effective; however, there is also growing anecdotal evidence that that providers adopt the language of the setting in which care is delivered. To the extent to which such language is unacceptable to providers, they are encouraged to educate others within their team and setting about their rationale for using alternative language.

Within this document, the term *behavioral health* is used to refer to mental health and addictions. Behavioral health is distinguished from "general health," recognizing the imperfections in the distinction and the language used to describe it. Behavioral health is also distinct from healthy or health behavior. Unless otherwise noted, the term *health conditions* refers to all health conditions and is not specific to behavioral health.

What Makes an Integrated Behavioral Health and Primary Care Team Effective?

This is not a simple question. Hundreds of research articles have been published on effective teams.[6] Multiple professions, including business, psychology, organizational development, sports, and outdoor education, have studied teams to determine what makes them work. Based on this literature, a team is defined as "a collection of individuals who are interdependent in their tasks, who share responsibility for outcomes, who see themselves and who are seen by others as an intact social entity embedded in one or more larger social system (for example, business unit or the corporation), and who manage their relationships across organizational boundaries."

An important question is whether previous definitions of "team" adequately describe integrated care teams with members who may have more blended roles than a traditional team. As previously noted, one such definition of integrated care is "the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population."[7] In integrated care, it is less about each member playing a specific role and more about the interconnectedness of interventions to address the whole person. This distinction strikes at one of the unique aspects of integrated behavioral health and primary care teams and a hypothesis still to be determined: is the team actually the treatment to a large degree? The effectiveness of the team and the degree of collaboration and synergy between team members may actually be what makes the treatment successful. In that case, the team becomes an essential ingredient rather than simply a means to an end.

So how does one define an effective integrated care team? An initial conceptualization may be a group of multidisciplinary providers working together with the patient using a shared treatment approach and assisting the patient to achieve specific physical and behavioral health outcomes. This definition will be the working definition used throughout the document. Other features of "effectiveness" may include the team embracing responsibility for a shared population or community, team members identifying their role in providing care as part of a team, and the team successfully providing the model of collaborative care as it was designed.

[4]The Interprofessional Education Collaborative (IPEC). (2011). *Team Based Competencies: Building a Shared Foundation for Education and Clinical Practice.* Conference proceedings.

[5]American Board of Medical Specialties. (2013). ABMS professionalism definition. In Institute of Medicine (IOM). (2013) *Establishing transdisciplinary professionalism for improving health outcomes: Workshop summary.* Washington, DC: The National Academies Press. p, 1-1.

[6]Mitchell, P., M. Wynia, R. Golden, B. McNellis, S. Okun, C.E. Webb, V. Rohrbach, & I. Von Kohorn. (2012). *Core principles & values of effective team-based health care.* Discussion Paper, Institute of Medicine, Washington, DC. www.iom.edu/tbc. P.5.

[6]Cohen, S.G. & Bailey, D.E. (1997). What makes teams work: group effectiveness research from the shop floor to the executive suite. *Journal of Management*, 23(3), 239-290.

[7]Peek CJ and the National Integration Academy Council. Lexicon for behavioral health and primary care integration: concepts and definitions developed by expert consensus. AHRQ Publication No.13-IP001-EF. Rockville, MD: *Agency for Healthcare Research and Quality.* 2013. Available at: http://integrationacademy.ahrq.gov/lexicon.

Integrated Care May Require Unique Team Development

Due to the unique features of integrated care teams, there may be additional complexities to team development that require innovation. One such theme is the cultural shifts that must occur for providers and their organizations as additional treatment areas (medical or behavioral health) are added. Primary care and behavioral health providers have different educational backgrounds and different models of practice. The cultural shifts needed to integrate these differences are both conceptual and practical. The language providers use, the workflow, how cases are conceptualized, and how treatment goals are prioritized are all areas that require cultural shifts and integration by providers. In addition to the specific language used, the process of communication often changes and requires practice. For example, behavioral health providers can and do learn to describe a case to a primary care provider within minutes rather than writing extensive case notes. Primary care providers also learn the language of behavioral health and incorporate it in their approach to patient care.

The importance of healthcare funding and regulations are other features that require innovation by teams. Although the model of care has become more collaborative, the funding, regulations, and operational components of healthcare remain largely unchanged. Organizations engaged in integrated care must then develop systems that translate the integrated clinical approach back into discrete services. Often organizations are creating secondary system teams to support the clinical team. The need for this parallel system development was a common theme and presents a significant challenge to collaborative care. These secondary systems provide a mechanism for the organization to deal with the administrative complexities of integrated behavioral health and primary care separate and apart from clinical integration issues.

Although each team in this project responded to these challenges with individualized solutions, there were surprisingly similar themes discussed across the groups. The essential elements of these teams are outlined in four main categories: leadership and organization commitment; team development; team process; and team outcomes. Underlying themes of each essential element are explored and specific examples provided to bring the process of team building to life in the context of caring for patients that may have complex behavioral health and primary care needs.

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ESSENTIAL ELEMENTS

Leadership and Organization Commitment

Integrated care teams are not created in a vacuum. The foundation for the team is the organization in which it resides. Development of a quality team requires careful design and construction by the leadership and organization. Wheelan (2013) emphasizes the need for greater attention to the organization's role in creating effective teams.[8] When leaders fail to commit the broader organization to the team's development, the model either does not fully form or is not sustained.

Every interviewee contacted for this project spoke to the importance of organizational commitment to an integrated model and strong senior leadership focused on the team. Statements such as, "you have to have leadership buy-in at the top to make this work" were common. A number of themes were evident as each team described the contributions of their leaders.

Commitment to the Philosophy of Integrated Care

The interviewed teams described leaders who clearly understood the need for a new approach to care and who were committed to a vision of whole person-centered care. Specific visions differed between organizations. However, all organizations consistently discussed a commitment to treating the whole person using a multidisciplinary team of providers who addressed medical and behavioral healthcare needs. The teams indicated that a clear vision became an anchor for decision-making.

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[8]Wheelan, S.A. (2013). *Creating Effective Teams: A guide for members and leaders*, 4th Edition. Sage Publications.

Because these leaders were committed to this philosophy of care, they understood the importance of an effective team. Team members described leaders who were willing to allocate resources to facilitate the developmental process, including the time needed for cultural shifts, changes to practice, and team process. Some teams described periods of development in which it was understood that non-billable hours were valuable for the long-term model despite the short-term hardships. Team members viewed this as essential foresight by leaders in building an effective team and subsequently an effective model.

This commitment, foresight, or allocation of resources came with consequences. Executive leadership who participated in interviews articulated the financial challenges in allowing teams to spend significant amounts of non-billable time building an effective team. These leaders were clear that it had to be a commitment in phases, meaning that the quantity of time that teams spent in development needed to decrease over time with an eventual (sooner than later) return under an integrated model to more billable hours than non-billable hours.

Perhaps these leaders had unique patience, as another theme identified was that they had tried integrated care previously and described "failed experiments" or lessons learned. It was striking how often clinical leadership worked towards an integrated model for long periods (some for decades) and, as a result, they had a deep appreciation for the challenges of creating an effective team.

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CASE STUDY EXAMPLES

Cherry Street Health Services — The CEO described 10 years of work to get to the present moment. He described a "failed experiment" seven years ago that occurred in the same organization. The organization had the absolute need to co-locate; however, they were not able to work through the cultural issues between primary and behavioral health practices: "[We] learned a lot in the experiment."

For the current team, the integrated development team members spent 4-6 hours a week on developing the model (a subsequent section details this developmental process).

CommWell Health — Leadership used a strategy meeting parallel to the clinical team meeting to develop the model and oversee team development (greater description provided in a subsequent section). A senior leader stated, "These strategy sessions involving senior leadership will be running concurrently for as long as needed. [We] see it as a think tank and use PDSA (Plan Do Study Act) cycles to resolve issues."

Marana Health Center — The Chief of Behavioral Health Services described a strong commitment to integrated care from leadership going back 15-20 years. The organization provided integrated care as a small rural provider 20 years ago and has remained committed to the model conceptually.

Without Leadership — In addition to the examples of exemplary leadership and organizational commitment, there were two sites who described a lack of leadership and organizational commitment that resulted in less successful model development. A rural North Carolina health clinic described the loss of their entire integrated programming because of a lack of organizational commitment and a board that had not ultimately committed to an integrated care model.

In a second rural health clinic based in California, the integrated model remains stagnant and has struggled to advance because of limited organizational support and vision. The providers described the development of a team and a more holistic model of care as limited without the organizational vision to guide the process and to support the changes required for advancing the clinical model. For example, some physicians do not attend the team meeting and this limits the development of collaborative care and the team process. In addition, there are minimal organizational resources for development of the model and no time provided to develop the team. Maintaining the status quo and addressing current patient care needs takes precedence over the integrated team development. Two areas in which the providers believed leadership commitment could have immediate impact included requiring all medical providers to attend team meetings and providing time to conduct cross training between team members..

Motivation

Another theme was the heart of the organization. Effective teams articulated that the organization committed to delivering "the right care" for the population served despite the reality that the funding had not evolved to match the complexity of whole person care. Teams then used this clarity on the organizational level to make decisions about model development; this became a guiding value that provided ongoing direction. Organizational heart also had a secondary motivating factor: many providers came to the model with passion for a specific population, and when they felt a genuine commitment from the organization to provide "the right care," their sense of satisfaction and excitement increased and furthered their commitment to both the organization and the population.

CASE STUDY EXAMPLES

UF CARES — These integrated behavioral health and primary care team members, which included physicians, psychiatrists, behavioral health counselors, nursing staff, and peers, explained that the team initially served HIV-positive youth. However, as a group, they recognized that the mothers, who were also HIV positive, were bringing in their children, but were not getting care themselves. Team members described leaderships' foresight for making the paradigm shift to integrating services for the women's care and the pediatric patients. It brought on a whole new identity for many team members and expanded their practice dramatically, but it was "the right care" for the population.

Risk Taking

For organizations to be able to provide vision for the future and commit to a model of care that is not yet fully funded, a degree of risk taking is required. In interviews, both leaders and team members described taking a leap of faith that the integrated behavioral health and primary care model would succeed and that eventually funding systems to support an integrated model will catch up to the innovation in clinical care. These organizations took the risk that the upfront resource expenditure would be worth the time in development to obtain the desired outcomes and subsequent eventual funding.

Clearly, this is a balance and it takes stewardship to evaluate the risk and the appropriate degree of innovation versus the stark reality of funding. The rural health clinic that had to abandon their integrated model stated that the organizational leadership, including the board of directors, had decided the model was not worth the risk and, thus, the model was ended.

Leadership

The last organizational theme is simply solid leadership. Although members may not have used leadership terms, they described similar management skills with exceptional leadership qualities across organizations. These leaders had vision for the future of care and the ability to inspire those around them to commit to the vision of integrated behavioral health and primary care. Yet, these leaders also allowed flexibility in the "how" of the vision and gave space for teams to innovate. Wheelan (2013) describes this as a key organizational task in creating effective teams: "when you put people together as a group, combining their intelligence and creativity, it often leads members to come up with new and unexpected ideas and solutions. If the group is functioning in an organization that encourages new ideas and new ways of doing things, group members feel energized and supported."[9] The leaders of the integrated behavioral health and primary care teams share this vision.

The leaders interviewed also seemed to engage in integrative thinking,[10] holding the tension between this new model of care, requiring significant resources upfront, with the realities of running a healthcare business. In this way, they had both the ability to be visionary and charismatic (transformational) and attend to specific implementation details creating a clear path to success. In addition, these leaders empowered the local leaders and champions in their organizations to create successful teams and provided space for team-based innovation. Finally, team members (psychiatrists, primary care providers, social workers, psychologists, peers), described leaders that used "buffering" to create a safe and secure environment in which the team could focus on its development. The leaders buffered these teams from the disruptive demands of the external environment for a distinct period of time.[11] A decision to provide time for a team to develop while the clinic is closed is an example of this kind of buffering. Another example of buffering is leaders temporarily allowing teams to focus on clinical model development, without concerns about specific billing codes.

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[9]Wheelan, S.A. (2013). *Creating Effective Teams: A guide for members and leaders, 4th Edition.* Sage Publications, p. 112.
[10]Martin, R. (2007). *How Successful Leaders Think.* Harvard Business Review, June, 2-9.
[11]Ernst, C., & Chrobot-Mason, D. (2011). *Boundary Spanning Leadership: Six Practices for Solving Problems, Driving Innovation, and Transforming Organizations.* McGraw Hill: New York.

BEHAVIORAL HEALTH AND PRIMARY CARE TEAM DEVELOPMENT

Another essential element of integrated behavioral health and primary care teams is team development. Although this may appear to be common sense, team development may often be overlooked or minimized. The specific and sharp emphasis placed on this aspect of the model cannot be overstated. During the interviews, there was laughter when asked about team development, demonstrating that this is the area in which the "real meat" of the work occurs and where issues of culture shift become paramount. The leadership of these projects discovered behavioral health and primary care team development required considerable time and attention and is the area in which challenges become most apparent. Their descriptions highlight the central importance of team development, both formal and informal, to the success of these teams. The interviewees stressed the importance of vision; team values; formal development; and attention to supporting operational issues such as team meeting schedules, development of job descriptions and appropriate billing for services.

Vision

As previously discussed, the importance of a shared vision with leadership support is vital to successful teams. The shared vision provided structure and clarity for the team as challenges increased over time. The connection between the senior leadership's commitment to delivering a new care model and the team's internalization of that vision is what allowed the model to move from conception to reality. This is congruent with literature on team development, which identifies successful teams as ones in which there is symmetry between a team's goals and the larger organization's future: "A team's purpose should have a clear line of sight between the team's goals and where the company is headed."[12]

IOM's core principles and values of effective team-based healthcare (2012) also emphasize the importance of shared goals for healthcare teams. According to an IOM report, "The foundation of successful and effective team-based health care is the entire team's active adoption of a clearly articulated set of shared goals for both the patient's care and the team's work in providing that care."[13] Although, teams in this project tended to refer to "shared vision" rather than "shared goals," the concepts are clearly the same. Team members shared an understanding of the population, the outcomes desired, the evidence-based treatment approach, and the notion that team-based care was essential.

Shared vision is generally fostered by a combination of leadership foresight and visualization with team creativity, definition, and implementation. In other words, the team members further refine the vision and translate it into day-to-day care. A frequent theme was the use of team-building exercises focused on input into the vision, goals, and mission of the treatment team. Many teams even developed the mission statement together, which increased team commitment and cohesion.

CASE STUDY EXAMPLES

CommWell Health — Early in their team-building process, CommWell Health conducted an activity directed at refining the vision of care. As a group, the team discussed, "What is the vision?" "What is a patient-centered medical home?" "How can we make this work?" "What are challenges, how do you envision this, and how do you see it working?" There was team consensus on whole person care and wanting to talk about all of those components (e.g., nutrition, substance use, depression, chronic illness). According to senior leadership, by the end, "The group collectively drafted a vision specifically for the Ryan White patient population."

UF CARES — This organization has an annual working team retreat to revisit goals, vision, and mission. The vision evolved over time as the core team continued to evaluate the needs of the community and population. They revised their mission statement with the whole team present.

In discussing whether the funding structure affects the vision creation, they described a commitment to the model and vision, regardless of funding. Instead, they make the funding work by matching it to the vision of care. Over the years, they have been creative about new funding opportunities that can layer on the model's other components, allowing them to add care components, provide care differently, or simply add more of what they are already doing. Having the vision is essential to shaping what that next layer of opportunity and funding might address to continue to expand the integrated model.

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[12]Duke Corporate Education. (2005). *Building Effective Teams*. Kaplan Publishing, p. 15.
[13]Mitchell, P., M. Wynia, R. Golden, B. McNellis, S. Okun, C.E. Webb, V. Rohrbach, & I. Von Kohorn. (2012). *Core principles & values of effective team-based health care*. Discussion Paper, Institute of Medicine, Washington, DC. www.iom.edu/tbc., p.6.

A key question for the organizations interviewed was whether the specific funding structure (i.e., FQHC, Ryan White, rural health clinic, Medicaid and Medicare) changed the vision of care or how the model of care was designed. In other words, did the funding drive the model of care provided? The case studies demonstrated the vision was clearly the model's driver and most teams identified minor changes to the team design or implementation due to funding structures. The vision of care was primary and the funding affected the nuances of implementation.

Team Values

IOM's core principles of effective team-based healthcare (2012) describes the importance of personal values: "In addition to particular behaviors that facilitate the function of the team, we heard from the behavioral health and primary care teams we interviewed that certain personal values are necessary for individuals to function well within the team."[14] Integrated behavioral health and primary care teams identified the personal attributes of team members that support team-based integrated care. However, they also described shared team values — values that were essential for the behavioral health and primary care team to hold together as a group. The specific shared values provided a foundation and guidance to the larger care model. At times, these shared values also reduced conflict and provided clarity of action in patient care. Fundamental behavioral health and primary care team values included:

- **Quality Patient Care** — Teams identified clearly defined, high standards of care for a distinct population. They had a targeted vision of what successful integrated behavioral health/primary care was for the population they served.

- **Patient-Centered** — Teams consistently discussed the patient's vital role as a member of the team. This included the importance of patients understanding their specific roles and responsibilities in care. A UF CARES team member described, "Engaging patients in their care is the ultimate goal and making decisions not in a vacuum but in best interest of the patient and what they wanted." Teams genuinely invested in having a person-centered approach, with continued efforts to meet the specific patient populations' needs and listen to what patients wanted and needed.

CASE STUDY EXAMPLES

UF CARES — The organization holds a monthly consumer advisory board meeting comprised of current patients and staff that provides feedback on and ideas for improving care. The care team received the feedback directly from this board.

Cherry Street Health Services — They described efforts to educate patients in the care model and the notion of team care. As the CEO described, "Patients are now so used to an integrated approach that they no longer understand separate care." For example, if he asked a patient, "Did you initially come here for a medical or behavioral health problem?" the patient would respond, "What is the difference?" This demonstrates how integrated the care has become, and that the patients have been a part of redefining care.

- **Non-Hierarchical Team Structure** — Behavioral and physical healthcare providers comprised the integrated care teams, and staff emphasized the importance of humility among team members and that part of that humility was a shared team value of equality and "team-ness" between providers. Humility is one of the personal values the IOM report referred to as important for the "creation of an environment of mutual continuous learning."[15] Many teams identified the lack of hierarchy among providers as important to communication among members, sharing valuable ideas, and assisting the members' work as a team rather than individual members.

> **Advice from Teams**: "Hire the right providers for this model. [You] need individuals without egos who want to participate on a team and who value feedback."

[14]Mitchell, P., M. Wynia, R. Golden, B. McNellis, S. Okun, C.E. Webb, V. Rohrbach, & I. Von Kohorn. (2012). *Core principles & values of effective team-based health care*. Discussion Paper, Institute of Medicine, Washington, DC. www.iom.edu/tbc. P.7.
[15]Mitchell, P., M. Wynia, R. Golden, B. McNellis, S. Okun, C.E. Webb, V. Rohrbach, & I. Von Kohorn. (2012). *Core principles & values of effective team-based health care*. Discussion Paper, Institute of Medicine, Washington, DC. www.iom.edu/tbc. P.14.

CASE STUDY EXAMPLES

Cherry Street Health Services — They clearly articulated the importance of the shared team value of humility in developing their team and in communication with providers.

According to an internist, "[You] need people without big egos willing to work on a team. There is no team leader, nobody runs the huddle or takes charge. [We] function as a group because we've been doing it together naturally and do it as a group. Everybody is on equal footing. [The] MA and PCP all have equal say in what happens."

A health coach spoke to the importance of this value being genuine for her and among other health coaches. She described coming into the model with a natural deference to the internal medicine providers and how important it has been that the internal medicine doctors have given all providers the opportunity to feel that they are on equal footing and have expertise. "It is easier to have a conversation when you feel that you are both working equally."

UF CARES — The organization identified a non-hierarchical culture as particularly relevant in an academic setting, where hierarchy between providers may be more common. A non-hierarchical team structure has been part of their culture and team process since the start and continues to be something they look for in hiring new providers. This is a cultural expectation of the team.

Marana Health Center — Cultural shifts may be easier in a smaller organization when team reliance is essential, constant, and part of the natural workflow. As organizations grow in size and complexity, providers may become more attached to the hierarchical structure and separate systems.

Marana Health Center started as a small rural health clinic and began to provide integrated care 15-20 years ago. At that time, the cultural divide was smaller between providers and they naturally functioned as a team. As an LCSW described the past:

"We were all elbow to elbow, stuffed into one building. Our proximity to each other made it easy to work cooperatively. When a medical patient came in to see his [primary care practitioner] (PCP) and just couldn't get his/her blood sugar under control, it was easy for the PCP to send somebody down and grab a therapist to help the patient and figure out was going on and develop a plan that worked for the patient. The PCP was then free to see somebody else. This kind of collaboration was easy and effective.

"The ease and efficacy of doing this helped us all to realize that there really isn't any difference between physical health and behavioral health; it is all just health...It worked well and continues to work well for two reasons. First, we were easily available to each other because we were physically close together. Second, the behavioral health staff and medical staff realized this was mutually beneficial, and most importantly, we developed solid relationships based on understanding, experience, and knowledge of how each could contribute to the health of our clients.

"Because of the ease and natural development of this integrated team, the leadership at Marana was surprised when they implemented integrated care years later in a new setting. The new teams were struggling with cultural shifts in a way that the older "naturally created" teams had not. The organization has grown substantially since that initial team and the leaders suspected that the cultural patterns in a larger organization may be part of the resistance to team-based care."

Formal Development

All teams talked about the formal and structured awareness of team development. This was not an ancillary part of the integrated care process, but a central focus of building an integrated care system. Literature on effective teams documents certain components of formal team development, including selection of team members, strong personal relationships, and clarity of roles and responsibilities. Other components of formal development described may be more unique to integrated behavioral health/primary care, including: expansion of provider roles, cross-training, and development of the operational support for the integrated model.

> "Looking back, I'm amazed at how much time it took. There was a great deal of planning and research needed in order to determine what specific training was needed to implement the care delivery system. [It] took much longer than we would have thought would be the case."
>
> — **Cherry Street Health Services**

Team Relationships

Interviewees value strong relationships among team members. They describe concerted time and energy directed towards developing these relationships, through activities both in the work setting and outside of work. The IOM core principles and values of effective team-based healthcare also describes the importance of personal connections among team members, especially for building trust.[16] The IOM report outlines the time, space, and support required to allow team members to get to know each other and build rapport. The integrated care teams describe this process as important for building trust and often describe the importance of having fun together as an important element of building effective communication and fundamentals as a team. This may be an essential element of culture shift for integrated care teams as providers become personally connected and thus more comfortable being vulnerable after learning new professional skills or making difficult changes. Team building may be the catalyst for this process, while genuine relationships take time and are cemented through repeated shared experiences.

CASE STUDY EXAMPLES

UF CARES — In addition to their formal work retreat, UF CARES hosts half-day retreats to do fun team-building activities, such as bowling, and to spend time together in a different setting.

Cherry Street Health Services — They get together on a quarterly basis for social events to build rapport and get to know each other personally. One interviewee said, "Getting to know people inside and outside of the work setting made a big difference. We were more comfortable with each other."

Hiring Providers

For collaborative care models, hiring the right providers becomes even more important. Not all healthcare providers are suited for behavioral health and primary care team-based care and it is important that the match between the model and the provider is carefully considered. The IOM report, Core Principles & Values of Effective Team-Based Health Care, outlines five personal values that characterize effective members of teams in healthcare, including: honesty, discipline, creativity, humility, and curiosity.

These five attributes were identified as important in the case studies for this project. However, behavioral health and primary care teams also identified additional personal attributes that they look for in providers. For example, integrated care teams consistently identified passion and compassion for the population served as important. In some instances, the teams reported that this shared passion served as another important factor for team cohesion and increased interpersonal connection. It is noteworthy that all of these teams serve safety-net populations "at risk." Other attributes frequently mentioned were providers being team players, flexible, and internally motivated.

Adjusting to the culture of the organization is yet another important aspect when making hiring decisions for a behavioral health and primary care team member. Primary care settings are fast-paced and require flexibility from behavioral health providers to move from office to office, to allow for interruptions in their normal business day activities, and be willing to facilitate and accommodate "warm hand-offs" from medical staff. As collaborative care continues to evolve, the specific provider attributes required for effective team behavior will be an important area of workforce development.

Advice from Teams: When possible, hire providers with whom you or your partners already have experience. This makes it easier to find providers that will fit the model and that you know have the personal attributes desired. It is also good to involve the team in interviews to immediately show the culture of team care and to gain a better "feel" for whether a provider is a good fit for team-based care.

Roles and Responsibilities

Another component of formal behavioral health and primary care team development is clarifying individual team members' roles and responsibilities. Traditional team roles are often characterized into three categories: individual (members have no collective decision-making and tasks are individual); group (there are no individual assignments and there are collective decisions); and hybrid (a mixture of individual and collective

[16]Mitchell, P., M. Wynia, R. Golden, B. McNellis, S. Okun, C.E. Webb, V. Rohrbach, & I. Von Kohorn. (2012). *Core principles & values of effective team-based health care.* Discussion Paper, Institute of Medicine, Washington, DC. www.iom.edu/tbc. P.7.

responsibilities).[17] In behavioral health and primary care integrated care models, understanding team roles and responsibilities is important and complex. Providers adapt their competencies, shift traditional models of function, and explore how to combine skills to treat the whole person. The provider function becomes central because different types of behavioral health and primary care providers can deliver the same function. For example, a nurse and a case manager can both provide the function of care management and thus the role is no longer defined by the discipline — as is traditional — but rather by the team and model. Integrated behavioral health and primary care teams focus on ensuring that the needed functions are provided rather than on defining roles and responsibilities along traditional discipline lines.

Additionally, integrated behavioral health and primary care team members get to know each other's style of care and begin to blend styles and delivery of services. Often, this results in team members knowing each other well enough to use each other's strengths to maximize care. In this way, integrated behavioral health and primary care teams are often more of a group or hybrid model, as defined above, and this shift towards collective decision-making and responsibility may demand stretching and blurring of traditional roles.

As the complexity of role definition increases with integrated behavioral health and primary care, so does the importance of formally addressing the issue of behavioral health and primary care team members' roles and responsibilities. In the case studies, there were examples of innovative methods of creating clarity of roles as part of formal behavioral health and primary care team development. The attention these teams and their leaders gave to defining roles, exploring provider functions — both differences and interconnections — and knowing how to then orient new staff joining an established behavioral health and primary care team were significant. In essence, the teams outlined what behavioral health and primary care integration and collaboration meant and identified the touch point, or blurred boundaries, between providers in each practice.

> Providers adapt their competencies, shift traditional models of function, and explore how to combine skills to treat the whole person.

CASE STUDY EXAMPLES

CommWell Health — As part of their initial team development and behavioral health and primary care team vision creation, team members wrote their responsibilities on flipchart pages and then hung them around a room. Then each member of the behavioral health and primary care team shared his or her abilities, specific skill set, and responsibilities. Members could then ask questions about this role (e.g., how many referrals do you get, what is the workflow for this function or activity). Members started to look at each team member role and how the specifics related to or affected their own role on the team. In addition, the team started to identify the organizational structures needed to maximize the effectiveness of some of the interconnections between provider functions. According to the leadership, this exercise resulted in clarity of roles but also a "spontaneous team [in which] everyone had the concept and saw themselves as a team."

Cherry Street Health Services — The agency described using their morning huddle, in which they discuss the day's cases, as a way of defining roles and responsibilities and starting to shape the function of the team. This huddle began when the clinic was only partially open and for 3-4 patients a day it would take 1.5 hours. With significant practice, the team developed a highly efficient huddle that could review 40 patients in 30 minutes. Part of this evolution was clarity of provider roles and responsibilities and getting to know each other's skills, and part was clearly a cultural shift. According to the Project Director, " We did some team development to get to know each other [using] Myers Briggs, trying to get to know each other's patterns, who speaks up, who doesn't speak enough, practice the huddle script, and would say to each other, 'Do it again, do it again' until we got it. The Health Coach added, "[We] learned how to fine tune our skills. Blend those worlds."

UF CARES — They use a specific orientation process to ensure new members understand the various disciplines and functions of the team, as well as the roles of other parts of the behavioral health and primary care team (e.g., their research team). Each discipline manager provides training and specific orientation checklists for new staff so that they understand the roles. New staff meet with each team leader and spend time in each area so that they truly understand what each subgroup does and how they contribute to the larger behavioral health and primary care clinical team. An important aspect of this process is not simply reviewing work expectations but also the cultural expectations of the team model.

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[17]Cohen, S.G. & Bailey, D.E. (1997). *What makes teams work: group effectiveness research from the shop floor to the executive suite*. Journal of Management, 23(3), 239-290, p. 253.

Cross-Training

In addition to clarifying roles and responsibilities, integrated care teams must understand each other's skill sets and train each other on vital elements of care. According to Wheelan (2013), shared education is part of what defines a team: "groups with goals and tasks that require continuous learning are the most successful groups. In fact, the best thing about a group with such goals and tasks is that its members will learn from each other and will seek out information to learn more about how to proceed. If a group's goals and task don't require new learning, a group format is probably not necessary for their accomplishment."[18] This is a significant portion of the cultural shifts that occur on integrated teams. There are expansive lists of cross training for teams; however, areas such as language use, primary health indicators, key risk factors, skill development, and differences in documentation are common. It is an important aspect of team development and is vital to improved care as all disciplines begin to understand more of a person's whole health status and needs. This process often facilitates the blurring of traditional discipline boundaries of knowledge and practice.

Cross-training was a central aspect of formal team development for the teams interviewed. A medical provider on the Cherry Street Health Services team described the importance of this shared time and training: "[We] found out very quickly that we weren't even speaking the same language. Abbreviations are different, etc. For example, 'MI' — [behavioral health providers] are talking about motivational interviewing and I'm talking about a heart attack! Very different... Getting on the same page, talking the same language, understanding how we practice, and what we do when we see a patient [are] very different things. [We spend] a lot of time just talking to each other and cross-training. We'd do a presentation of diabetes basics and how we manage them for the health coach and then I'd get a presentation on dialectical behavioral therapy. Learning from each other and bringing in some outside experts to teach the team as a whole — it was six months together in the group — learning these things about each other and learning each other's focus before we ever saw a patient."

A health coach on the same team described the process of having to change the way physicians reviewed psycho-social assessments as they did not have time to read long, in depth reports. The health coaches had to learn to present a clinical case within minutes and identify the most important aspects to share with medical providers. This process was part of the team's morning huddle and it required practice. Team members presented the same case over and over using a script to get the presentation tighter and more succinct. This time together eventually enabled them to review 40 patients in a 30-minute huddle as a whole team.

CASE STUDY EXAMPLES

UF CARES — "Education, Education, Education!" The team has high expectations for education and requires that all providers continue to receive education, especially specific to HIV services. They also completed training on engagement and pre-engagement and stages of change. The goal is for all team members to attend all trainings. However, they make sure a representative from each discipline attends each training so that they all hear it as a team and have the opportunity to address their specific perspective on the training material.

Cherry Street Health Services — They cross-train their integrated development team (described above). This cross-training extends to the larger clinical team as well. They also have many of the trainings professionally videotaped so that team members who were added later could also receive the cross-training.

Rural Health Clinic in California — One of the behavioral health providers described the challenge of not having time for cross-training and the impact this has on the team and patient care. She described feeling ineffective in her interventions, which other providers compounded by not understanding mental health because of a lack time or ability for cross training. The lack of training has affected the perception of the patient and she believed team members sometimes blamed patients as a result. In fact, both behavioral health and medical providers described feeling ineffective and that their interventions may not be fully understood because of a lack of shared knowledge. All of the providers acknowledged that cross-training and more time as a behavioral health and primary care team sharing these thoughts would be helpful to the team members individually and to improved patient care.

Although cross-training of team members can be time consuming and a challenge for scheduling and productivity, the teams interviewed described it as essential to the team functioning and high quality of care.

[19]Wheelan, S.A. (2013). *Creating Effective Teams: A guide for members and leaders, 4th Edition.* Sage Publications, p. 115-116.

System and Operational Support

For these teams, formal team development was a major component that is largely unique to integrated behavioral health and primary care teams. As mentioned previously, the current funding climate and healthcare requirements significantly affect integrated care models. Oftentimes there are barriers to providing a behavioral health and a medical service on the same day to the same patient, even though two separate providers saw the patient. There continues to be a need for claims payers to implement innovative solutions to support integrated behavioral health and primary care models. There is a clear need to review old systems and eliminate operational constraints across the areas of credentialing, billing, and documentation.

Each site had a unique solution for managing this extra component of operational support. In each approach, behavioral health and primary care members were well aware of the current system limitations and barriers, however, their leadership protected them from changing the clinical model merely due to operational constraints. The consistencies of these behavioral health and primary care teams were that each team had been creative in their approach, found that the solution took time and resources, and viewed this as part of formal team development. Often, there were system or operational teams being built alongside the clinical team, as well as evidence of parallel processes and symmetry between the teams. This process also appeared to be foundational for some teams in understanding some of the cultural shifts required and where additional energy may need to be spent to get to the specific vision of integrated care.

CASE STUDY EXAMPLES

CommWell Health — The agency uses two different team meetings to address the need for clinical time as a group, as well as time working out the systemic and operational challenges. The clinical team meeting includes all clinical team members and senior leadership and focuses specifically on clinical cases, the clinical model, and how the team provided care. A second "strategy meeting," with similar group composition, focuses on the system and operational needs of doing the clinical work, including funding and the "how" of the clinical model. These last approximately one hour. One leader described this meeting as the "think tank" for whatever issues identified as part of the treatment team process that need to be resolved. For example, when an issue arises in the clinical team meeting regarding systemic limitations or questions about how to operationalize an aspect of care, the issue is identified and marked for the strategy team to address.

The two meetings will run concurrently for as long as needed. CommWell Health found that this model allows for clinical team time to focus on patient care and innovation of the clinical care, while still having time as a team to address the larger system needs to support the model. The strategy team was also instrumental in observing and overseeing the team development process and is a place to discuss issues such as communication breakdowns or challenges with new members joining the team. They believe that senior leadership commitment and participation in both meetings is essential.

Marana Health Center — The organization described the importance of leadership commitment to the model in helping to overcome some of the operational restraints created by current regulations. In Arizona, state regulations requiring separate waiting rooms for individuals receiving physical health and mental health services limited the proposed model. Marana Health Center's goal was to provide integrated care to a population with serious mental illness and they constructed their building around the vision of a single waiting room. The Chief of Behavioral Health Services used her relationships and stature within the community to convince state authorities that this rule would prevent new and effective models of care developing in the future. As a result, they became the first site in the state with an integrated waiting room. In addition, Marana leadership has been instrumental in educating and persuading the regional behavioral health authorities to embrace integrated care.

Cherry Street Health Services — At the beginning of the developmental process, Cherry Street was actually three separate organizations (Cherry Street Health Services, Touchstone innovarè, and Proaction Behavioral Health Alliance) that later merged. The three organizations created the integrated development team, which was a small subset of the larger integrated clinical team and included staff from all three organizations. The team's initial goals were to examine what an integrated team needed to know how to do, what kind of training was needed, and what practice management was needed for effective integrated care. In addition, this interdisciplinary team started to identify cultural changes that would need to be addressed (both system oriented and clinical) and they were charged with figuring out how to create the changes. This team also identified specific groups to work on areas of change or problems.

The core development team members examining how to conduct integrated care were actually members of the ultimate clinical team. This allowed them to build the team as they were working on the idea of how to build it. Providers described the time together as important in developing behavioral health and primary care team relationships. At the same time, they were also identifying cultural shifts, training needs, and specific system components needing attention to make the model effective.

As they implemented the model, they continued investing time in the work groups to address the clinical team's system and operational needs. For example, for a time, the finance work group, which included billing, the chief financial officer, and project manager, met weekly to examine claims to maximize the funding streams and billing components of care provided and to help health coaches code services as accurately as possible.

A striking aspect of the **Cherry Street model** was the resource, time, and design given to the development of the clinical model and specifically the team. The team worked on development for a period of time without providing patient care and then with limited patients before the clinic fully opened. This may in part be a result of the unique structure (merging three organizations) of this site. However, the leadership also believed that this start-up time would contribute to the model efficiency and effectiveness long-term and based on what the team described, the time in development has been borne out in team cohesiveness, efficiency, and significant outcomes.

Team Development with No Patients:
February-May 2010

Team Development with Limited Patients:
June-September 2011

Clinic Fully Open:
October 2011

Cherry Street Health Services

List of Work Groups

Practice Management

Client Selection

Information Technology

Building Space

Curriculum

Finance

Staff Selection

Culture

TEAM PROCESS

Once members of a multidisciplinary team have developed relationships and a sense of team, there are process components of the teamwork. The IOM core principles and values of effective team-based healthcare report discussed measureable processes and outcomes on teams as: "The team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team's goals. These are used to track and improve performance immediately and over time."[19] The process elements discussed by the effective teams in this project included both formal and informal communication, assessment of how the team functions, and whether the team maintained the collaboration and growth gained in the developmental process. Effective teams asked themselves. "Is the team process working the way it is designed, and at its best for patient care?" and then made adjustments to improve care delivery.

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[19]Mitchell, P., M. Wynia, R. Golden, B. McNellis, S. Okun, C.E. Webb, V. Rohrbach, & I. Von Kohorn. (2012). *Core principles & values of effective team-based health care*. Discussion Paper, Institute of Medicine, Washington, DC. www.iom.edu/tbc. p.18.

Effective Communication

The IOM report states, "Effective collaboration without regular communication among providers is impossible."[20] Effective communication is a core competency and foundation for all effective teams. This is especially true in integrated care settings because the degree of collaboration among team members has such significance to the effectiveness of care and ultimately to patient outcomes. The teams in this project identified three kinds of essential communication: clinical care review, day-to-day operational communication, and process communication.

Clinical Care Review

All teams described a formal structure to review patient care and integrated treatment plans. The format varied between weekly or biweekly team meetings, daily huddles, or a mixture of both. However, all teams focused on clinical case review and evaluation of individualized clinical progress. In most settings, this meeting included the entire clinical team with all disciplines. However, on some teams it was a subgroup of disciplines. In a few examples, these meetings expanded to include additional consulting team members (e.g., dentists, pharmacists, or dietitians) and external community partners. This time was described as essential for teams to create a shared treatment approach and share differences in perspective or information about a patient's status. Often the integrated treatment plan was reviewed and updated during these discussions. This structure allowed teams to review aspects of care and then agree on an immediate plan for the next appointment. Once the plan was clear, whichever provider saw the patient next was prepared to meet the immediate goals outlined by the team (whether the need was a blood test or a check-in on housing).

CASE STUDY EXAMPLES

UF CARES — Their clinical team meeting includes the entire team and meets weekly to discuss each patient that has an appointment the following week. They view the EHR (electronic health record), review the plan for care, and create a plan for the visit to ensure that the team makes the most of the appointment, addressing all of the patient's needs. This includes a review of medical issues, access to housing, food, transportation, and any other needs that may be a part of the plan.

UF CARES partners with numerous other treatment providers in the community and has collaboration agreements with medical case management organizations and with every substance use and mental health provider in the region. They are deeply invested in these partnerships and any provider can attend the weekly team meeting to case-conference shared patients. Outside the meeting, they use CAREWare, which is a specific HIV/AIDS software package to facilitate sharing the clinical record and continue to communicate regularly to coordinate treatment. CAREWare is a free, scalable software for managing and monitoring HIV clinical and supportive care, which quickly produces a completed Ryan White HIV/AIDS Services Report (RSR). It is widely used by Ryan White HIV/AIDS programs.

Cherry Street Health Services — "[The] key to making this work is the huddle." Each morning, they meet for a 30-minute huddle to review 40 or more patients who are coming into the clinic that day. One day a week, the meeting is an hour because more providers are present. EHRs are displayed in the meeting. The key aspects of the case review include new information, case specific priorities, and what is needed that day to help motivate and activate the patient. The team also reviews the stage of change for each patient and the status of the chronic health condition(s). In addition, a brief update is provided by whoever saw the person last and what was done so that needs for the current appointment can be determined. The team has worked to make this meeting highly structured producing a script and practicing the script to make the meeting as efficient as possible.

A pharmacist comes monthly to consult with the team and a representative from a local hospital that refers many patients attends bimonthly to coordinate care for shared patients. A Cherry Street dentist has also recently started to attend daily huddles to coordinate dental needs of patients.

CommWell Health - Their clinical team meeting (as described previously) ends with a treatment team progress note and the team signs off on all cases discussed. This helps the team track and record the clinical case review. They are exploring the possibility of having patients join the treatment team meeting to discuss their care. A peer advocate on the team is exploring patient interest in the idea.

Advice from Teams: A number of teams improved efficiency and impact of the clinical meeting when they integrated the EHR and visibly displayed it for each case review.

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[20]Seaburn, D.B., Lorenz, A.D., Gunn, W.B., Gawinski, B.A., & Mauksch, L.B. (1996). *Models of collaboration: A guide for mental health professionals working with health care practitioners*. Basic Books, p. 15.

Day-to-Day Operational Communication

In the day-to-day of patient care, and in-between the structured meetings, effective teams continue to communicate regularly regarding patient care and sharing information relevant to the team functioning. Team members use various communication avenues, including face-to-face contact wherever providers can connect with each other. Marana Health Center described "hallway conversations" as a standard practice due to the frequency of communication with medical providers caught in the hallway. Many teams describe the importance of space and the proximity of providers to one another to increase the opportunities to engage in continuous conversation and to facilitate integrated treatment planning. Some teams designed space in a clinic specifically to encourage this face-to-face communication outside of exam rooms.

Many teams have found EHR tasking technology particularly helpful for day-to-day patient care, management, and updates. Other teams used email in place of tasking or in addition to tasking, particularly for sharing non-patient information or other communication needs. Using one integrated EHR for behavioral health and primary care improved collaboration and made integrated service planning more effective than those that used two separate EHRs.

Process Communication

Effective integrated teams described elements of process communication that were crucial. For example, a UF CARES team member stated, "Transparency is vital among the providers and among leadership and back and forth." Setting a culture of honest, open, and direct communication was important to the development and maintenance of the integrated team. A leader at Marana Health Center described their leadership's focus on open communication, saying, "[We] schedule meetings and plead with people to put their concerns out on the table. 'Let's not let [our concerns] come out later in various obscure ways.' And [we] encourage people to talk directly to one another." Strong relationships built during team development fostered this kind of open communication and furthered the teams' growth as they worked through day-to-day challenges with vulnerable and complicated patient populations. Open communication became a key skill set when barriers arose and team members needed to work together, share alternative perspectives, and find a solution. Similarly, transparent information from leadership was pivotal to understanding the changes ahead, as well as how activities at an organizational level would affect care and how leadership viewed the future.

> The culture of open communication was also paramount to team members supporting each other in their day-to-day work.

Although conflict was not common among these teams, some teams described the importance of communication about realistic expectations. Teams stated that providers have such passion for patient care that they can have unrealistic expectations of other team members and what can be accomplished. This may be especially true as team members begin to expand their knowledge base, but have not yet fully digested the limitations or challenges to specific aspects of care. Therefore, the ability for team members to directly and openly discuss those expectations and what care is realistic is important not only for patient care but also for reducing tension or frustration among team members.

The culture of open communication was also paramount to team members supporting each other in their day-to-day work. As safety-net providers, teams manage significant clinical need, complex community situations, and usually a sense that there is more need than there are resources. The team members' ability to support one another in providing care and sometimes incremental clinical improvement was identified as central to continued motivation and commitment.

Continued Assessment of Team

In addition to effective integrated teams regularly reviewing the clinical care, they continuously reexamined the team functioning. As a UF CARES team member described, "Continual reminder and review of the expectations and as things change make sure that the team is still moving in the right direction. [We] have to get out of a rut and actually take a step back and look at the process and not just 'do.' Spend that effort and time to step back and look at 'are we doing what we said we set out to do.'" Despite the day-to-day pressures and clinical work being done, these teams consistently observed their own process and whether the team's growth and functioning is maintained.

> Conflict or disagreements — even regarding patient care — were unusual among these teams. They all described moments of disagreement as opportunities for sharing different perspectives of the patient, finding new solutions, using standards of care to guide treatment, or returning to core values (e.g., best care possible).
>
> "It is rare that we don't end up on the same page - we have discussion and find a solution."
>
> — **Cherry Street Health Services**

CASE STUDY EXAMPLES

UF CARES — They hold a monthly continued quality improvement team meeting to review issues of clinical care, outcomes measures, and process regarding team functioning. The information goes back to the clinical team. This is one way to track the team's functioning and process and evaluate whether the team is functioning as designed. As mentioned earlier, they also have a consumer advisory board that provides feedback to the clinical team on consumer experience with the care provided.

CommWell Health — Their strategy meeting, as described previously, focuses on the system and operational issues involved with providing integrated care. This meeting plays an additional process role of continuously assessing the team's functioning and then addressing areas for growth or maintenance. The leadership indicated an interest in a formal team process measure that could be used to provide feedback to the team on team process over time.

TEAM OUTCOMES

A defining aspect of integrated behavioral health and primary care is that it is evidence-based and patients' treatment is tracked and monitored through objective measures (i.e., scales or laboratory tests). Progress is examined continuously and compared to predetermined desired outcomes. Therefore, an essential element of an integrated team is a continual evaluation of these outcomes and the ability to use case specific, as well as population-based data, to make adjustments in care to reach goals and maximize treatment effectiveness. Most of the teams demonstrated consistency in identifying predetermined treatment outcomes, specific treatment goals for the population, and had a process in place for the team to receive feedback on progress towards outcomes. Many behavioral health and primary care teams followed specific care guidelines for their population as the foundation of treatment outcomes. These behavioral health and primary care teams then reviewed the data and adjusted to the treatment approach, as needed.

Teams identified clear, predetermined outcomes as a reason for reduced conflict regarding the integrated treatment approach. The shared understanding of treatment success, which may be different from a medical provider perspective than from a behavioral health provider perspective seemed to create clarity and reduced conflict over treatment goals while guiding their care of the patient. In addition, teams felt comfortable discussing in their team meetings what was not working and creating alternatives to guarantee achievement of the agreed upon outcome.

CASE STUDY EXAMPLES

Cherry Street Health Services — They had a formative evaluation by Altarum Institute prior to the clinic fully opening. After the formal evaluation, Cherry Street continued to evaluate a number of outcome measures including:
- Depression: Patient Health Questionnaire (PHQ-9)
- Anxiety: Generalized Anxiety Disorder 7-item (GAD-7) Scale
- Substance Abuse: CAGE-AID
- Pain: Brief Pain Inventory
- Body Mass Index (BMI)
- Blood Pressure
- Fasting Blood Sugar, Hemoglobin A1c Test (HbA1c)
- Patient Activation, PAM-13
- Self-perceived health status, EQ-5D
- Cost and claims data

CommWell Health — The agency used the Ryan White HIV/AIDS Bureau (HAB) measures as the base of outcome measures and customized some to meet their specific population. For a complete list of HAB Measures, visit http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html.

Marana Health Center — The center pulls data monthly and plots the data quarterly. Outcomes measure the percentage of patients with controlled diabetes (A1c), hypertension, hyperlipidemia, pharmacy utilization, as well as the rate of hospitalizations (for behavioral health population, they measured rates of serious mental illness). They are adding an experience of care for quality of life measure: **The Alberta Continuity of Services Scale for Mental Health**.

In addition to clinical outcomes, most behavioral health and primary care teams collected data on patient satisfaction and worked closely with patients to gain regular feedback on their experience of behavioral health and primary team care and additional needs. UF CARES also formally examined staff satisfaction with the behavioral health and primary care team model, which informed the work done in their annual retreat.

CASE STUDY EXAMPLES	
Cherry Street Health Services **SMI Population** **Year One Results** 41% reduction in number of psychiatric admissions 47% reduction in psychiatric days Estimated savings: $167,920.00 Statistically significant reductions in: · Depression · Anxiety · Substance Use · Diastolic Blood Pressure · BMI Statistically significant increases in: · Patient Activation · Perceived Health Status	**Marana Health Center** **Initial Outcomes** **Dual Diagnosed Population** Increased percentage of patients with controlled: Hemoglobin A1c — Diabetes BP — Hypertension LDL — Hyperlipidemia Hospitalization (for behavioral health patients, controlled meant a reduction in the need for hospitalization) Pharmacy Utilization — most dramatic outcome (controlled meant a reduction in pharmacy use). *Marana's regional behavioral health organization also indicated that behavioral health patients in their integrated care program cost the system less than patients not in integrated care programs.

Identified Challenges and Barriers

Despite a growing evidence base for integrated healthcare models, there remain significant challenges to implementation. Collaborative care represents a meaningful shift in how health is conceptualized and delivered and requires genuine change among providers, organizations, and educational systems. The Interprofessional Education Collaborative outlined a number of "restraining factors" in the healthcare environment to broad implementation of team-based healthcare. These include:

- **Absence of role models**: Educational providers may not have been educated or practice in team-based settings and, therefore, may be limited in understanding the relevant skills that students will need.

- **Reimbursement**: The challenge of providing a model that is not fully reimbursed, and the need for adequate reimbursement for team-based care. In addition, there is a need for reimbursement for organizations and educational settings to support educating students in team-based care.

- **Resistance to change**: Team-based care requires a culture shift for most healthcare providers and there may be resistance as power and status shift.

- **Logistical barriers**: Educational systems are not prepared to expand classroom space or time to educate multiple professions together, especially since these professions currently reside on separate campuses.[21]

- **Training**: Future training programs for behavioral health and medical providers should include curriculum focused on teaching students how to practice in integrated team based behavioral health and primary care settings.

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[21]The Interprofessional Education Collaborative (IPEC) (2011). Team Based Competencies: Building a Shared Foundation for Education and Clinical Practice. Conference proceedings.
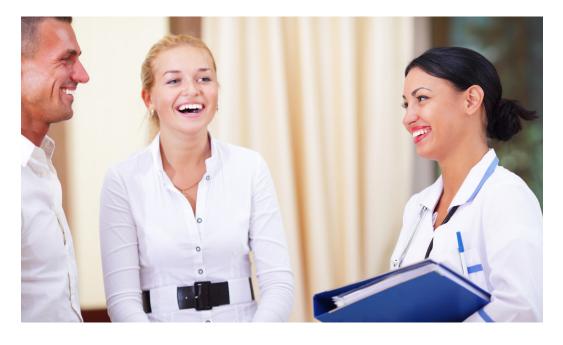
These restraining factors apply to organizations trying to implement integrated primary and behavioral healthcare. In this project, the barriers that were most consistent across teams were the limitation caused by lack of adequate funding for providing integrated services on the same day and the logistical barriers related to a care model that does not match current healthcare systems and regulations. Some states required separate entrances for both medical and behavioral health patients, which does not assist an integrated team process. Logistical challenges, such as differences in documentation standards for medical and behavioral health providers when utilizing a shared EHR, become difficult but are paramount to successful integration. Often, the logistical challenges are interwoven with the funding limitations compounding day-to-day challenges such as effective workflows, the ability to allocate non billable hours for team development, changes to culture, and implementation of other clinical innovations.

The teams demonstrate that these barriers can be overcome and that innovation and persistence can result in sustainable models of team-based care. It requires strong leadership willing to balance innovation with organizational risk, angst, and hard work. Team members have to be flexible and creative in finding solutions to the day-to-day challenges, as well as be open to the individual changes in practice needed. These teams introduce what this innovation and change can look like, and offer a good start to the conversation on how to produce effective, integrated behavioral health and primary care teams.

Putting it All Together: Perfecting Your Team Approach to Care

Summary Statement
Although this document highlighted the positive and effective aspects of a small number of integrated behavioral health and primary care teams, all of the teams interviewed indicated that growth is not always smooth, there are numerous "ups and downs," and mistakes are made throughout the process. However, all of the teams responded to these challenges by learning from the "downs" and viewing mistakes as opportunities for improvement.

Additional Advice from Teams:
- Don't bite off more than you can chew — provide as much focus as possible to each element along the way.

- Providers need to have clear expectations regarding team-based care, roles/responsibilities, and workflow.

- CF Cares found that collaboration and partnerships with outside organizations produced increased job satisfaction for team members. Being given the opportunity to collaborate and partner broadly in the community provides well-rounded perspective for staff and helps team members feel motivated to be part of something that has an impact at the community level.

This project is an initial exploration of the essential elements of effective integrated care teams in primary and behavioral healthcare settings. The hope is to spark conversation, additional exploration and research for those interested in what makes integrated care teams effective. In addition, it may inform or further define areas of future research, including organizational support, team development, team process, and outcomes. While more time-consuming investigation occurs, the information provided by these teams offers organizations in the midst of implementation of collaborative care practical guidance and examples regarding team development. An important lesson may be that individualized solutions are important and that the organizational culture surrounding integrated care teams needs to be highlighted. As these teams demonstrate, there may not be one answer to how to develop collaborative care teams, and the individualization may be an important contribution to effectiveness. The success of an individualized approach and the innovation created by teams may provide hope for those currently starting out on this path.

A useful visual summary of many of the themes in this project is this "Processes to Innovate" created by the Health Information Management Systems Society. The identification of core competencies creates an essential foundation for preparing and further developing a workforce to deliver integrated care. These competencies can be used to further that agenda in multiple ways.