

# **Building the Integrated Behavioral Health Team through Teamwork: A Structured Lean Problem-Solving Approach**

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Building the Team in Team-based Integrated Health Care  
**2018 Integrated Health Care Conference**

Hosted by Arizona State University's Doctor of Behavioral Health Program

# Healthcare Management Topic & Declarations

- **Workforce Training and Development**
- **Funding Sources:** The case study in this presentation was drawn from a project supported by grant number 1R03MH099157-01A1 from the National Institute of Mental Health sponsored research under the Dissemination and Implementation Review Section
- **Conflict of Interest:** None to disclose



# LEARNING OBJECTIVES

At the conclusion of this session, the participant will be able to:

1: Describe the **key elements** of high performance teams

2: Explain the **stages of a structured Lean approach** to team development through team-based problem solving

3: Identify how the IBHPC Toolkit approach can be used in a setting familiar to them to **increase team development and improve integration of care**



# Theory & Practice



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# Lessons Learned

- Teams are best fostered by focusing on a **performance challenge**; teams are the means, not the ends
- Teams do not suppress **individual contributions** but allow individuals to distinguish themselves
- Team performance arises out of **discipline**: clear and consistent expectations, based on customer need, to which team members and their organization hold them accountable
- There is a **dose-response relationship** of increased teamwork with reductions in errors, central line-associated infections, and mortality



# Key Elements of High Performance Teams

- Understand **urgency and direction**
- Selected for **skills**
- Supported team meetings, e.g. **facilitator**
- Establish team **norms**
- Set immediate **tasks and objectives**
- Refreshed with **facts & information** regularly
- Spend **time** together
- Receive **positive feedback & recognition**

# Premise

We know that:

- Redesigning primary care to integrate behavioral health care requires attention and deliberate effort; a “just do it” approach has real limitations
- A redesign team, using a structured method, can increase integration of behavioral health services
- The work of redesigning for integration can produce a design that calls for team-based care

**The work of designing integrated care  
builds teams for Integrated Care**



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# The Lean Approach

- Redesign work around the needs of the **“customer”**
- **“Just in time”** flow of information & resources to do work when it’s needed, eliminating waste
- **Team-based problem solving**, including front line health care delivery workers (providers & staff)... and patients
- **Structured protocol** to do the problem solving, as a team discipline





# Case Study

# Rural Family Medicine Practice

- Family medicine practice in the center of VT
- 2014-15: 17,700 adult and child visits/year
- Panel: 7,400 individuals
- 6 MDs, 1 APRN
- 2 co-located and integrated psychologists
- EPIC electronic health records system
- Staff include a community health nurse
- Integration-friendly regulatory environment

# Past Lessons Applied

- **Performance challenge:** improve care for patients with poorly controlled DM (improve A1c results, reduce delays between lab tests)
- **Individual contributions based on skill:** physician, BH providers, practice manager, nurse, community health nurse
- **Discipline:** Lean toolkit protocol for integration focused on workflows supporting patient need
- **Teamwork:** as a team, design team-based care that includes patients, staff, and providers



# **Building a Team: A Structured, Toolkit Approach**

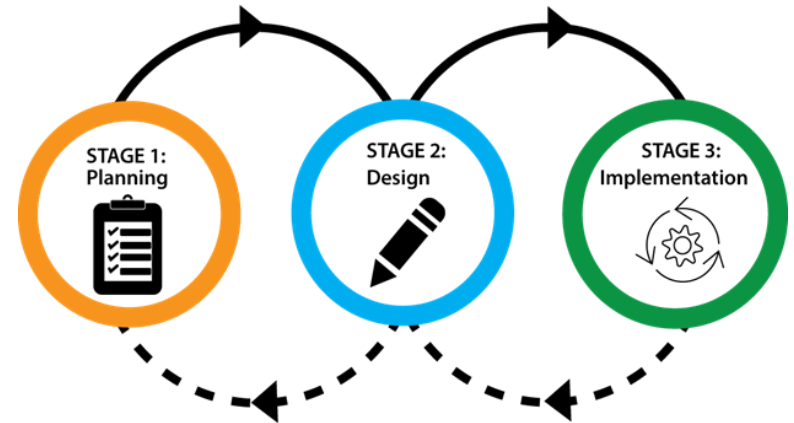


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# Three Stages



- Pre-Team Start Up: **Identify performance challenge** and prepare team
- Stage 1: **Plan** the scope and boundaries of the team's work
- Stage 2: **Analyze** the workflow of the current work process & **design** the future care process
- Stage 3: **Implement** the new care process workflow



# Start Up

- **Identify** the Planning Team members for the performance challenge
- **Make a schedule** and set a start date
- **Identify and test tools** (self-assessment tools for the team, health risk assessment tools for patients, communications with the practice)
- **Collect baseline data**
- **Communicate vigorously** with the rest of the practice

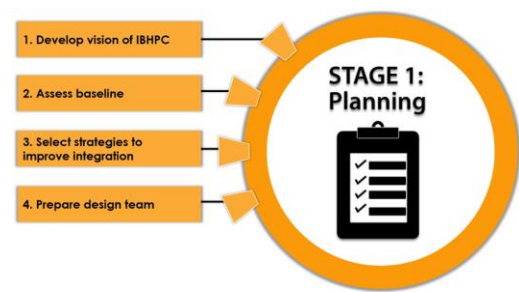


# What that looks like:

- **Stealth recruitment**
  - The practice manager, asked to assist in recruitment, became part of the team
- **Organized time and place**
  - Lunches became longer meetings, with time carved out of the practice
- **Baseline data**
  - Patient lab results and visit dates
  - Perception survey: how's "integrated care" working for our patients right now?
- **Communication:**
  - Follow up at staff/provider meetings



# Stage 1: Plan



- **Create a shared vision of “integrated care”**
  - Population management, between-visit care
  - No referral to BH provider; care initiated by nurse
- **Assess baseline**
  - Patient outcomes and practice member perceptions
- **Answer key strategic questions**
  - Which providers will be involved
  - Which patients will be included
  - What BH services offered; how documented
  - Practice roles: who will provide what services
  - Sustained communication



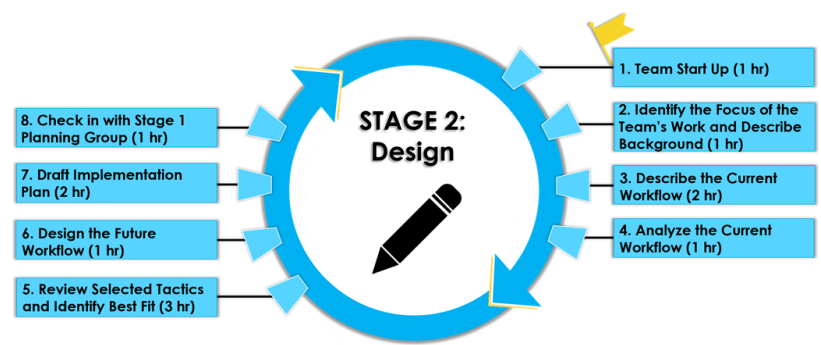


# What that looks like:

- **Vision:** a population management protocol for patients with high A1c, without referral to BHP
- **Who:**
  - Providers available to participate in pilot (2 out of 7)
  - Adult patients not under specialty care nor in LTC
- **Services & Roles:**
  - Community health nurse: outreach and care
  - Continued referral to BHP when needed (once)
- **Communication:**
  - Updates on protocol pilot with 20 eligible patients



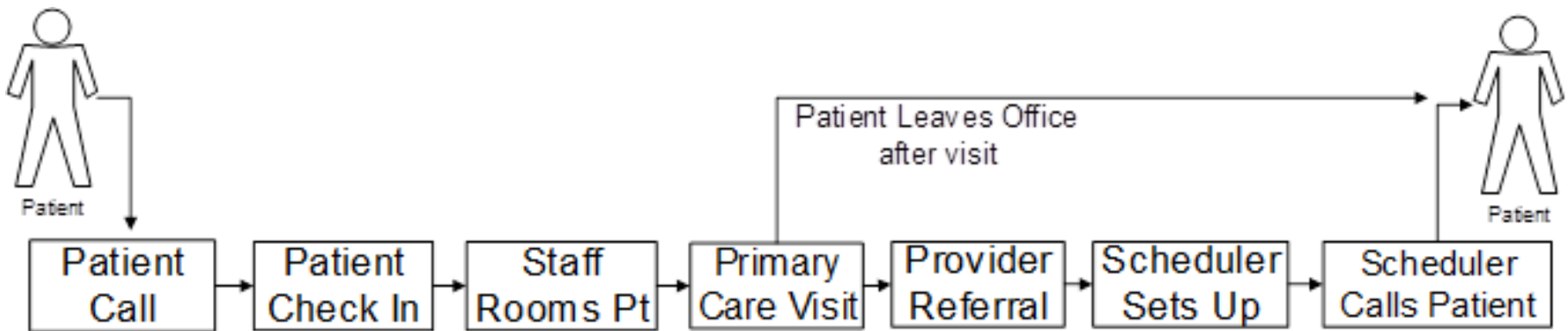
# Stage 2: Design



- **Analyze current workflow**
  - How does care for these patients work now?
- **Select tactics**
  - Of the possible changes, which are best for us?
- **Design future workflow**
  - How could care for these patients work?
- **Draft implementation plan**
  - Who needs to do what by when?
- **Recommend changes to leadership**



# What that looks like: Current Workflow



Value Stream  
Map



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# What that looks like:

## Select Tactics to Match Vision

1. Coordinate access to BHPs to make it easy to arrange short or long visits for BH services

2. Streamline referral and scheduling to BH services so that they are completed as part of the PC visit

**3. Engage care team in managing care with protocols for chronic conditions and “reach out” between visits**

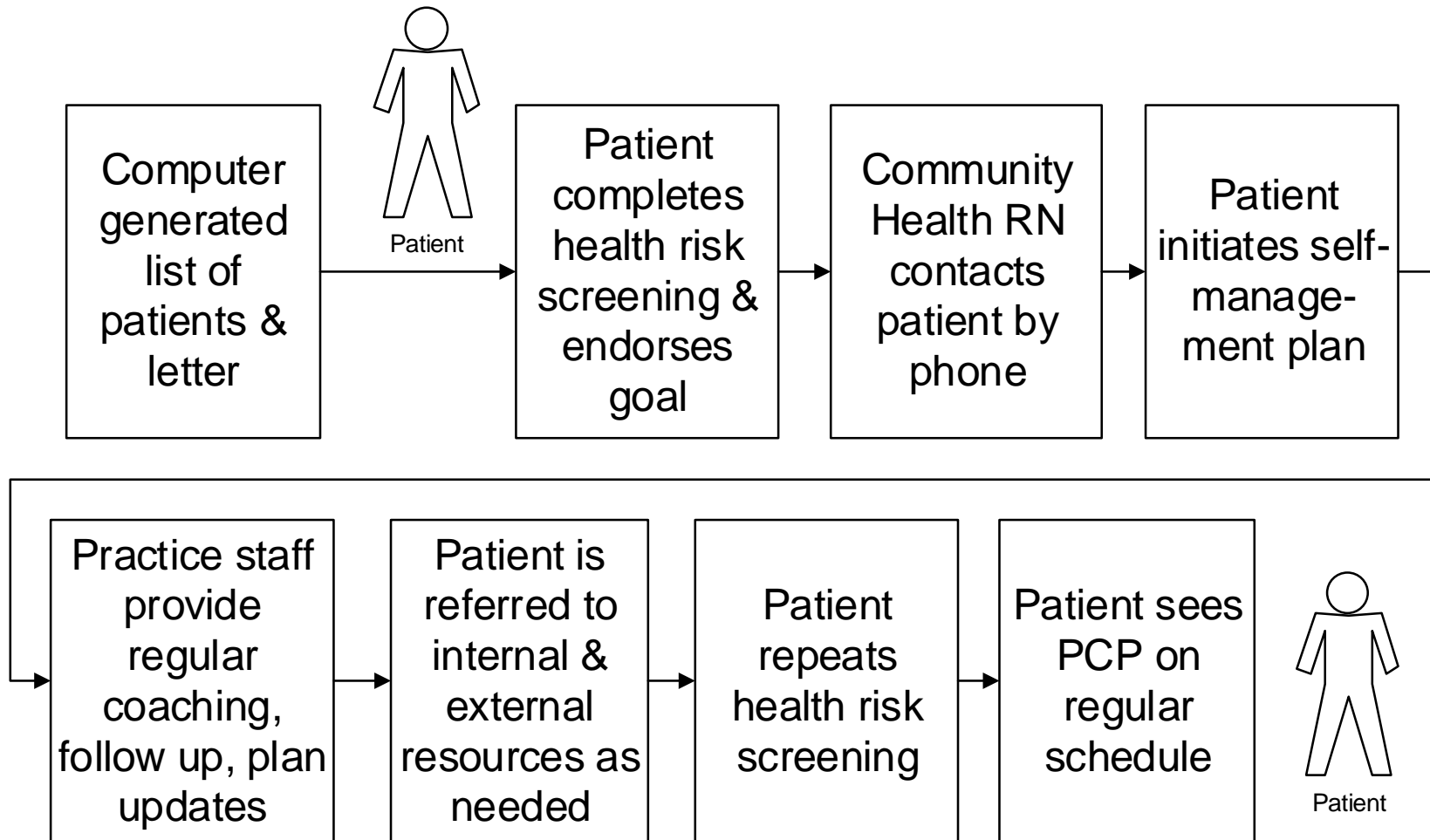
**4. Identify patients in need of BH services**

5. Redesign shared workspace to support workflow

**6. Optimize use of electronic health record, using registries and integrating documentation across all providers**



# What that looks like: Future Workflow



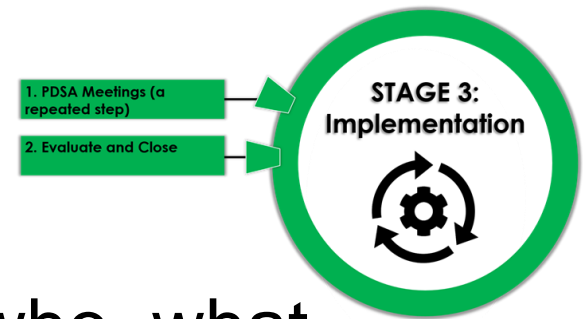
# What that looks like: Implementation Plan

## Checklist for population management pilot:

- Create process to generate patient letters
- Set up incoming health risk screening results to go to community health nurse
- Create scripts for follow up phone calls to patients
- Identify documentation process for results of phone calls and message providers as needed



# Stage 3: Implement



- Schedule the tasks of the plan: who, what, when, where, how
  - Plan, Do, Study, Act (PDSA) with regular updates
  - Measure frequently
- Evaluate
  - Assess
  - Communicate
  - Celebrate and Close

**Note:** the work of implementation also builds the team's skills and performance

# What that looks like:

- Patients with poorly controlled diabetes
  - 10 pilot patients compared to 116 outside of pilot
  - Of the 10, 1 dropped out and continued with PCP
- Change in HbA1c before/after pilot
  - Pilot patients: 9.21 → 8.76 (-0.45)
  - Non-pilot: 9.43 → 9.24 (-0.19)
- Days between lab tests before/after pilot
  - Pilot: 145 days
  - Non-pilot 185 days
- **Note:** results were not significant



# Integrated Care QI Team: How did they do as a team?

- **Performance challenge:** moved from integrated “depression and anxiety” referred care to population management of patients with a chronic, comorbid condition, without referrals
- **Urgency:** low, but grew with increased commitment during a year of working together
- **Skills:** understood the local processes and how to change work flow, knew what integrated care was capable of, able to practice team work and, eventually, team-based care



# Team Prerequisites

- **Support:** an experienced Lean facilitator with meetings squeezed into lunch times over a year with JCAHO & NCQA obligations
- **Team norms:** regular between meeting thinking and doing; listening & responsive to each other
- **Immediate tasks:** steps of the Lean approach
- **Facts & information:** from EHR and field logs
- **Time spent:** 27 meetings over 1 year
- **Leadership feedback:** minimal... pilot ended

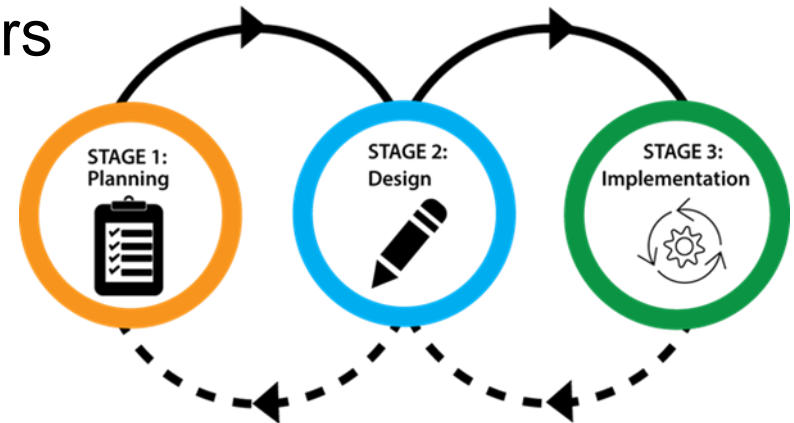


# Why did the Pilot end?

- Did the pilot develop a team-based approach with members trained to work in a team? **Yes**
- Was it credible to practice members? **Yes**
- Was there a protocol to support ongoing implementation practice-wide? **Yes**
- Could practice members adjust the protocol, as needed to meet individual patient need? **Yes**
- Was leadership able to provide resources (EHR, health risk screening) to spread the pilot across the practice? **No**

# How to get started:

- **Start with the focus:** what change is needed that is a meaningful performance challenge?
- **Assess:** are practice members willing to practice a team-based discipline?
- **Identify:** who is needed to work on this and what resources (leadership support, staff time, facilitator or coach) are essential?
- **Agree:** what is the structured method of problem solving (e.g. Lean) that will support the team and who will facilitate this method?
- **Engage:** Teams will create team-based care practices!



# Acknowledgments

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- **Case Study Co-authors:** Rodger Kessler PhD ABPP, Arizona State University; Benjamin Littenberg MD, Larner College of Medicine, University of Vermont

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