

## APPENDIX N

# Interdisciplinary Teaming in Behavioral Healthcare

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### Definition of Teaming

Teaming is an ongoing group-based process used for case-level learning, reasoning, and decision making. In teaming, appropriate people join together to help achieve agreed upon wellness and recovery goals for a person receiving services.

### The Six-Cs of Teaming

Teaming involves ongoing group-based processes that build and sustain: *[The Six-Cs of Teaming]*

- Communication – ongoing exchange of essential information among team members (supporting an individual receiving services) that is necessary for achieving and maintaining situational awareness in case practice.
- Coordination – organization of information, strategies, resources, and participants into complex arrangements enabling team members to: work together, identify a person’s needs and goals, select strategies for a course of action, assign responsibilities for action, contribute and manage resources, and track and adjust strategies and supports to achieve goals.
- Collaboration – operation of shared decision-making processes used to identify needs, set goals, formulate courses of action, implement supports and services, evaluate results.
- Consensus – negotiated agreements necessary for achieving common purpose and unity of effort among members of a person’s team.
- Commitment – promises made by members of a person’s team to help achieve a set of goals, related courses of action, and resources supplied by members to the same.
- Contribution – provision of time, funds, or other resources committed by the person and members of the person’s team necessary to support ongoing teaming and to implement the course of action agreed to by the person and person’s team members.

These six elements of teaming may be performed by using a variety of media [with the person’s knowledge and consent]; e.g., texting members to update them on an emergent event; using email communications to ask or answer questions; sharing assessments, plans, and reports; conducting conference calls via telephone; using skype conferences; and, conducting face-to-face meetings with the person present when key decisions are made.

## **Core Concepts of Teaming**

### Shared Decision-Making.

Person-centered, wellness- and recovery-oriented practices, and self-directed care principles put the person's needs, aspirations, and choices at the center of service provision efforts. A team-driven, shared decision-making process helps the person create a vision for a better life based on aspirations for well-being, supports for living, improved daily functioning, and role fulfillment. Informal supporters and service providers join with the person to define wellness and recovery goals to be achieved along with related strategies for provision of supports and services. Because the efforts of many participants may be applied in helping the person, achieving *common purpose* and *unity of effort* are essential for success, creating the organizational *glue* that holds things together in practice for the benefit of the person receiving services. Teaming is most useful in complex case-practice situations.

### Common Purpose.

Common purpose is created when the person and service providers involved agree upon and commit to clear goals and plan a related course of action supported with resources necessary for effective implementation. An ongoing, person-centered, shared decision-making process may be used to achieve consensus and maintain commitment to a set of well-planned goals and related strategies based on a strong sense of common purpose that drives the planned course of action.

### Unity of Effort.

Unity of effort is based on achieving and maintaining:

- A common understanding of the person's situation;
- A common vision for a better life experienced by the person served;
- Coordination of efforts to ensure coherency and continuity;
- Common measures of progress and ability to change course as necessary.

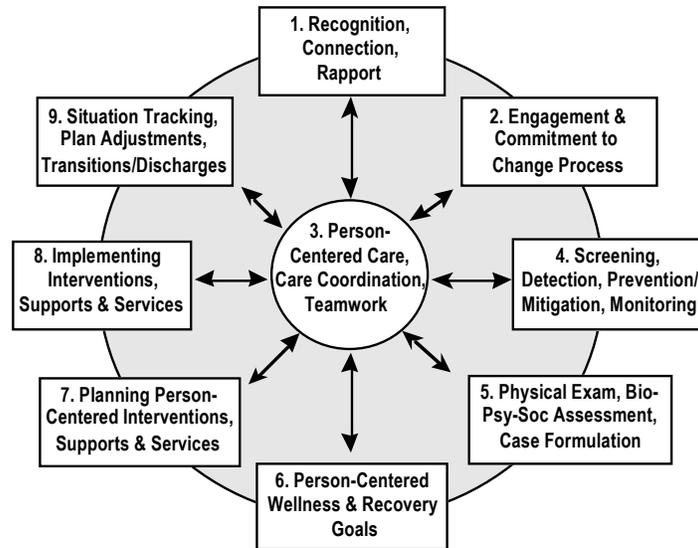
Unity of effort is achieved and maintained via ongoing teamwork, coordination of actions among participants, and integration of services across providers, settings, funding sources, and points in time.

## **Teaming is a Central Practice Function**

Core practice functions are essential processes used in case practice to identify problems and unmet needs, to plan strategies and services used to solve complex problems and meet needs, and to ensure effective delivery of strategies and services in order to get desired results. The practice wheel shown below illustrates a combination and sequence of processes used in effective case practice to plan and

provide need-responsive services. [A separate tip sheet booklet explains the practice wheel functions shown below.]

## Practice Wheel: Functions in Integrated Care Practice



Practice Functions May Occur Interactively, Concurrently, and Progressively

Core practice functions include engagement, assessment and case formulation, planning goals and strategies, implementation, tracking, adjustment, and teaming. Teaming (see function 3 in the display above) provides the central learning, decision-making, and service integrating elements that weave all of practice functions together into a coherent effort for helping a person served meet needs and achieve life goals. Teaming and care coordination are logically interrelated elements.

### Considerations for Teaming

#### Teaming Supports Shared Decision Making.

Fast moving case-level service situations in behavioral healthcare require people who know how to team, people who have the skills and flexibility to act in moments of potential collaboration when and where they appear. They must have the ability and authority to act quickly, move on, and be ready for the next such moments. Teaming relies upon old-fashioned teamwork skills such as recognizing opportunities, clarifying interdependence, building trust, and figuring out how to communicate, coordinate, and collaborate in case practice situations. There may be little time to build a foundation of familiarity through the careful sharing of personal history and prior experience or the development of shared practice experiences through working together. Instead, people must develop and use new capabilities for sharing crucial knowledge quickly. They learn to ask questions clearly, quickly, and

frequently. They act on what they learn. They make adjustments through which different skills and knowledge are woven together into timely strategies, supports, and services for the people they serve.

#### Teaming is an Engine for Case-Level Learning and Action.

Teaming is an engine of case-level learning and action in providing social and behavioral health services to persons having complex needs. Teaming and collaboration refer to the abilities to cooperate as a member of a successful action-focused group, to interact smoothly with others involved, to share information effectively, and to work together with one or more people to achieve a goal. Effective teams are those with clear goals, well-designed tasks that are conducive to teamwork, team members with the right skills and experiences for the task, adequate resources and time to get the job done, and access to any needed coaching and technical support.

#### Teaming is a Process, Not an Event.

Teaming is an ongoing problem-solving process, not a discrete event - such as holding a meeting. It is teamwork on the fly. Teaming is a dynamic activity, not a static group or structure. It is largely determined by the mindset and practices of teamwork. Teaming involves coordinating and collaborating without a prescribed or rigid team structure that would become burdensome or self-limiting over time.

#### Teaming Should Be Person-Centered.

From a “person-centered” point of view, case-level teaming happens only when the person whose needs and services are being discussed is actually present at the team meeting. Any meeting at which the person is absent when their needs and services are discussed is an *agency staffing*.

#### Team Formation: Effective Teaming Requires the Right People.

Effective case-level teamwork involves having the right people working together with and for the person being served. The team should have the technical and cultural competence, the knowledge of the person, the authority to act on behalf of funding agencies necessary to commit resources, and the ability to flexibly assemble supports and resources in response to specific needs. Members of the team should have the time available to fulfill commitments made to the person.

#### Team Functioning: Effective Teaming Supports Ongoing Collaborative Problem Solving.

Successful collaborative problem solving is a key indicator of effective team functioning. Teaming is used for:

- Understanding a person’s situation (e.g., unmet needs, urgent problems, aspirations, life goals, support system) and what would have to change in order for the person to get better, do better, and stay better;

- Planning a course of action (i.e., strategies, supports, and services) for meeting the person's needs and goals;
- Solving complex problems encountered that may thwart life-change efforts and,
- Determining when needs are met, goals are achieved, and when services should be changed or concluded.

Team functioning is evaluated on the basis of the actual results achieved, rather than evaluated based on the good intentions of those involved or compliance with funding requirements.

#### Team Coordination: Effective Teaming Requires Leadership.

Leadership and coordination are necessary to:

- Form and convene a person-centered team and facilitate teamwork for a person receiving services;
- Plan, implement, monitor, modify, and evaluate services provided;
- Integrate strategies, activities, resources, and interventions agreed upon by the team;
- Measure and share results to determine progress and change strategies that do not work;
- Ensure a unified process involving a shared decision-making approach.

While leading and coordinating may be appropriately discharged by a variety of team members, it is most effectively accomplished by a designated and qualified leader (e.g., a care coordinator) who prepares team members, convenes and organizes meetings, facilitates team decision-making processes, and follows up on commitments made. Individual(s) filling these roles should have strong facilitation and negotiation skills, authority to convene teams and act on team decisions, and, as appropriate to role, clinical skills in assessing, planning, monitoring, and evaluation. In a case where several agencies and providers are involved, use of negotiation skills may be necessary to achieve and sustain a coordinated and effective service process. Leadership and coordination responsibilities can be shared with an empowered and capable service recipient in order to increase self-direction of care.

#### Effective Team Meetings Require Preparation, Facilitation, and Follow-Up.

**Preparation:** A team meeting may be used when making decisions that could alter a person's life or make a major change in service arrangements. Basic considerations for team meeting preparation include making sure that the:

1. Person and other participants understand the purposes of the meeting and the issues to be addressed sufficiently prior to the meeting to allow time for participants to organize thoughts and materials necessary.
2. Participants are ready, able, and available for team participation.
3. The right people are invited to the meeting:
  - a. People necessary for the major decisions to be made.

- b. People invited by the person for their own support.
  - c. People invited by the agency for service provision.
4. Participants know the purpose of the meeting and how to contribute in a positive way:
    - a. Come prepared and ready for decision making.
    - b. Speak to their concerns in constructive ways.
    - c. Listen with respect to others' concerns.
    - d. Recognize and build on the person's strengths and needs.
    - e. Share information, ideas, and resources.
    - f. Keep personal and confidential information private.
  5. Participants know what to bring to be prepared as well as when and where to meet.
  6. Logistical arrangements are made:
    - a. Meeting place and time should be mutually convenient for the person and other participants.
    - b. Meeting place should be conducive for private and confidential conversations.
    - c. Refreshments and restrooms should be available for participant comfort.
    - d. The agenda should include the person's statement to begin or end the meeting.
  7. The facilitator is prepared to accomplish the primary purposes of the meeting.
  8. The facilitator and agency staff are prepared to follow-up on decisions made and on next step plans.

Making important decisions and the related next step plans for implementing those decisions should be the basis for a team meeting agenda.

**Facilitation.** Team meetings are facilitated by a person who has completed an approved meeting facilitator training program and who is competent to facilitate meetings that focus on wellness and recovery. Any relevant cultural issues of the person are recognized and accommodated before, during, and after the meeting. A qualified facilitator:

1. Convenes the meeting, defines the goals and ground rules of the meeting, introduces participants and their roles, defines decisions to be made and the possible range of actions to follow the decisions.
2. Uses consensus-building decision-making techniques, handles any conflict as it surfaces, selects appropriate idea-building processes, solicits all view-points, clarifies options, refocuses as necessary to stay on task and on time, monitors and manages the flow of discussion to ensure that all are heard and no one dominates, brings discussions to closure with decisions made, and moves on to next steps, assignments, and commitments. This is done by:
  - a. Sharing inspiring visions to guide decisions and plans.
  - b. Focusing on results, processes, and relationships.

- c. Designing pathways to action for realizing opportunities, building capacities, and solving problems.
  - d. Seeking maximum, appropriate involvement in decisions.
  - e. Facilitating the group to build agreements and meet challenges. [What could go wrong with this plan?]
  - f. Coaching others to do their best.
  - g. Confronting problems honestly and respectfully.
  - h. Managing power and control issues that arise.
  - i. Balancing person-centered practice with any court-ordered requirements.
  - j. Celebrating successes and accomplishments.
3. Builds an understanding of assessment results, the person's aspirations and challenges, court requirements, and programmatic or funding requirements:
    - a. The person's story, strengths and needs, risks, barriers to change, and desires to improve.
    - b. Requirements for behavior change by external sources -- the court, school, or family.
    - c. Changes the person must make plus their potential, motivation, and progress as it is being made (prognosis).
  4. Summarizes decisions, clarifies goals, and secures commitments.
  5. Sets goals for change, selects change strategies, plans interventions and support with the person and the person's supporters.
  6. Secures commitments from participants for plans made.

**Service Planning and Follow-Up.** Case-level team meetings serve as vehicle for service planning, coordination, communication, and accountability. The person's team develops, monitors, and evaluates an individualized, strengths-based, needs-driven service plan that responds to the person's strengths, needs, goals, and preferences identified in the assessment. Via the planning process, the team may help the person develop and use a network of informal supports that can help sustain the person over time. The person's team develops, monitors, and evaluates any individualized child service plans for a child or youth with special needs.

### **Challenges that May Thwart or Disrupt Effective Teaming**

A powerful and continuing set of factors presently operate in state services that effectively prevent or discourage effective teaming. Among these factors are:

- Service siloes (i.e., programmatic structures) created by state and provider agencies that lack boundary-spanning authority for use of cross-agency service coordinators to support teaming for persons receiving services from multiple programs and funding sources;

- Funding constraints that limit reimbursements for team member participation;
- Need for qualified team facilitators having the skills necessary for effective team preparation, facilitation, and follow-up;
- Care coordinators lacking the authority to convene and facilitate teams as well as lack of sufficient time to facilitate teaming activities due to excessive caseload assigned.
- Lack of role definitions (concerning who does and pays what) and support for team members from multiple agencies serving the same person.
- Concerns about personal, professional, and agency liability for shared information and group-based decisions in a litigious service environment.
- Differences in organizational cultures and languages used in multi-disciplinary settings and teaming situations may lead to confusion and conflict in teaming situations.
- Perceived power differentials between potential team members (e.g., physician, community support coordinator, peer support provider) and their time availabilities for teaming processes seen as disruptive to teaming.

These are persistent factors that undermine local agency efforts to provide effective teaming for persons having complex service needs.