



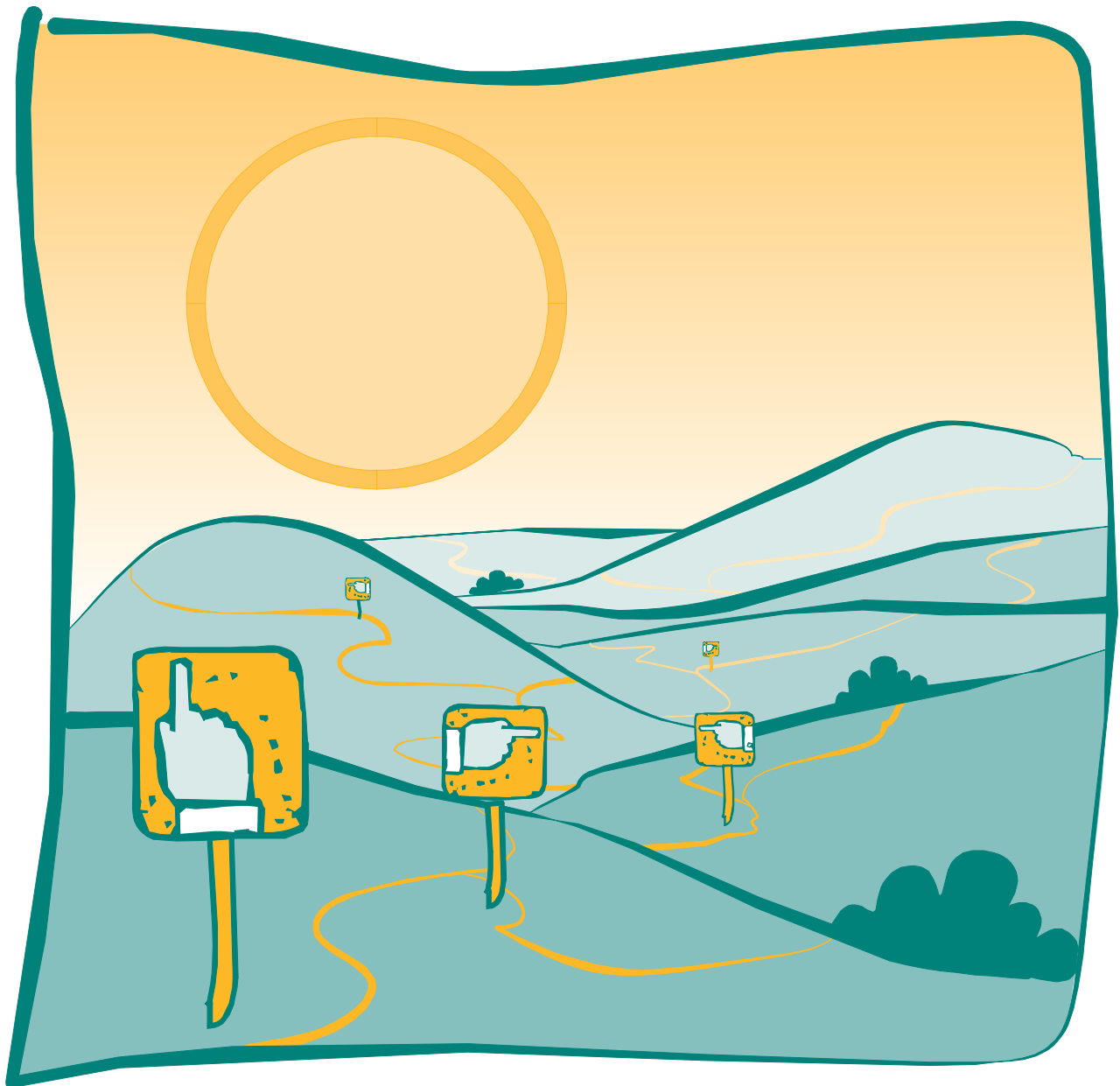
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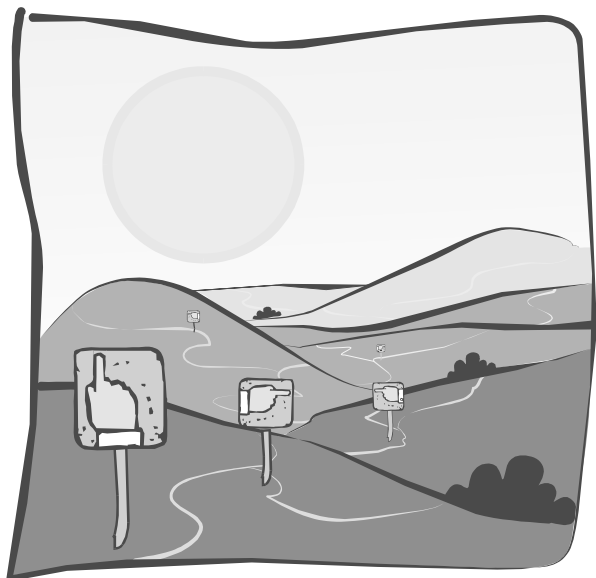
GETTING *Started*

WITH

Integrated Care Pathways



GETTING STARTED WITH INTEGRATED CARE PATHWAYS



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Clinical Pathway and Algorithm Implementation Plan

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Clinical Pathways Starter Kit

- London Health Sciences Centre, University Hospital Campus, London, Ontario

Quality Workbook - Clinical Pathways/Algorithms

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INTRODUCTION

One of the main challenges facing health professionals, managers, and administrators in Saskatchewan health districts is trying to make the best use of limited resources while providing high-quality, timely care.

Framing the challenge are the components of quality set out by the Canadian Council on Health Services Accreditation (CCHSA). As part of its accreditation review, the CCHSA assesses

- Acceptability;
- Accessibility;
- Appropriateness;
- Competence;
- Continuity;
- Effectiveness;
- Efficiency; and,
- Safety.

It is difficult for health professionals to stay abreast of the ever-growing amount of medical evidence available. However, systematic literature reviews on a wide variety of clinical and health system issues—now easily accessible via the Internet—can help streamline this information-gathering process.

Integrated care pathways – What are they?

Integrated care pathways (ICPs) use the current best evidence gained from systematic reviews, as well as input from multidisciplinary teams, to outline the optimal course of care for all patients who have a specific condition or who are undergoing a specific procedure. Other common names for these tools include clinical pathways, clinical care pathways, and Care Maps®.

ICPs plot out for a particular diagnosis or procedure the optimal sequence and timing of interventions by physicians, nurses, and other professionals. Because pathways prescribe treatment across different care settings and even between different health districts, they help ensure that coordinated, quality service is provided over the full continuum of care. Care pathways are designed to minimize delays, make best use of resources, and maximize quality of care.

ICPs that are inter-sectoral, multidisciplinary, and portable between health districts have the potential to improve discharge planning and coordination, and information flow between professionals, care settings, and districts.

Benefits of integrated care pathways

- **Care pathways bring quality improvement to the bedside.** Regular tracking of key indicators and processes can identify areas where patient care can be improved.
- **Pathways ensure the care process is better monitored and streamlined for the majority of people in a given patient population.** Pathways provide patients with more consistent care/service, by minimizing variations in practice. Because pathways are based in part on similar previous cases, providers are better equipped to predict all aspects of the care process (including milestones, complications, outcomes), and improve the quality of care provided to the next patient with the same condition.
- **Care pathways help ensure a high degree of efficiently delivered care for a patient population.** Once a pathway has been put in place, key indicators are regularly monitored (e.g., quarterly) to assess the effectiveness of care provided. This information is not used for judging individual performance, but rather for learning, monitoring quality (i.e., benchmarking comparisons, trends over time, etc.), and targeting areas in need of improvement.
- **Evaluation processes are built into pathways when they are developed.** Pathway indicators

can be tied into a district's existing quality or performance indicator program and can reflect qualitative as well as quantitative information. This information can be used at many different levels within the district.

- **Because care pathways include outcome evaluations, they enable health providers to monitor the appropriateness of interventions.**
- **Care pathways provide all team members with daily information on a patient's progress and status.**
- **The patient version of pathways enables people to play an informed, active role in their own care.**

- **Care pathways are an excellent tool for educating students and new staff.** They provide a visual representation of the care plan and the expected course of care. Pathways serve as a useful orientation tool in teaching hospitals, where medical students and residents frequently rotate through different services, or in health districts that rely on locum coverage or have high rates of staff turnover.
- **Doctors can earn continuing medical education credits for helping districts develop and monitor care pathways.** Under new guidelines from the Royal College of Physicians and Surgeons of Canada, physicians will earn two credits per hour for participating in this district activity.

Developing and implementing integrated care pathways

Pathways are developed and implemented in four main phases:

- Getting started
- Developing integrated care pathways
- Implementing integrated care pathways
- Analysis and review

Although each phase represents a distinct stage on a timeline, it is not uncommon to move back and forth between phases in the process of developing a pathway. Your timeline will be highly dependent on the availability of resources (information, human, and financial) and the complexity of your pathway. **Most organizations should plan to spend at least six months on the initial three phases.**

Team development, data collection and analysis, and communication are integral parts of all four phases.

PHASE	1	2	3	4
	Getting started	Developing integrated care pathways	Implementing integrated care pathways	Analysis and review
TIME	1 month	3 months	2 months	Ongoing
Team development _____	→			
Data collection and analysis _____	→			
Communication _____	→			

PHASE I: GETTING STARTED

1.1 Goals of integrated care pathways

1.2 Team approach

1.3 Developing the team (Steering Committee/Working Group)

1.4 Choosing a patient population

1.5 Including key stakeholders

1.6 Borrow or build?

1.1 Goals of integrated care pathways

Care pathways are designed to achieve several goals:

- Maintain or improve patient outcomes while making efficient use of district resources;
- Increase clinical effectiveness by decreasing variation in practice and streamlining the care process for all patients in a specific patient population;
- Ensure all interventions are appropriate and performed on time, with no critical aspects of care omitted;
- Enhance continuity across the care continuum by ensuring coordinated discharge planning from Day 1;
- Enhance multidisciplinary planning and problem solving;
- Identify opportunities for improving care delivery;
- Ensure that consistent, quality care is less dependent on individual provider or site (e.g., hospital, community care, district); and,
- Enable patients and their families to take an informed role in care planning (through patient versions of the pathways).

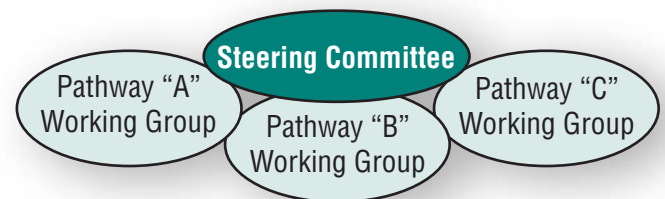
To achieve these goals, the patient care recommended in pathways is, wherever possible, based on evidence from current medical literature rather than on “the way we’ve always done it.” This may require dramatic changes in some practices, but only minor modifications in others. Good communication is one of the keys to successfully managing change.

1.2 Team approach

It is crucial that you use a multidisciplinary, team approach when developing care pathways. The inter-

action and collaboration within such a group will result in optimum care planning for the patient by facilitating information flow and coordination of care.

Your first step is to form a steering committee. Its function will be to coordinate the review of existing care pathways, identify and arrange in order of priority diagnoses or procedures requiring new pathways, and oversee the different working groups developing various care pathways.



Your next step will be to strike separate working groups for each pathway. These groups should include representatives of front-line staff from all disciplines involved in delivering care to the specific patient population you are targeting. You may also need to recruit additional individuals who have specific areas of expertise.

The support of doctors is critical to the success of care pathways. A “physician champion” who has expertise in the specific case type and the respect of colleagues is an essential member of your pathway development and implementation team.

1.3 Developing the team (Steering Committee/Working Group)

✓ Please refer to the sample terms of reference for steering committees and working groups in the appendices at the end of this document.

Effective pathway teams share a number of common elements. Members are

- Available to meet regularly;
- Committed to working together toward the goals of the process; and,
- Drawn from front-line care, day-to-day management, and system leadership.

To ensure effective team meetings, several issues should be addressed at the outset, then incorporated into the written terms of reference for the team:

- Who will lead the group and be responsible for ensuring that the process advances and remains productive?
- How will decisions be reached? A consensus approach is difficult, but far more likely to lead to successful implementation of the care pathway.
- How often will the group meet, for how long, and where?
- How will the group deal with conflicting opinions?
- What are the roles and responsibilities of each team member?
- How will agendas be set and minutes recorded?
- How will team meetings be assessed or evaluated?
- Do you have a physician champion with the right expertise and credibility among peers?
- Are the various caregiver groups represented?
- Does the team include members from across the entire continuum of care?
- Will you need help from a computer expert, data analyst, financial expert, health records technician, or others? Do these experts need to be on the team or simply available for consultation?
- Should you include a representative from the patient population that will be affected by the pathway?

Setting these ground rules creates common expectations for behaviour within the group. Group cohesion will also be enhanced if everyone involved agrees on common goals for the team.

1.4 Choosing a patient population

Developing and implementing integrated care pathways is not easy. It takes time and resources—particularly in the early phases—so it is important to choose patient populations carefully. Pathways are most suited to those diagnoses or procedures with four or more of the following criteria:

- High volume;
- High cost;
- Significant variability in practice;
- High morbidity/mortality;
- High public profile (as result of media attention, political pressure);
- Reliance on multidisciplinary team;
- Demonstrated interest of caregivers to participate and assist in the process; or,
- Systems in place to support ongoing tracking for the purposes of analysis and maintaining improvements.

You may need to review utilization data from your district to identify patient populations that have significant variability in care (length of stay, testing protocols, care/treatments by day of stay, reasons for delays, etc.).

Many centres begin with surgical pathways because the post-surgical course is easier to map and track than treatment for more complex medical conditions. That said, some medical patient populations have the most to gain from better coordination of multidisciplinary care across settings.

1.5 Including key stakeholders

Everyone who might be involved with or affected by a care pathway should be kept informed through all the phases of its development. Representatives of key stakeholder groups should participate on the pathway development committee, with one of their major responsibilities that of keeping colleagues apprised of project progress and decisions made.

Be sure to provide a mechanism through which all stakeholders can ask questions or voice concerns. It is better to understand and address these issues early in the process than be ambushed by them when you are trying to put your new pathway into practice.

The steering committee/working group must determine

- How stakeholders will be kept informed;
- Who will be responsible for communicating with stakeholders; and,
- How to ensure stakeholders' concerns are addressed.

There are a number of ways to share information with stakeholders about your pathways project, including

- News bulletins or articles in relevant newsletters;
- Open forums or nursing unit-based meetings;
- A telephone voice-mailbox or email address where individuals can submit questions or concerns;
- An established working relationship with your district's communications office, to ensure all levels of the organization are kept informed;
- Presentations at meetings of stakeholder groups; and,
- Academic detailing (one-on-one or small group meetings with key individuals).

1.6 Borrow or build?

You have two main options when developing a care pathway: you can adapt an existing pathway developed elsewhere or you can create your own from scratch.

Existing pathways are available from a number of sources. Other jurisdictions, individual facilities, or

consultants with pathway development experience will often share their work, sometimes for a fee. Pathways from elsewhere must be evaluated to ensure they are based on the latest evidence, and modified by your working group to ensure they fit circumstances within your health district.

Developing your own care pathway fosters a sense of ownership that is important in getting the tools applied in your district. Similarly, the multidisciplinary collaboration that goes on during a pathway's development contributes to its subsequent adoption and use. You may find it useful to examine existing care pathways to identify elements you should include in your own pathway. To create a pathway that will be effective in your district, be sure to consider the resources available locally and your district's culture.

“Find a physician champion to lead the charge.”

(McMillan, 2000)

“Get sponsorship and support from everyone involved, from administration to the bedside.”

(McMillan, 2000)

PHASE 2: DEVELOPING INTEGRATED CARE PATHWAYS

2.1 Review the evidence

2.2 Collect data

2.3 Review current practice

2.4 Identify key indicators

2.5 Draft an integrated care pathway

2.6 Review and revise draft

2.7 Develop patient version of care pathway

2.8 Monitor indicators

2.1 Review the evidence

Conduct a thorough review of the literature to identify the best evidence on caring for the patient population you are targeting. This information should be assessed to ensure it is relevant to your circumstances and consistent with best practice models. During this step, be sure to involve members of your pathways team who have experience doing systematic literature reviews. A summary report highlighting the key points from the literature should be distributed to all members of your working group.

2.2 Collect data

Collecting data during this phase will enable you to objectively assess current practices and establish a baseline for future evaluation of your pathway's impact.

To keep things manageable, collect only those data directly related to the condition or patient population on which you are focusing. Include resource utilization data (case costs, length of stay, acuity measurements by day of stay, laboratory/diagnostic-imaging utilization) as well as selected qualitative data from patients and care providers.

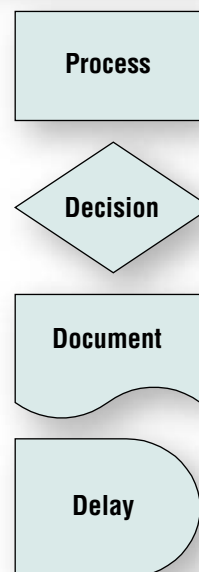
Where you look for data will depend on the focus of your care pathway and the structure of your health district. Before you embark on time-consuming chart reviews or patient surveys, find out what data are already available or can be easily retrieved. Your district's utilization coordinator, health records manager,

chief of staff, chief executive officer, or director of research should be able to help you here.

2.3 Review current practice

Have those professionals, staff, and physicians who actually work in the area you are targeting help identify and illustrate current practices and processes. This type of information is usually recorded in a flow chart, which is a graphic depicting the order of steps in a particular process (**See diagram below**). Your quality improvement analysis will be productive only

Symbol Representation for Flow Charts



These symbols are commonly used when developing a flow chart:

if your flow chart accurately reflects the process on which you are focusing.

Be sure to track or capture all issues and improvement ideas as you develop your flowchart. You should also have working group members review existing practices. To evaluate improvements in process and patient outcomes, gather as much information as possible on variables likely to be defined as key components, milestones, and expected outcomes. Try not to spend more than two working group meetings developing a flow chart of current practice.

2.4 Identify key indicators

Key indicators are milestones against which you can measure a patient's progress along a care pathway. They are based on current literature and tell you where patients should be at specific stages in their recovery. Indicators must be monitored on a daily basis to ensure an individual is receiving optimal care. Some examples of key indicators to monitor are

- Mobile at Day 2;
- Eating solid food at Day 3;
- Discharge at Day 4; and,
- Wound healed at Day 12.

The Canadian Council on Health Services Accreditation defines indicators as measurements, screens, or flags used as a guide to monitor, evaluate, and improve the quality of care, clinical services, support services, and organizational functions that affect patient/client outcomes. According to the CCHSA

- Indicators should alert the care/service provider when the activity has reached an acceptable/unacceptable target (e.g., wait times);
- Indicators may be used as points of reference for evaluation (e.g., prior to implementation of care pathway vs. post-implementation);
- Indicators can be used to examine trends over time (e.g., comparing the present three-month period with the last four three-month periods); and,
- Measuring and reporting of indicators should challenge teams and organizations to provide better care/services, which in turn should improve health outcomes.

Indicators are neutral. Their sole purpose is to provide information that is used in its aggregate form. They are not designed for evaluating the performance of individual staff members.

There are various types of indicators:

Structure Indicators reflect the environment in which care/service is provided.

- These indicators measure the characteristics of care or resources used to deliver care to the patient/client/resident.
- They include the physical facilities, characteristics of administrative organization, and qualifications of staff and physicians.
- Environments with good structural properties typically provide quality care and service.

Process Indicators reflect the way in which care/service is provided.

- These indicators measure the actual delivery of care or activities used to deliver care/service.
- They include the degree to which care/services conform with the standards and expectations of the provider and the client.

Outcome Indicators reflect the achievements of the delivered care/service.

- These indicators measure the result or end products of care/service delivery, such as improved survival, functional health status, or quality of life.
- They measure the extent to which a desired change, effect, or result was achieved for a patient/client.

Before you put your new pathway into practice, identify all key indicators and outcomes to be measured. Your district's utilization management coordinator (or equivalent) can help identify relevant and appropriate indicators, as well as additional resource people and materials.

By putting in place mechanisms for monitoring system and patient outcome indicators, all stakeholders—from front-line staff and physicians to administrators—will be able to evaluate the impact of the care pathway. Doing this will also ensure that all the data you need to study indicators and outcomes can be collected at the appropriate time.

2.5 Draft an integrated care pathway

Analyze the current process of care and modify it as necessary so that it is evidence-based and supported by the multidisciplinary team actually providing clinical care, other service providers, patients, and families involved.

During your analysis, you may find that a decision-making process is unclear at some major point in the care process. If that occurs, your working team may want to develop a relevant algorithm. Algorithms are designed to guide clinicians through the “if X, then Y” decision-making process required when there is variation from or clinical complexity within a pathway.

Construct your pathway as a multidisciplinary plan and record of care that includes all key evidence-based recommendations and indicators. Consult with your forms committee to integrate all relevant information from existing forms and systems. Doing so will help you avoid double-charting, ensure accurate record-keeping on the pathway form, and that pathways meet your organization’s health records requirements. This new form can now serve as the primary charting form on which all members of the care team will document their interventions and assessments.

Ensure that the components of your care pathway cross the continuum of care—from pre-admission, to acute care, community care, and out-of-district care as required (See diagram below) .

To enhance and improve the efficiency of your care pathway, you will need to develop supporting documents and forms, such as standard physician orders and patient education materials.

2.6 Review and revise draft

Before you print copies of your new pathway and try to put it into practice, obtain feedback and sugges-

tions for revisions from other representatives of all relevant disciplines and professions. This input, however, must be considered carefully. If the comments you receive at this stage deviate from the best relevant evidence, you may need to educate providers about recommended practices and the research evidence.

Testing a revised version of your pathway in a small sample of the target patient population will help identify any further process, design, or system changes that are required before you implement it across your district. You can also collect a sample of key indicator data during pilot-testing to check validity.

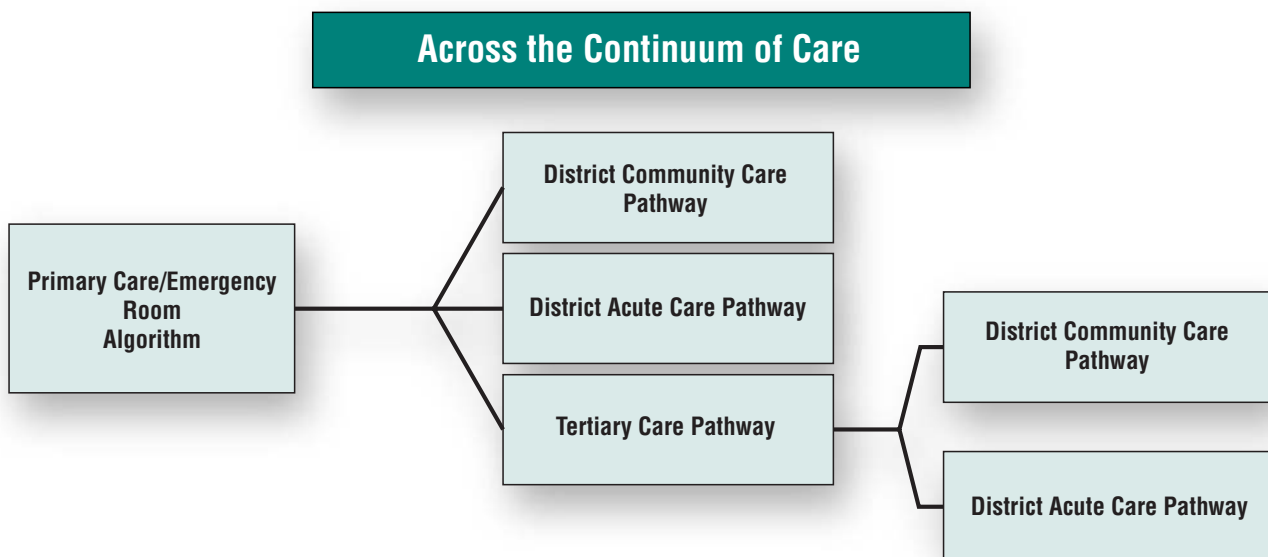
2.7 Develop patient version of care pathway

A patient version of the pathway is a useful way to educate and involve patients in the care process. It also provides an opportunity to answer some of the common questions patients are likely to have about their plan of care and various interventions.

Use plain language (Grade 6 reading level is a good target) to explain the various steps in the pathway and their projected timing, and provide key contact names and telephone numbers in case patients want more information.

2.8 Monitor indicators

It is important to establish a system for monitoring indicators in your pathway. The method you use will depend on the stage of your pathway development and processes or outcomes you are monitoring:



- Implementation/Evaluation – In the initial stages of implementation, you may need to frequently monitor several of your proposed pathway indicators to identify problems within the pathway itself. Once the pathway is established and implementation issues have been addressed, it can then be evaluated and revised annually to reflect new evidence and best practices.
- Patient Population Outcome – These indicators relate to the entire group for which you have

developed a pathway. They help identify system limitations and facilitate quality of care reporting.

- Individual Patient Progress – These indicators look at individual patients' progress along a pathway. Variations in the expected course at any stage will have implications for subsequent steps in the care process. Discharge and community care planning can then be adjusted accordingly.

“Don’t try to change the whole world at once. Choose workable pieces to start on.”

(McMillan, 2000)

“Incorporate clinical judgment into the plan.”

(McMillan, 2000)

PHASE 3: IMPLEMENTING INTEGRATED CARE PATHWAYS

3.1 Finalize clinical and patient versions of pathway

3.2 Communication and education strategies

3.3 Linking with other districts

3.4 Implementation strategy

3.1 Finalize clinical and patient versions of pathway

Once you have reviewed and revised your care pathway (as described in section 2.6), you are ready to print both versions (clinical and patient) and distribute them to the appropriate care settings.

3.2 Communication and education strategies

You should develop an education package and dissemination strategy to inform all members of the multidisciplinary care team and other clinicians about the pathway design, new processes of care, and service delivery. Include in these materials any relevant evidence supporting the new process and any changes to the current timing and provision of services and care.

To be effective, your education strategies must recognize the different needs and learning styles of each audience. Some teaching tools you may want to consider include academic detailing, reminder systems, in-services, existing communication systems, and various forms of written materials.

3.3 Linking with other districts

Establish education and communication links with referring and referral centres. This will ensure that the course of care and progress outlined in your pathway is followed when patients are initially seen in another district or leave your district to receive care elsewhere.

3.4 Implementation strategy

You may need to monitor progress and provide education during the transition between the old process of care delivery and the new pathway-based process. Changes in practice patterns can bring feelings of frustration, uncertainty, and resistance. Patience and gentle reinforcement with support and education will help make the transition go more smoothly. Be sure to provide plenty of positive feedback.

Key indicators identified during the development phase should be monitored regularly so you can quickly spot any variances—these may indicate system or performance measures requiring modification. You may have to revise your care pathway or make system changes if you find that specific elements of the pathway cannot be achieved.

“Keep everyone informed and applaud success.”

(McMillan, 2000)

“Respect the contributions of everyone involved in this multidisciplinary process.”

(McMillan, 2000)

PHASE 4: ANALYSIS AND REVIEW

4.1 Evaluation framework

4.2 Outcome/variance analysis

4.3 Feedback to care providers and system administrators

4.4 Continuous quality improvement

4.5 Working group review

4.1 Evaluation framework

Develop an evaluation framework to describe the types of outcomes currently measured in your district. Knowing which outcomes are already measured and where the information is located reduces

duplication of effort and enables your working group to focus on pathway-specific outcomes. The following table includes examples loosely based on one district's quality framework.

CATEGORY	EXAMPLES OF OUTCOMES	POTENTIAL SOURCE
Patient/client perspective	Patient satisfaction: <ul style="list-style-type: none"> – Respect for patient values, preferences, and needs – Coordinated care – Information and education – Reduction of fear and anxiety – Involvement of family and friends – Continuity of care 	Patient/client surveys
Internal process perspective	Effectiveness of care: <ul style="list-style-type: none"> – Outcomes following episodes of care – Unscheduled readmissions – Adverse events – Mortality 	Health records Pathway working groups Utilization manager
Learning and innovation perspective	Evidence-based care: <ul style="list-style-type: none"> – Number of patients on pathway vs. number not Staff and care provider competencies: <ul style="list-style-type: none"> – Opportunities for education and certification 	Pathway steering committee Researchers Staff surveys
Financial perspective	Efficiency of care: <ul style="list-style-type: none"> – Length of stay – Cost per case – Number of unnecessary tests or procedures 	Utilization manager Financial services
Pathway-specific perspective	Specific expected process and outcome indicators (e.g., number of patients mobilizing on Day 3, complication rates, number and type of variance in practice, etc.)	Pathway working groups Finance department Utilization manager

4.2 Outcome/variance analysis

It is important to regularly assess the effectiveness of your pathway. Initially you will need to determine whether key activities and events are presented in the right order and whether the targeted patient population is in fact keeping pace with the expectations laid out in the pathway. A tracking tool such as the variance record shown below can help identify sequencing and system problems.

Variances indicate a change in expected progress (either system or patient outcomes) and can be positive or negative. Even positive variances, such as faster mobilization, should be documented so projected dates for subsequent events (e.g., discharge or provision of community service) can be adjusted accordingly.

Variances can be the result of system issues such as bottlenecks for certain tests, staffing shortages, clinician decisions based on judgment or opinion, and patient/client/family situations that arise unexpectedly.

Using a variance record will enable you to quickly identify changes in progress that may affect outcomes and resource use. Using this information,

you can then alter plans and reallocate resources accordingly.

After you have sorted out system and care sequencing problems, shift your focus to determining whether desired outcomes have been achieved. Individual districts may use different systems for collecting and analyzing the data required to answer that question. While electronic patient records, software, and databases help streamline this task, existing systems and some manual collection of data can provide most of the information you need.

A database for monitoring outcomes should include such information as

- Demographics;
- Pre-existing risk factors for prolonged hospital stay (e.g., living situation, co-morbidities);
- Complications/adverse events;
- Discharge delays;
- Specific outcomes to be tracked;
- Community care/follow-up; and,
- Readmissions.

DATE	PATH DAY	VARIANCE	CATEGORY	REASON	ACTION
	Day 1	Ambulation did not occur	System	Physio therapy not available	Review weekend staffing
	Day 3	Follow-up X-ray done early	Clinician	Clinically indicated	None
	Day 7	Extra home care visit	Patient/family	Family caregiver not coping	Reassess scheduled visits

4.3 Feedback to care providers and system administrators

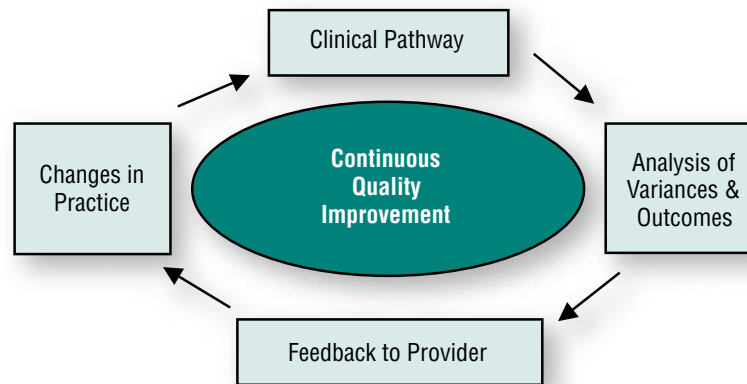
Regular reporting of outcome and variance information provides care providers and system administrators with an opportunity to identify trends in service requirements, incorporate evidence into practice, and formulate new research questions. Effective application of the information gathered through monitoring can lead to better use of resources and improved quality of care.

4.4 Continuous quality improvement

Analyzing variances and outcomes contributes to continuous quality improvement; it provides care providers and system administrators with regular feedback and it encourages changes in practice that incorporate this information. You will want to incorporate these changes in your care pathway so that the next round of variance and outcome analysis captures the impact of the new practices.

4.5 Working group review

The working group is responsible for reviewing the analyzed data and identifying system or practice changes that should be implemented. Its members are also responsible for ensuring that new research evidence and system changes related to the pathway are reviewed and incorporated as needed.



“Minimize documentation duplication and analysis points.”

(McMillan, 2000)

“Be consistent in both process and product. Adapt minor elements to meet site specific needs.”

(McMillan, 2000)

CONCLUSION

Integrated care pathways reflect the ideal treatment and plan of care for a typical patient admitted for a given diagnosis or treatment. Not all patients will follow the pathway. Some will require a more customized approach to meet their unique needs due to co-morbidities, complications, etc. For the vast majority of patients in a given population, however, an integrated care pathway will ensure they get the care they need when they need it, and that critical aspects of care are not forgotten or omitted.

Integrated care pathways are becoming a popular tool for

- Improving the quality of patient care;
- Ensuring that care and treatment is based on the best current evidence available;
- Decreasing the fragmentation of care delivery across the continuum of care; and,
- Ensuring the most efficient and effective use of health care resources.

A successful program of integrated care pathways can help health professionals, managers, and administrators in Saskatchewan's health districts meet one of their biggest challenges: making opti-

mal use of limited resources while delivering top-calibre, timely care.

To be effective, pathways need:

- Support from senior administration and physicians;
- Interdisciplinary involvement throughout the process;
- Clear goals, objectives, roles, and responsibilities;
- Effective communication systems;
- Systems for collecting and analyzing clinical and cost data;
- A culture of evidence-based decision making;
- Research support; and,
- A collaborative approach.

Integrated care pathways can facilitate effective patient/client-centred care across the continuum both within and between districts. Using a coordinated, collaborative approach to develop and implement your pathway will reduce duplication of efforts and ensure that patients/clients move smoothly along a given path of care, regardless of the service setting or district.

“Don't be afraid to try, or to make mistakes.”

(McMillan, 2000)

RESOURCES

Helpful Internet Sites

1. Agency for Healthcare Policy & Research
<http://www.ahcpr.gov/clinic/index.html#online>
2. Canadian Council on Health Services Accreditation
www.cchsa.ca
3. Canadian Institute of Health Information
www.cihi.ca/eindex.htm
4. Canadian Medical Association Infobase
<http://www.cma.ca/cpgs/index.asp>
5. Cochrane Collaboration
<http://www.cochranelibrary.com/clibhome/clib.htm>
6. Health Services Utilization and Research Commission
<http://www.hsurc.sk.ca>
7. MedNet Clinical Paths/Guidelines Connections
<http://www.sermed.com/clinicalpaths.htm>
8. National Health and Medical Research Council – Australia
<http://www.health.gov.au/hfs/nhmrc/publicat/pdfcover/cp30covr.htm>
9. National Pathways Association
<http://www.the-npa.org.uk/>
10. New Zealand Guideline Group
<http://www.nzgg.org.nz/tools.cfm>
11. Norris Medical Library – Evidenced-based Medical Resources
<http://cwis.usc.edu/hsc/nml/e-resources/ebm.html>
12. Scottish Intercollegiate Guidelines Network
www.show.scot.nhs.uk/sign/pdf/sign39.pdf

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Steering Committee

1.0 Purpose

The purpose of the steering committee is to oversee the development of care pathways and algorithms that maintain or improve the quality of care and services while making effective and efficient use of health district and provincial resources.

2.0 Functions

The steering committee is directly accountable to senior administrators in the health district and Saskatchewan Health. It will assume both advisory and decision-making roles in the following functions:

- Provide direction and identify priorities for care pathway and algorithm development;
- Approve a standardized format for clinical pathways and algorithms;
- Assist with securing support for the working groups in all stages of developing, piloting, and implementing care pathways and algorithms;
- Provide guidance and feedback to working groups on objectives, outcomes, and evaluation;
- Monitor the status and progress of each care pathway/algorithm being developed;
- Receive and review the evaluation information on pilot tests of care pathways;
- Review quarterly tracking reports on variance/outcomes for all care pathways and algorithms.

3.0 Membership

Committee membership will depend on the group's scope (provincial vs. district), but could include

- Chief of staff;
- Medical department head;
- Surgical department head;
- Director of health records;
- Director of patient services;
- Utilization management coordinator;
- Researcher;
- Ad hoc members as required; and,
- New members approved by the chair.

The chair of the steering committee could be designated by the province or district, or chosen by committee members.

4.0 Commitment

Meetings will be scheduled monthly or at the call of the chair.

The steering committee will review its terms of reference and membership on an annual basis.

Working Group

1.0 Purpose

The purpose of the working group is to assist the Province/District in maintaining/improving the quality of care and services delivered to patients while maintaining the effective/efficient use of resources. The group will accomplish this by developing and implementing a clinical pathway/algorithm that will be used to facilitate care/treatment delivery to a specific diagnosis or patient group identified by the steering committee.

2.0 Functions

The working group is accountable to the steering committee. It should play a direct role in developing, implementing, and evaluating a clinical pathway/algorithm for the targeted patient population. The group will

- Map out the current processes in care delivery, including variations and delays;
- Systematically review the literature to identify best practices and medical evidence;
- Evaluate whether a clinical pathway, algorithm, or both are required;
- Review any existing, published clinical pathways/algorithms that could be adapted for local use;
- Identify, using the evidence, improvements that are required in the delivery of care/treatment;
- Develop a patient version of the clinical pathway/algorithm for patients and their families;
- Report regularly to disciplines represented on the working group;
- Promote use of the clinical pathway/algorithm during pilot-testing and encourage constructive feedback; and,
- Provide regular feedback to the steering committee on the status of the clinical pathway/algorithm being developed.

3.0 Membership

Working group membership will include

- District representative, co-chair (e.g., Utilization Coordinator, Director of Care, etc.)
- Physician, co-chair
- Representatives of front-line staff from all disciplines involved in the care/service delivery for the specific patient population. This may include but is not limited to:
 - Nursing, Physiotherapy, Occupational Therapy, Pharmacy, Respiratory Therapy, Coordinated Assessment Unit, Social Work, etc.

The district chairperson and a physician will jointly lead the working group. Members will take turns recording and distributing meeting minutes.

4.0 Commitment

Meetings will be scheduled at the call of the co-leader(s) in consultation with working group members. The group will remain in existence through implementation and evaluation of the pathway.

APPENDIX 2 CARE PATHWAY TEMPLATE

	INITIAL HOURS	DAY 1	DAY 2	DAY 3	1 WEEK	1 MONTH
Date						
Consults						
Assessments						
Diagnostics						
Treatments						
Medications						
Activity						
Nutrition						
Elimination						
Patient/Family Education & Psychosocial Support						
Discharge Planning						
Patient/client outcomes	Pain free	V/S stable	Knows how to use _____	Understands discharge instructions	Attending special program	Normal activities resumed
Variance tracking						
Signatures						

“Charting gets people back to the bedside and ensures that everyone is on the same page.”

(McMillan, 2000)

Academic detailing

One-on-one educational sessions presented to physicians and other clinicians.

Algorithms/clinical practice guidelines

Evaluation and management strategies presented step-by-step in a flowchart or decision-tree format to assist providers in delivering care for a specific clinical diagnosis or procedure—often to address a complexity within a pathway. Algorithms/practice guidelines are evidence-based statements to help physicians and patients make decisions about appropriate health care under specific clinical circumstances. The algorithm/clinical practice guideline may either be a stand-alone tool or inserted into an appropriate section of a care pathway.

Benchmarking

Measuring a product or service against established standards of excellence both within and outside the health care field.

Care pathways/Care Maps®/clinical pathways

Multidisciplinary, clinical management tools that describe the optimal sequence and timing of interventions for a particular diagnosis or procedure. They are designed to minimize delays, make best use of resources, and maximize quality of care.

Data

The raw, unorganized material from which information can be generated. Data on their own have no meaning. It is not until they are interpreted through some form of data-processing system that data become information.

DRG

American acronym that stands for diagnosis-related group. Our Canadian equivalent is case-mix group (CMG).

District or health district

A geographically defined collection of health service facilities, programs, and providers governed by a single board.

Effectiveness

A care/service, intervention, or action that achieves the desired results.

Efficiency

Achieving the desired results with the most cost-effective use of resources.

Evidence-based decision-making

Making decisions about clinical issues or policy on the basis of the best available evidence. Most systems developed for grading evidence rank expert opinion lower than research-based evidence.

Objectives

Concrete, measurable steps to be taken to achieve identified goals.

Outcome

Consequences, results, or impact of an intervention(s) that may or may not be intended.

Outcome indicator

For patient care teams that provide direct or indirect patient care, outcome indicators should be patient-related and measure those changes in the patients' health status that can be attributed to preceding care and service (i.e., processes and structures).

For support services, governance, and management teams where the link between service delivery and patient health is not a direct one (i.e., information management, human resources, and governance activities), outcome indicators should measure the desired end results of the processes.

Patient-related outcome

Change in a patient's health status that can be attributed to care and service received.

Patient satisfaction outcome

A patient's level of satisfaction with the amenities and results of care.

Performance indicator

A measurement tool, screen, or flag that is used as a guide to monitor, evaluate, and improve the quality of care, clinical support services, and organizational functions that affect patient outcomes.

Performance measurement

Using tools and other methods to quantify processes and outcomes.

Quality

Doing the right thing, doing it well, and satisfying the consumer.

Quality improvement

An organizational philosophy that seeks to meet patients' needs and exceed their expectations by using a structured process to selectively identify and improve all aspects of service.

Variations

Deviations from an expected course of care and progress. Reasons for variations in processes and outcomes can be related to the system, caregiver, or patient.

APPENDIX 5 10 C'S OF SUCCESSFUL CARE PATHWAYS

- Champion:** Find a “physician champion” to lead the charge.
- Commitment:** Get sponsorship and support from everyone involved, from administration to the bedside.
- Communication:** Keep everyone informed and applaud success.
- Collegiality:** Respect the contributions of everyone involved in this multidisciplinary process.
- Chunk it up:** Don't try to change the whole world at once. Choose workable pieces to start on.
- Clinical judgment:** Never lose this. Incorporate clinical judgment into the plan.
- Consistency:** Be consistent in both process and product. Adapt minor elements to meet site-specific needs.
- Complexity:** Pathways can be simple too. Minimize documentation duplication and analysis points.
- Charting:** Charting gets people back to the bedside and ensures that everyone is on the same page.
- Challenge:** Don't be afraid to try, or to make mistakes.

*Excerpt from Stewart McMillan's presentation at Integrated Care Pathway Workshop, Nov. 2000



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