

Effective Interventions Unit

Developing and Implementing Integrated Care Pathways

Guide 2: Developing Integrated Care Pathways

WHAT IS THE PURPOSE OF THIS GUIDE?

This is the second in a series of guides on developing and implementing Integrated Care Pathways (ICPs). In this guide we identify the steps involved in developing an ICP and examine each process in more detail.

WHO SHOULD READ IT?

Anyone involved in commissioning, planning, developing, delivering and evaluating services for drug users.

BACKGROUND

The Effective Interventions Unit (EIU) launched **Integrated Care for Drug Users – Principles and Practice** in October 2002. As part of this work, the EIU consulted service providers and service users on the **key principles of assessment, planning and delivery of care** in the drugs field in Scotland. The findings from these consultations are used throughout the document. In response to the interest from the field in developing evidence-based care systems the EIU undertook to produce this guide. For more information on integrated care for drug users please see www.drugmisuse.isdscotland.org/eiu/intcare/intcare.htm

DEVELOPING INTEGRATED CARE PATHWAYS

The Health Service Utilisation and Research Commission (HSURC) of Canada identified 8 steps to developing ICPs. **Integrated Care for Drug Users – Principles and Practice** provides **outline** pathways for accessibility, assessment and planning & delivery of care. This guide provides further information on each of the 8 steps, and refers to the 'Assessment Process' as a practical example.

8 STEPS TO DEVELOPING ICPS

- 1 Review the evidence
 - 2 Collect data
 - 3 Review current practice
 - 4 Identify key indicators
 - 5 Draft an integrated care pathway
 - 6 Review and revise draft
 - 7 Develop client version of care pathway
 - 8 Monitor indicators
- (HSURC 2001)

STEP 1: REVIEW THE EVIDENCE

Conduct a thorough review of the literature to identify the best evidence on caring for the client population that you are targeting. This may already be available, e.g. EIU treatment reviews, Cochrane database. This information should be assessed to ensure that it is relevant to your circumstances and, where applicable, consistent with national guidelines and standards. During this step, be sure to involve members of your pathways team (see Guide 1) 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. **Integrated Care for Drug Users (Chapter 4)** examines and discusses the process of assessment and describes the key principles of evidence-based, effective assessment.

STEP 2: COLLECT DATA

Collecting data during this phase will enable you to objectively assess your team's current practices and establish a baseline for future evaluation of your pathway's impact. To keep things manageable, collect only data directly related to the situation or client population on which you are focusing. Where possible, include economic data (case costs, length of treatment) as well as selected qualitative data from clients and care providers.

Where you look for data will depend on the focus of your care pathway and the structure of your organisation. Before you embark on time-consuming processes, find out what data is already available or can be easily retrieved. Your Drug Action Team coordinator, ICP Facilitator, Clinical Effectiveness staff or health records manager should be able to help you here.

Sources of information might include:

- Casenote reviews
- Local prevalence data
- Corporate Action Plans
- Client surveys
- SMR24 data

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STEP 3: REVIEW CURRENT PRACTICE

Professionals, staff, and practitioners should identify and illustrate current practices and processes. This type of information is usually recorded in a flow chart, which is a graph depicting the order of steps in a particular process (**See diagram below**). Your quality improvement analysis will be productive only if your flow chart accurately reflects the process on which you are focusing.

Assessments are often service-led, resource-focused and time-consuming.

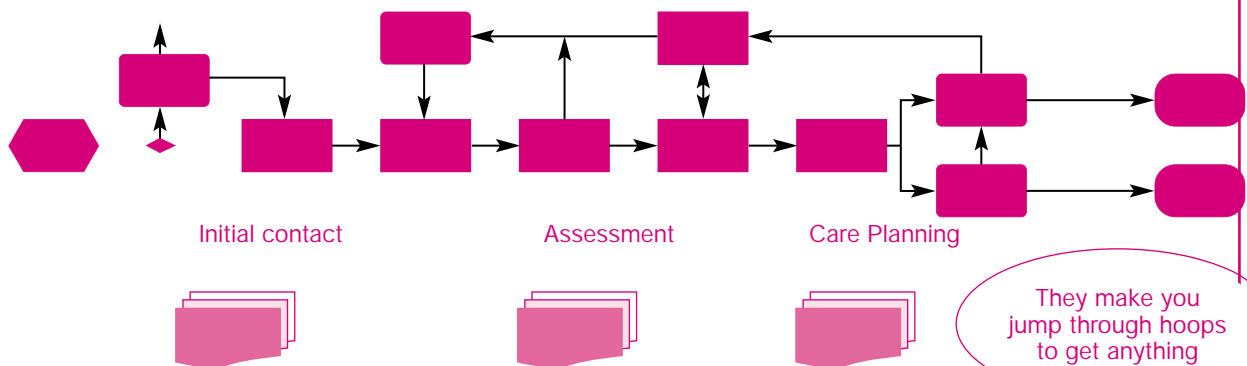
EIU Service Provider Consultation 2001

I just don't understand why there can't be one file that's got all the information on you and that goes from place to place... What's difficult about that?

EIU Service User Consultation 2001

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 client 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. Comprehensive guidance on Process Mapping can be found at: www.modern.nhs.uk/improvementguides/reading/processmapping.pdf

Process Mapping Diagram



EIU Service User Consultation 2001

STEP 4: IDENTIFY KEY INDICATORS

Key indicators are milestones against which you can measure a client's progress along a care pathway. They should be based on current literature and tell you where clients should be at specific stages in their care. Indicators must be monitored on a regular basis to ensure an individual is receiving optimal care. 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 client/client outcomes'.

- Indicators should alert the care/service provider when the activity has reached an **acceptable/unacceptable target** (e.g., waiting 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);
- Measuring and reporting of indicators should challenge teams and organisations to **provide better care/services**, which in turn should improve health outcomes; and
- The purpose of indicators is to **provide information** that is used in its aggregate form. They are not designed for evaluating the performance of individual staff members.

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There are three types of indicators: Structure, Process and Outcome.

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 client. They include the physical facilities, characteristics of administrative organization, and qualifications of staff. 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 detoxification, reduced injecting behaviour or reduction in criminality. They measure the extent to which a desired change, effect, or result was achieved for a client.

Before you put your new pathway into practice, identify all key indicators and outcomes to be measured. Your local ICP Facilitator (or equivalent) can help you develop relevant and appropriate indicators, as well as additional resource people and materials. By putting in place mechanisms for monitoring system and client outcome indicators, all stakeholders – from front-line staff and clinicians 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.

STEP 5: DRAFT AN INTEGRATED CARE PATHWAY

Analyse the current process of care and modify it as necessary so that it is evidence-based and supported by the multidisciplinary team actually providing care, other service providers, clients, and families involved. During your analysis, you may find that a decision-making process is unclear at some point in the care process. If that occurs, your working team may want to develop a relevant algorithm. Algorithms are designed to guide practitioners through the 'if X, then Y' decision-making process required when there is variation from or other 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 administrative colleagues to integrate all relevant information from existing forms and systems. Doing so will help you avoid double documenting, ensure accurate record keeping on the pathway form, and that pathways meet your organisation's records requirements. This new form can now serve as the primary documenting 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 initial assessment, to care provision and rehabilitation, and out-of-district care as required. To enhance and improve the efficiency of your care pathway, you will need to develop supporting documents and forms, such as standard procedures and client education materials.

The following features have been identified as being important in a good pathway document

Documentation

- A single record of client care
- Standard format
- Simple in design and easy to follow
- Abbreviations explained if used
- Provides an audit tool

Wording and content

- Written in plain language
- Include client information
- Highlight roles and accountabilities
- Include signatures of stakeholders
- Include realistic goals, timeframes and measurable outcomes
- Dynamic and flexible
- Incorporate guidelines, protocols and standards
- Follow a logical sequence ensuring no duplication of information

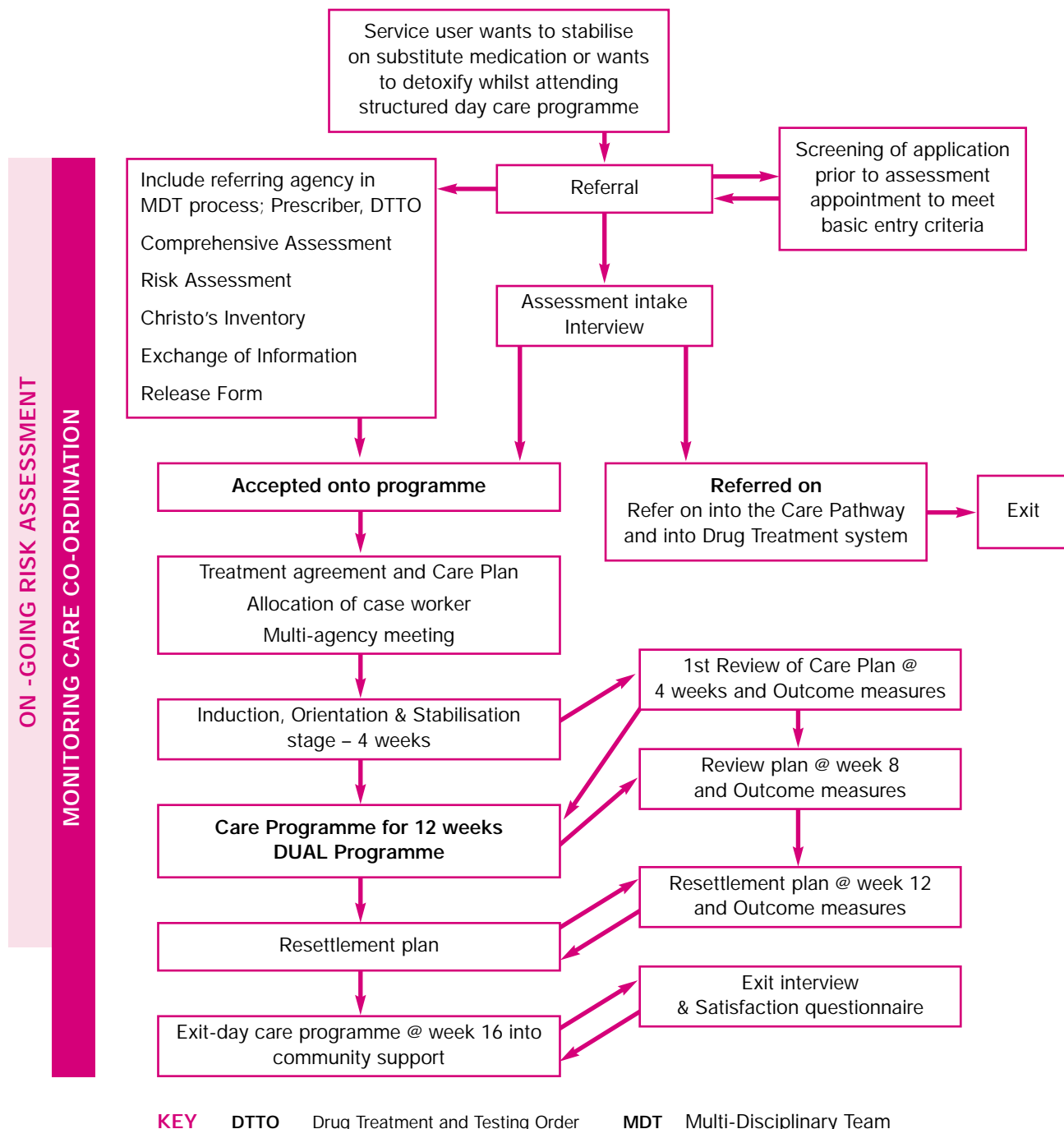
Compliance

- Easy to complete
- Easy to find relevant information
- Variations recorded together with related actions

An introduction to Clinical Pathways, Putting patients first, The National Assembly of Wales (Sept 1999)

EXAMPLE OF INTEGRATED CARE PATHWAY (A)

Care Pathway into Phoenix House Day Care Programme

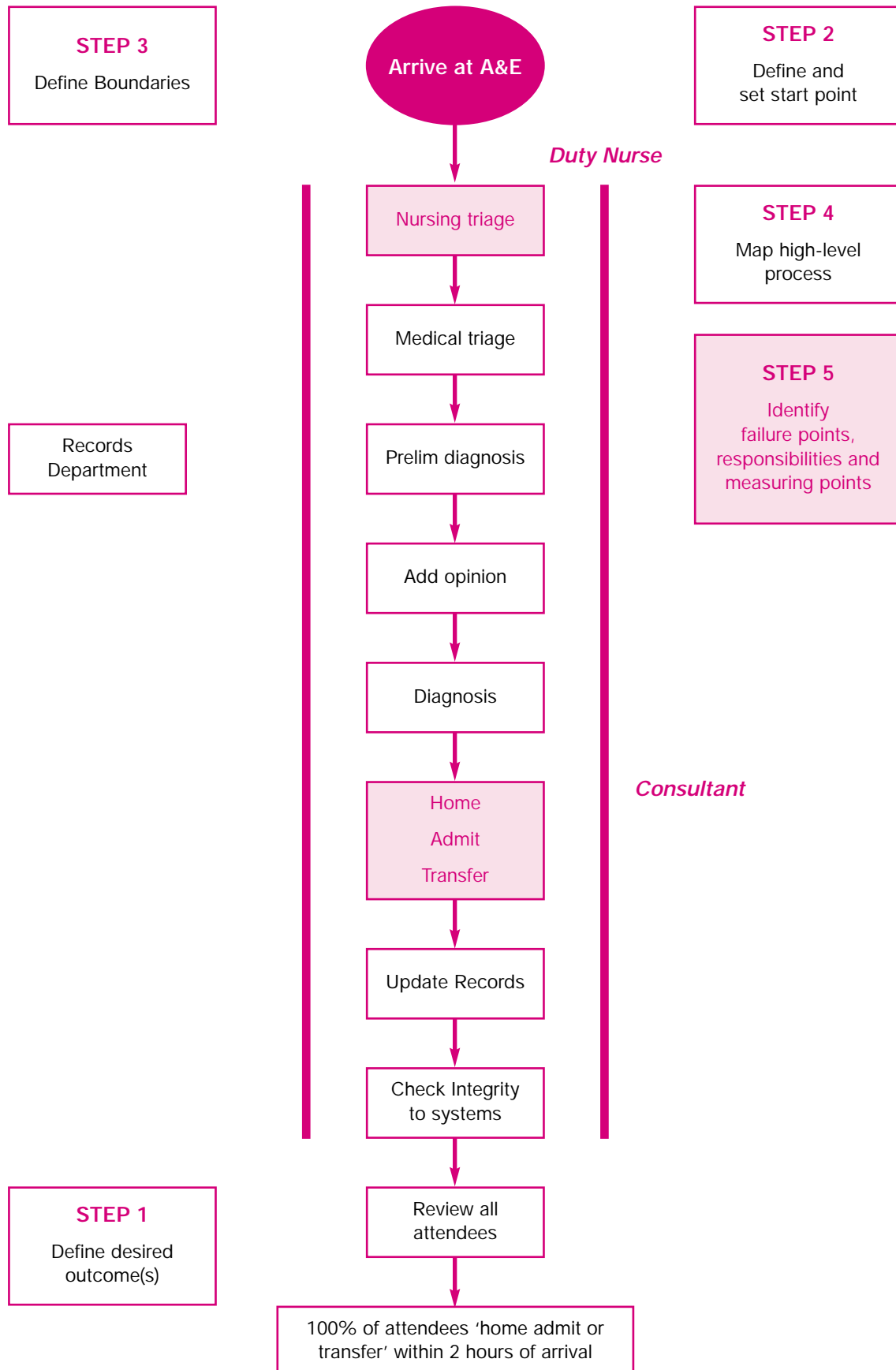


Outcomes

- NTA Minimum Data Set
- Service user satisfaction questionnaire – 6 weeks and exit
- Multi-agency reviews
- CISS
- Care planned
- Review
- Dates met
- Screening results – positive vs negative screens
- Attendance sheets
- Completed programme
- Improvements in DOH outcome domains – Health, Social Functioning, Criminal Justice, substance use
- Childcare & Parenting
- Personal development & Psychological functioning – Rosenberg self Esteem, CISS

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EXAMPLE OF INTEGRATED CARE PATHWAY (B)





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<http://www.drugmisuse.isdscotland.org/eiu>

STEP 6: REVIEW AND REVISE DRAFT (PILOTING)

Before you print copies of your new pathway and try to put it into practice, obtain feedback and suggestions 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 evidence regarding best practice, 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 client 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 that your ICP works the way you intended it to work.

STEP 7: DEVELOP A CLIENT VERSION OF THE CARE PATHWAY



A client version of the pathway is a useful way to educate and involve clients in the care process. It also provides an opportunity to answer some of the common questions clients are likely to have about their plan of care and various interventions. Use plain language to explain the various steps in the pathway and their projected timing and provide key contact names and telephone numbers in case clients want more information.

The 'client-held' record should be used by workers and clients to record key pieces of information that the client requires or wishes. This might include appointment details, individual goals, drug use diary, strategies and contingency plans. This record should be used to inform the ongoing monitoring and evaluation of the individual's care of the Integrated Care Pathway.

STEP 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.
- **Individual Client Progress** – These indicators look at individual clients' progress along a pathway. Variations in the expected course at any stage will have implications for subsequent steps in the care process. For example, discharge and community care planning will need to be adjusted accordingly.
- **Client 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, e.g. waiting times, treatment length and accessibility of services for specific client populations.

NEXT STEPS

This is the second in a series of four guides on developing and implementing Integrated Care Pathways. It will be followed by '**Implementing integrated care pathways**' (Guide 3) and '**Analysis and review**' (Guide 4). Later guides will focus on developing ICPs for specific interventions.

The Effective Interventions Unit would welcome feedback on the style and content of this guide. We would be happy to receive suggested topics for the later guides as well as notes of interest from people who would wish to be involved in developing these.

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