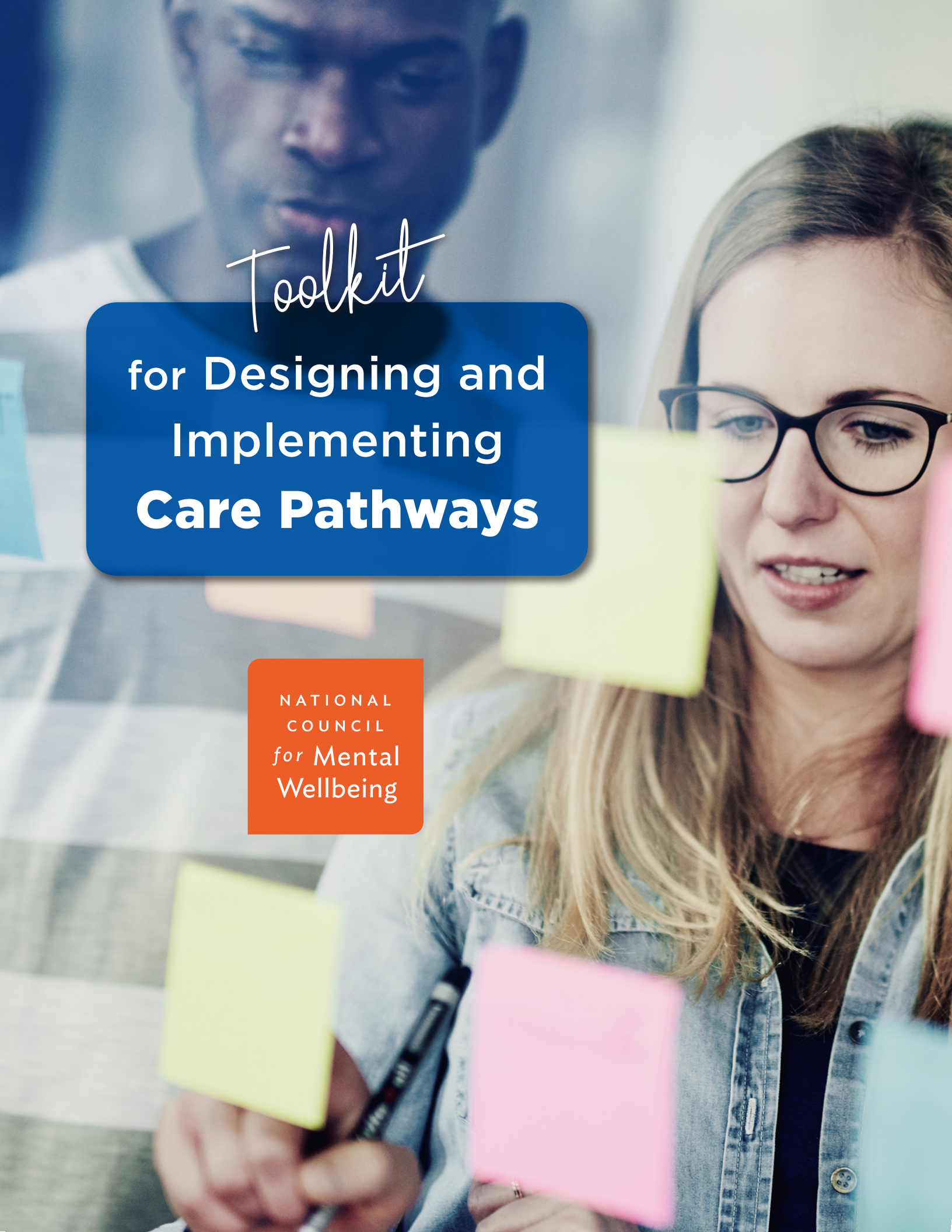

Toolkit for Designing and Implementing **Care Pathways**

NATIONAL COUNCIL *for* Mental Wellbeing

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INTRODUCTION

As the health care system increasingly transitions to value-based models that promote efficient and effective care, providers must adopt strategies that ensure clients are receiving the right services at the right time. Care pathways provide standardized guidelines for identifying client needs and adopting the appropriate clinical best practices.

The guidance, tools and worksheets within this document and its appendices are designed to provide your organization with a framework for development and deployment of care pathways that match client's needs to the appropriate, evidence-based care in an organized way. Every provider is unique, so feel free to adapt these approaches and tools as you see fit.

What is a Care Pathway?

A care pathway is a standardized set of processes or management guidelines applied to a group of clients with a similar condition, typically in the form of a flowchart or process map. Care pathways are used to improve the quality of care by recommending best practices approaches at various stages of a condition. More complex care pathways guide and monitor a patient's journey of care between health professionals and across sectors.

Care pathways include both clinical (e.g., prescribing, therapy), financial (e.g., documenting and billing), and administrative (e.g., reviewing data, team meetings) workflow behaviors which staff engage in when delivering care. Care pathways guide a client's plan of care from initiation through attainment of specified health outcomes, with the goal of improved health and reduced intensity of care.

The benefits of care pathways include standardization of care, shared documentation, and evaluation tools. Use of care pathways is associated with decreased cost and length of stay and increased staff morale, client and family satisfaction and health literacy. In the shift from fee-for-service to value-based care payment, this framework is valuable to providers working to improve consistency in quality care and payers seeking data-driven approaches that drive outcomes and efficiencies.

A care pathway offers the client:

- Screening, assessment, and stepped evidence-based treatment with clearly defined treat to target parameters. Treat to target is a strategy that involves setting a specific treatment goal that signals improvement and continuous monitoring and adaptation if progress is not being made.
- Client and family engagement to ensure health literacy and collaborative development of treatment plan.
- Interdisciplinary team-based care that employs population health management and risk stratification to monitor progress and adjust care based on achieving treatment targets.
- Care coordination between onsite staff and with offsite providers to ensure information sharing and seamless transitions of care.

A care pathway offers staff:

- Protocol-based, standardized sets of clinical and administrative workflows to direct engagement and assistance of clients with specific social determinant, physical and/or behavioral health needs.
- Written protocols that define care management components into replicable, measurable workflow steps, that support staff in successful operationalization.
- Ongoing quality improvement to assess effectiveness and efficiency of the pathway.

A care pathway offers payers and policy makers:

- A clearly articulated measurement-based value-proposition a provider can bring to market.
- Service targets and associated structures for designing value-based contracts.
- Processes for linking the cost to clinical process and outcome metrics.

Why Care Pathways are Important

In today's competitive health care marketplace, safety-net providers need to demonstrate their ability to enhance client experience, improve population health, and reduce costs while improving staff's experience to provide care. In addition, they must ensure services are easy to access and trauma- and culturally-informed; effectively address social determinant, physical, mental health and substance use disorders; and coordinate care across providers and other supports. This focus on clinical conditions, social determinants of health (SDOH), services efficiency (i.e., providing services on time and on cost) and achieving process and outcome quality metric targets, requires services that are innovative and structured.

As providers increasingly implement population health approaches to ensure that the highest intensity client populations are receiving the highest intensity interventions, use of risk stratification and evidence-based practices is critical. However, training in evidence-based practices can vary by clinician, resulting in large variations in client care, despite similarities in diagnosis, health history, or social determinant needs. Care pathways provide an opportunity to set standardized expectations on the use of evidence-based practices — both clinical and administrative — and provide your staff tools to successfully implement these protocols.

> **Social Determinants of Health (SDOH)** are the conditions in which people are born, grow, work, live, and age, as well as the wide set of forces and systems that shape conditions of daily life. These forces and systems include economic policies and systems, social norms, social policies and political systems.
> — *World Health Organization*

The Benefits of Care Pathways

Care pathways provide an approach to continually assess, structure, and monitor the clinical and administrative aspects of services so providers can meet and exceed these challenges. They standardize clinical and administrative daily workflow processes that ensure a client's social determinant, physical and behavioral health needs are met while providing staff with a predictable, efficient, work environment with a focus on client engagement.

The benefits of this approach include:

- Clearly defining the coordination of care with and across teams, other provider agencies, the person's natural supports, and the client.
- Reducing confusion and variation in care provision, data collection, communication, and billing, therefore reducing duplication and waste.
- Improving structure, efficiency, and predictability so staff have more time to identify and meet their healthcare needs by developing meaningful relationships with clients.

- Using measurement-based care anchored in evidence-based and best practices and treatment guidelines.
- Utilizing continuous quality improvement framework to monitor progress toward treatment targets and identify opportunities for service improvement.
- Focusing on the efficiencies, quality and outcomes that make organizations more attractive to payers and clients.

Designing and Implementing a Care Pathway

It is likely your organization already has the components of care pathways in place for many of the clinical conditions and social determinant needs you address. This toolkit will help you systematize how client health indicators are linked to administrative protocols and clinical team interventions, and organize by mapping a care pathway. Before doing so, it's important to understand the key components of a care pathway.

Screening and Assessment:
Validated biopsychosocial assessment tools for behavioral health, physical health and social determinant needs using validated tools is necessary to ensure the treatment plan is designed to match client needs.

Use of Evidence-based and Best Practice Services:
Established expectations on the evidence-based practices provided to client based on their level of care needs as determined through biopsychosocial assessment.

Standardized Processes and Guidelines:
Established processes and protocols for levels of care determination, treatment plan development, monitoring progress and adapting (i.e., providing stepped-care) level of care to ensure all clients are appropriately matched to the right services at the right time.

Team-based Care:
Staff collaborate and work as a team to deliver and coordinate care, support each other, conduct population health management and risk stratification, and engage in continuous quality improvement. For more guidance and information on adopting team-based care, see Resources in Appendix C.

Steps for Designing and Implementing a Care Pathway

1. **IDENTIFY** a client population.

2. **ASSIGN** an interdisciplinary quality improvement team.

3. **RESEARCH** the evidence-based or best practice guidelines associated with identified need(s) of the population.

4. **MAP** the current state of services provision and identify areas for improvement.

5. **DEVELOP** the revised care pathway protocol(s).

6. **TEST** the new protocol(s) using Plan-Do-Study-Act.

7. **IMPLEMENT** the new care pathway and monitor using continuous quality improvement.

STEP 1 IDENTIFY A CLIENT POPULATION

Identify the client population your care pathway will address. There are a variety of ways to approach this – by clinical condition, SDOH need, or level of care intensity. We recommend prioritizing your highest-risk clients since they are more likely to utilize high-cost services like emergency room visits or hospital admissions if they are not appropriately supported.

To identify your high-risk populations, you can use established tools like the Levels of Care Utilization System (LOCUS), which stratifies clients into a level of care based on identified physical, behavioral and environmental needs. You can also identify your own algorithm and approach for stratifying clients into levels of risk (high, medium, low). These levels can be based on criteria such as chronic behavioral health conditions and severity (e.g., use of DLA-20 to stratify

population needs), co-morbid conditions, high utilization of services such as hospitalizations or emergency rooms, or unmet social needs such as challenges with employment, housing or unsafe environments. More guidance on approaches for population health management and risk stratification are accessible in Appendix C.

Which client population are you designing a care pathway for?
Define this by risk level and identify the criteria for inclusion.

STEP 2 ASSIGN AN INTERDISCIPLINARY QUALITY IMPROVEMENT TEAM

Your interdisciplinary team is responsible for driving the process of mapping, piloting and scaling the care pathway. It is important to ensure diversity of participants (across roles and levels) to account for all perspectives across the organization. Consider including an executive-level champion to resource and guide the design and implementation process. Also include representatives from clinical, finance, and information technology teams as well as staff with quality improvement experience who can manage the process. Perspectives of clients, family and external stakeholders, such as community partners, should also be considered.

Who is on your QI team?		
List members of the team	*Organizational titles*	*Roles within QI team*

STEP 3 RESEARCH THE EVIDENCE-BASED AND BEST PRACTICE APPROACHES

Since your goal is to provide evidence-based or best practice care, it is necessary to review clinical practice guidelines and research evidence to determine which practices best meet the needs of your population's clinical conditions and social determinant needs. Guidelines provide time intervals and treat-to-target metrics that will be built into your care pathway. Some guidelines will be used for multiple care pathways (e.g., motivational interviewing and trauma-informed care guidelines and the resulting care pathway protocols will be the same for all care pathways).

TIP Learn how other organizations have achieved the results you are seeking. When possible, identify those who have successfully adopted care pathways and engage with them through discussion or site visits to learn what they did and how they are implementing it.

Example of Evidence-based Practices and Care Pathways in Action

Sally is a first-time client at Behavioral Health Center, although she has previously received treatment elsewhere. She was referred to the center after her third hospitalization in nine months with a diagnosis of major depression (her current PHQ-9 score is 24) and history of suicidal behavior. Sally's intake assessments also identified a childhood history of trauma and several health conditions, including unmanaged diabetes. She also reported having trouble sleeping and loss of appetite. Sally lost her job in the past year and does not currently have stable housing or a reliable support system.

Behavioral Health Center uses the Levels of Care Utilization System and has an established approach to risk stratification for their clients and linking them to evidence-based interventions. Based on Sally's behavioral and medical history, recent utilization of hospitalizations, and unstable environment, she is flagged as high-risk and placed into high-intensity community-based services for her initial treatment period while her progress is being monitored. Using the care pathways, Sally's clinical team worked with her to develop a treatment plan that included the following:

Screening & Assessment	Level of Risk	Service Bundle 18-28 months	Targets and Monitoring
• Adult female, 35 years old • Major depression • Diabetes • History of trauma • Unemployed • Homeless	• Chronic, unmanaged behavioral and health conditions • Unstable environment • Frequent hospitalization • Risk Level: High	• Case management • Trauma-focused cognitive behavioral therapy – weekly • Group therapy – twice/week • Medication adjustment and management skills • Diabetes self-management support,ongoing monitoring • Referrals and management with community partners for employment and housing assistance • Safety plan	• Attendance at appts • Medication adherence • Monitoring of A1C and maintenance at managed level • Established employment and housing • Symptom improvement as evidenced by improved PHQ scores

Ongoing monitoring by care team through weekly huddles.
Treatment plans revisited if no progress in PHQ-9 or A1C levels in 3 months despite continued engagement. If another hospitalization occurs, engage with unit staff to plan appropriate transition.

What evidence-based best practices will you incorporate for the risk factors within your population?	
Risk Factor	Evidence-based Practice
Ex: *Multiple hospitalizations in a short term*	*Care management*
Major depression	*Cognitive behavioral therapy, medication management*

STEP 4 MAP THE CURRENT STATE OF SERVICES

Mapping the care pathway helps determine and organize processes, decision points, and key players. By visualizing the process and identifying any potential issues before implementation you ensure thoughtful consideration of all steps, decisions, roles, measures and outcomes.

A care pathway **workflow** is a sequence of connected clinical and administrative process steps diagramed or flowcharted to explain the movement of materials, information, or people through a process with clearly defined start and stop points.

Mapping a care pathway is more of an art than a science. Use sticky notes, easel paper, a white board or Microsoft Excel or Microsoft Visio mapping software to put each of the steps in linear order, as well as corresponding thoughts, questions and answers. We encourage you to be creative throughout this the process. Workflow mapping tools and examples are included in Appendix C.

START WITH THE CURRENT STATE

Begin by mapping the current "state" of your clinical and administrative processes. The findings from these will be used as the baseline from which improvement areas will be identified and workflows refined to incorporate the identified evidence-based and best practices.

The current state mapping process should bring together the interdisciplinary quality improvement team as well as anyone else who provides clinical and administrative support for the targeted population – front office staff, care coordinators, etc. A broad range of participants is critical to ensure accurate depiction of the "current state" and to facilitate buy-in from staff who will operationalize the identified changes. Staff are more likely to be part of the solution if they take part in developing it.

TIP If you cannot gather the whole team at once, conduct this as a series of meetings to allow different staff to weigh in on the process. Plan meetings for at least two hours so team members don't feel rushed or distracted.

Throughout the mapping process, cast a critical eye on workflow inefficiencies and ineffectiveness. This includes instances where:

- Staff have different answers to the same questions about a clinical or administrative workflow step.
- Staff who cannot bill for a step — or are not trained or credentialed/licensed to do a process — are currently responsible for a workflow process step.
- Qualified staff who can bill and are not billing, do not know how, or are billing incorrectly.
- Staff have conflicting understanding of who is completing what steps.
- Staff are completing steps differently.
- Everyone believes or has evidence to show that a process step takes different amounts of time to complete.
- Demonstrated confusion or frustration with how a workflow step is done.
- There are no clearly written policies, protocols and procedures and associated training and supervision for how to conduct critical workflow steps (e.g., capturing data, billing, documentation, client engagement).
- There are clearly written policies, protocols and procedures that are not used or known to everyone.

CARE PATHWAY MAPPING EXERCISE

With your interdisciplinary team, map out the current workflows and processes for the identified population. Outline the current processes from start to finish using the following table for guidance. While answering these questions, keep in mind the key information you are trying to elicit:

- **What** is the current process?
- **Who** is responsible for execution?
- **How** is information being captured or documented?
- **Where** are the gaps or opportunities for improvement?

TIP

- Before sitting down to map your care pathway, gather copies of policies, protocols and procedures associated with each step.
- Mapping can be done using a large whiteboard, sticky notes, or poster paper.
- It's OK if this process is messy at first. Ensure that the input of everyone gathered at the table is heard and then go back and clean it up together.

Workflow Mapping Template			
Current Process	**Staff Responsible**	**Processes/Documentation**	**Service Costing**
Across each phase of the care pathway, identify the current activities/ processes.	**For each process:** List staff responsible for specific activities (screening, treatment plan development). Identify who the decision makers are for processes or changes. Identify connections and transitions between steps and who is responsible.	**For each process:** List policies, protocols and associated procedures and where they can be accessed. Identify decision support and protocols used to manage workflow. Identify where information is captured (electronic health records [EHR], registry, etc.), where it is saved and stored, and how it is shared with the necessary staff.	**For each process:** List billing codes used and who bills for them. Identify what necessary steps in the process are non-billable and any efforts to capture this information. Identify how much time each step takes staff, as this ties directly to costs.
Biopsychosocial Screening and Assessment			
List the validated tools used to screen and assess the identified population.			
Outline the processes/workflows for how results are incorporated into treatment planning.			
List current guidelines on timelines/use of reassessment to monitor progress.			

Current Process	Staff Responsible	Processes/Documentation	Service Costing
List tools to evaluate level of engagement or satisfaction with the client's experience of care.			
Measurement-based Care Using Evidence-based and Best Practices Services			
Outline your current risk algorithm/process for assessing and assigning client risk.			
List the evidence-based interventions in place for the identified population.			
List guidance in place for matching service plans and level of services based on identified needs.			
Identify treatment to target metrics for clinical conditions, SDOH needs.			
Identify trauma informed techniques used to engage clients and families in goal-setting and decision-making.			
Identify tools used to assess client health literacy and self-management.			

Current Process	Staff Responsible	Processes/Documentation	Service Costing
Team-based Care Management			
Identify the care team's established processes for collaboration and communication			
Identify how services are coordinated for referrals and transitions.		Identify agreements (partnership, data sharing) in place between referring sites and community partners.	

IDENTIFY THE IDEAL STATE

Use the current state mapping to identify the ideal state. As a team, ask yourselves, if clinical care, workflow and processes functioned perfectly, what would that look like? Identifying how you would like things to operate will indicate the departmental or organizational changes necessary to achieve that state.

This 'ideal state' will be your revised care pathway. In order to operationalize this, it's likely you will need to establish or revise current processes and procedures. If the list of improvement activities is very long, prioritize based on needs and approach changes in phases.

Current Clinical Processes	**Example Process 1: Screening at intake includes PHQ-9, GAD-7, AUDIT-C Plus 2**	**Example Process 2: Standardized treatment plan template used; Individualized treatment plan developed in collaboration with client by primary provider**
Current Administrative Processes	Screening results documented in EHR	Treatment plan inconsistently documented in EHR

Ideal Clinical Processes	Comprehensive screening at intake to assess for clinical and social determinant needs using PHQ-9, GAD-7, AUDIT-C Plus 2, Life Event Checklist (assess for trauma), DLA-20 (assess for social and environmental needs)	Standardized treatment plan template used Individualized treatment plan developed in collaboration with client, caregivers and primary provider and informed by standardized evidence-based interventions for identified needs and treat to target goals
Ideal Administrative Processes	Screening results documented in EHR Results aggregated to identify and assign client's current level of risk/care needs	Treatment plans consistently documented in EHR
Improvement Activities	Training of staff and incorporation of LEC and DLA-20 into intake assessment Develop levels of risk/ alignment with LOCUS levels of care Develop and implement standard operating procedures level of risk assignment	Establish protocol on treatment plan documentation in EHR

STEP 5 DEVELOP THE REVISED CARE PATHWAY PROTOCOL(S)

Implementing a new care pathway requires protocols that clearly convey what needs to happen, who is responsible and how it should be executed. Protocols ensure clinical care is provided based on the evidence-based standard of care AND that administrative procedures are followed, resulting in data being collected reliably and services documented and billed correctly. The pathway strives to deliver efficient and effective delivery of care – and ongoing monitoring ensures that the care pathway contributes to value-based care.

The care pathway protocol provides a step-by-step description of how each identified client population is addressed by your organization, including standardized guidelines for treatment of specific clinical conditions or approaches for addressing social determinants needs. It should be used to train current and new staff about how the organization provides care. Protocols that should be detailed within the care pathway include:

CLINICAL PROTOCOLS

- Steps for conducting intake biopsychosocial assessment (this applies to all care pathways).
- Steps for developing treatment plans.
- Decision trees for matching evidence-based or best practice interventions to identified client needs (Tip: Use these helpful tools from Institute for Healthcare Improvement).
- Steps for prescribing medications/medication algorithm.
- Steps for providing cognitive behavioral therapy.

ADMINISTRATIVE PROTOCOLS

- Screening and assessment data entry.
- Biopsychosocial documentation and/or progress notes.
- Care coordination data entry (e.g., referral, scheduling, data sharing).
- Team huddles (this would apply to/be the same for all care pathways).
- Team meetings where data is reviewed and risk stratification conducted.
- Individual and group supervision (this would apply to/be the same for all care pathways).
- Billing and revenue cycle.

STEP 6 TEST THE NEW CARE PATHWAY PROTOCOL(S) USING PLAN-DO-STUDY-ACT

Once you have completed documentation of your care map and protocols, a team needs to test them. Identify a team that will be trained in the new care pathway protocol(s) and how long you will pilot (Hint: to ensure enough data can be collected to assess impact, we recommend at least three-to-four weeks). Pilot testing will provide your team with actionable feedback to clarify and improve the pathway. From the standpoint of a Plan-Do-Study-Act cycle, the pilot testing

takes the "Plan" developed in Step 5 and pilot tests it (i.e., the "Do" and "Study" steps) to determine if the changes are ready to be deployed (i.e., the "Act" step). These Do and Study steps will provide your team with actionable feedback to clarify, improve and ultimately determine if the pathway is ready for implementation. For more detailed guidance on implementing continuous quality improvement, use the National Council's Quality Improvement Toolkit.

After the pilot, interview the team that piloted the care pathways protocol(s) and find out:

- What worked/didn't work from the standpoint of efficiency (time and cost)?
- What worked/didn't work from the standpoint of effectiveness (the care pathway helping clients achieve their treatment targets)?
- Do protocol elements need to be added, removed, or changed to make the care pathway more efficient and effective? If so, what are they?
- What did clients like or dislike about the care pathway? Did they understand their treatment plan? Did they feel the services provided were appropriate?
- Is another round of testing needed before making the care pathway standard operating procedure?

Engaging Clients in Change

Care pathways result in changes to the way clients experience care. This could be as simple as introducing them to new regular screenings or as complicated as stepping up or down care. Regardless, the client should be educated and engaged in this process of change. Discuss what is changing, why, and how it will benefit them. Work with your staff and clients to identify best messaging and approaches for relaying this information. As noted in Step 2, clients should be part of the development process for your care pathways.

Address any necessary changes identified through feedback before rolling out the care pathway across the organization (Step 7). It is not uncommon to initiate several pilots of a new care pathway before it is refined enough for deployment across the organization.

STEP 7 IMPLEMENT THE NEW CARE PATHWAY AND MONITOR USING CONTINUOUS QUALITY IMPROVEMENT

Successful implementation of any change initiative requires strong planning, and enacting a new care pathway is no exception. Implementation will require a communication and training plan for deployment, as well as a system for monitoring fidelity to the new care pathway protocols. When rolling out your care pathway, provide staff with clear information on what they will keep doing the same, what they will do differently, and what they will stop doing as it relates to the care pathway. Ensure that supervisors can clearly communicate this information and revisit often with staff, especially during

the first three to six months of implementation when changes are being adopted.

When rolling out your care pathway, ask the following questions to ensure you are developing a successful implementation plan:

- What are the key changes within the care pathway?
- Who will be responsible for which steps within the protocol?
- When will the changes go into effect?
- What additional resources are needed (staff, technology, money)? Have these been procured?
- What training or preparation is needed for staff?
- Will clients be affected? If so, how and when will this be communicated to them?
- How and when will you inform staff about changes, progress or other outcomes?
- Are supervisors on-board with monitoring fidelity to the new care pathway protocol(s) with their direct reports?

Once implemented, use a continuous quality improvement process to evaluate care pathways. Identify **process** and **outcome** metrics that monitor performance. Some of these will naturally be aligned with treatment targets, while others may focus more on adherences to newly established processes and protocols. Establish a process for regular monitoring, routine review and analysis with your team to ensure early identification of challenges or barriers. Building in time and resources to regularly review your results will help your organization be nimble and respond to information as it becomes available.

Process measures indicate what a provider does to maintain or improve health, either for healthy people or for those diagnosed with a health care condition. These measures typically reflect generally accepted recommendations for clinical practice. *Example: percentage of people receiving screening for clinical remission and follow-up plans.*

Outcome measures reflect the impact of the health care service or intervention on the health status of clients. *Example: percentage of people achieving depression remission at 12 months.*

TIP At least annually, review and update all care pathways with new guideline research and/or new efficiencies discovered by staff. If staff find a better way to provide care, the care pathway should be updated accordingly.

For example, if a team implementing the care pathway finds that clients are confused filling out the PHQ-9 in the waiting room, leading to unreliable scores, the team may team decide to change the care pathway and have the MA/LPN complete the PHQ-9 with the client.

PULLING IT ALL TOGETHER

Through standardization and clear documentation, care pathways provide a mechanism for delivering more efficient and effective care. When designed and implemented appropriately, care pathways can provide better experiences for the client through promotion of best practices and coordinated care, improve staff capacity through clearly established guidance and support in clinical decision-making, and increase provide marketability to payers through demonstrated efficient and outcomes.

This toolkit is designed to provide your organization with a framework for development and deployment of care pathways. The stepwise process and tools provided within this document can be adapted as you see fit, but remember these critical tips for success:

- **Ensure you engage the right people in development.** Care pathways include both clinical and administrative workflows, underscoring the importance of diverse perspectives and deep understanding of current processes.
- **Allow enough time for processing.** We often underestimate how much time is needed to complete a task and designing a care pathway is no small undertaking. It's ok to slow the process down to ensure you are capturing the right information and clearly documenting expectations for staff.
- **Adaptation is key.** Things rarely go as planned. Commit to soliciting feedback and adapting accordingly during pilots and when new pathways are scaled.

Appendix A: Care Pathway Worksheet

Instructions: Read the statements below and based on your experience place the appropriate number (Agree=3; Neutral=2; Disagree=1) next to the statement. Each member of your team should fill out this worksheet on their own. Once all team members have completed the worksheet meet as a team and discuss your findings. Averaging the scores across team members can help target areas of strength and opportunity.	Agree 3	Mixed 2	Disagree 1
1. Our organization has care pathway protocols describing the steps for how clinical conditions and social determinants of health needs are addressed through our services.			
2. Our care pathway protocols include the collection, analysis, and monitoring of process and outcome measures specific to the clinical condition or social determinant need.			
3.)Our job descriptions describe the specific scope of practice for each member of the interdisciplinary team (i.e., clinical and administrative staff).			
4. Our mental health, substance use disorder, and physical health care clinical pathway protocols are based on the latest evidence-based practice guidelines.			
5. Our social determinants of health care pathway protocols are based on latest evidence-based practice guidelines.			
6. Teams have access to service cost estimates for clients being served.			
7. Teams have access to timeframe estimates for achieving clinical and social determinant need outcome metrics.			
8. Our care pathways clarify the process and outcome measures being used to report findings as part of a population health management and risk stratification approach.			
9. Teams have access to the process and outcome data collected in the care pathways.			
10. A risk stratification process is clearly described in our care pathway protocol to help with decisions about stepping consumers up to more intensive services or down to less intensive services.			
11. We are using clinical and administrative data dashboards to aggregate and easily convey data findings for individual clients and populations served.			
12. Group and individual supervision include the monitoring of staff/team fidelity to the pathway protocols.			
13. Our teams have regular huddle meetings to discuss clients who were just seen and about to be seen.			
14. Our team has established open, safe, communication patterns.			
(Add the numbers in each column) **Subtotals**			
(Add all the Subtotals) **TOTAL**			
Care Pathway Efficiency & Effectiveness: 14-23 (Low) 24-33 (Moderate) 34-42 (High)			

Glossary of Terms

Care Pathway: A sequence of measurable and connected clinical and administrative staff work flow steps detailed in protocols describing the provision of care to help people with a specific medical, mental health, substance use disorder or social determinant need.

Policy: A principle of action adopted or proposed by a government, business, or individual that explains an intent to perform in a certain way (e.g., Infection Control Policy explaining how to protect staff and clients from infection).

Protocol: The set of procedural steps or system of rules that all team members agree to follow in a work flow to complete a task (e.g., Blood spill clean-up protocol which describes the steps to clean up a blood spill).

Procedure: One step in a protocol describing a staff work flow behavior (e.g., how to put on/take off rubber gloves when cleaning up a blood spill).

Scope of Practice: What a staff person is trained and licensed, certified and/or privileged by an organization to do in a care pathway (e.g., diagnosing, prescribing, accessing an EMR, etc.).

Appendix B: Team Based Care Worksheet

Instructions: Read the statements below and based on your experience place the appropriate number (Agree=3; Neutral=2; Disagree=1) next to the statement. Each member of your team should fill out this worksheet on their own. Once all team members have completed the worksheet meet as a team and discuss your findings. Averaging the scores across team members can help target areas of strength and opportunity.	Agree 3	Mixed 2	Disagree 1
1. Our organization has the creation or improvement of team-based approaches to care provision as a strategic goal/priority.			
2. Each administrative and clinical staff position has clearly defined roles and protocol linked/based workflow responsibilities.			
3. Our organization has protocols to support clinical and administrative staff in their workflows (e.g., how to use a screening tool) to ensure standardization of care provision across staff (i.e., reduce variability).			
4. Our teams have process and outcome metrics to demonstrate the effectiveness (e.g., clinical and administrative outcome metrics) and efficiency (i.e., clinical and administrative process metrics) of service provision.			
5. Our organization does a great job of celebrating successes (e.g., hitting a clinical target for a population of consumers) and identifying/addressing breakdowns (e.g., addressing conflict between staff or identifying when a care process is not standardized).			
6. Our organization uses brief team huddles and longer team meetings to conduct population health management (i.e., care coordination follow-up, risk stratification, review administrative and clinical protocols and data process/outcome measures).			
7. Staff in our organization feel like their opinions are valued by clinical and administrative leadership.			
8. Staff in our organization feel like their opinions are valued by their clinical and administrative coworkers.			

Instructions: Read the statements below and based on your experience place the appropriate number (Agree=3; Neutral=2; Disagree=1) next to the statement. Each member of your team should fill out this worksheet on their own. Once all team members have completed the worksheet meet as a team and discuss your findings. Averaging the scores across team members can help target areas of strength and opportunity.	Agree 3	Mixed 2	Disagree 1
9. Staff in our organization feel safe to share with their supervisor if they made a work-related mistake or have a question/concern.			
10. Staff in our organization feel safe to share with their coworkers if they made a work-related mistake or have a question/concern.			
11. The physical layout of our building facilitates a team-based approach to care (e.g., "bullpen" type office design, common meeting rooms with video monitors to project data for population health management, etc.).			
12. Our organization has the technology infrastructure to support team-based approaches (e.g., video conferencing for remote workers, data reports/dashboards for population health management, electronic health record that facilitates information sharing/care coordination, etc.).			
(Add the numbers in each column) **Subtotals**			
(Add all the Subtotals) **TOTAL**			

Team-based Care Score: 12-20 (Low) 21-28 (Moderate) 29-36 (High)

Adapted from: Leipzig, Hyer et al. (2002). Attitudes Toward Working on Interdisciplinary Healthcare Teams: A Comparison by Discipline J Am Geriatr Soc 50:1141–1148. Google Rework Study: https://rework.withgoogle.com/guides/understanding-team-effectiveness/steps/introduction/

Appendix C: Additional Resources

User Guide: Risk Stratification Tool and Chronic Conditions Calculator

- Risk Stratification Tool
- Chronic Conditions Calculator

Care Pathway Diagram Examples

Tools for Mapping Care Pathways

Team Meeting and Huddle Protocol Examples

Team Member Role Definition Template

Team-Based Care Resources