Developing and implementing shared care protocols

A shared care protocol reflects the shared desire to combine medical, caregiver, and medical social expertise to better manage a situation concerning one or more acute or chronic illnesses. It responds to a multidisciplinary issue identified by a team, within a healthcare facility or in an area. It takes patient experience into account and may pay particular attention to informal caregivers.

Key points

Shared care protocols are a natural support for teamwork. They consolidate coordinated work when they:

- rely on the experience and expertise of the professionals concerned,
- consider current literature data,
- formalise and harmonise existing practices,
- propose avenues for advancement, through new services or new roles,
- provide support and security for caregivers,
- can be easily consulted during care,
- conceive of care and "taking care" as a single concept,
- can be accompanied by financial valuations and resources that are appropriate to their use,
- are regularly updated in light of feedback,
- are part of the quality process of care teams.

What needs to be done

Stage 1 Preparing the protocol

- ***Select a situation***: ***a protocol must meet an explicit need of the team.*** This need may be identified via clinical consultation meetings, monitoring indicators, the healthcare plan of an MSP [Patient-centred medical home] or an area, patient feedback, etc. A protocol does not seek to deal with a clinical situation as a whole, but rather to concentrate attention on the “critical” point or points of the treatment.
- ***Inform all the professionals concerned about the plan:*** primary care team, medical social professionals and second line specialists, wherever they practice.
- ***Form a working group of several professionals*** to develop the protocol. This group must include members belonging to all the professions concerned.

Stage 2 Developing the protocol

- ***Analyse current practice:*** everyone expresses what they normally do for the situation examined and what information they need. Whenever possible, emphasise the existing relationships between professionals and rely on them to increase the number of professionals engaged in the dynamic.
- ***Define objectives:*** by confronting the needs identified in current practice, the local context and the components of good practice collected in the literature (on this point, the team may refer to the primary care Resource Centre provided by HAS, Appendix 1). When there is no evidence regarding an aspect of care, the team may adopt a position on the best possible practices on the basis of a group consensus.
- ***Design the protocol:*** specify the various clinical or organisational stages and their chronology, the scope of action of the various professionals, and the expected clinical outcomes at each stage. Emphasise the components of coordination and decision support. The Clinical Path method can be used to describe the procedures that are involved in patient care and treatment.

- ***Define and develop the tools that must be associated with the protocol:***
  - Screening tools for patients and situations concerned by the protocol;
  - Description of a diagnostic or therapeutic procedure;
  - Watch points:
  - Support for holding consultation meetings;
  - Individualised patient-centred care;
  - Standardisation of messages to patients.
- ***Formalise the protocol:*** in the form of a simple and brief document. This document must be easy to use during a consultation or visit (Focus 2). Prepare a protocol identification form (Appendix 2), which specifies the protocol contact person in particular.
- ***Check that there is no legal obstacle to the protocol:*** in particular, that the new roles assigned to a professional do not go beyond their area of expertise. In this case, prepare an "Article 51" type of cooperation protocol.
- ***Identify the logistics and support necessary for implementation:*** What are the needs of professionals for this purpose? What supports should be considered: healthcare equipment, involvement of a support coordinator for making appointments, calling patients during follow-up, etc.?
- ***Conduct an extensive protocol validation*** ensuring the agreement of all the professionals concerned. Patient associations can be involved in this validation phase. If this validation brings up questions or discrepancies, it may be useful to review some items.

Stage 3 Implementing and following the protocol

- ***Disseminate the protocol.*** The protocol must be accessible to all professionals concerned. It is the responsibility of each team to choose the protocols that it makes public to patients.
- ***Regularly document practice variations relative to the protocol.*** Several methods can be used for this (Focus 3). A protocol should not be followed blindly: it is the responsibility of the professional to deviate from it if they believe that the protocol does not apply to a patient. In this case, it is entered into the record with justification, so that other professionals who treat the patient are informed.
- ***Collect adverse reactions related to the use of the protocol:*** by using a registry, dedicated form or random record analysis for example.
- ***Discuss and analyse variations and adverse reactions with the multidisciplinary team*** and propose solutions to address them: organisation change, training, protocol changes, etc.
- ***Regularly update the protocol,*** at least annually, according to the experience of professionals and patients, scientific progress and recommendations or regulations. During this update, it may be noted that the practices promoted by the protocol have become routine, so that it becomes less useful for team members to consult it. In this case, the protocol may be archived, remaining available for new team members.

Proposed monitoring criteria

- Number of persons treated according to the protocol/number of persons concerned;
- Adverse reactions related to the use of the protocol;
- Changes in the results of care according to clinical or laboratory parameters;
- Professional and patient satisfaction.

What to avoid

- Increasing the number of protocols without reference to identified situations or needs;
- Increasing the number of meetings: Three meetings of 1.5 to 2 h appear to be a maximum for the development and validation of the protocol;
- Maintaining an unused protocol.

Conditions to meet

- Start by developing simple protocols with easily attainable goals: this experience will allow teams to increase their skill in working together;
- Organise experience sharing among teams, communicating about successful initiatives;
- Disseminate the protocol via a shared information system;
- Explicitly record the protocol in a process for improving practices;
- Provide the necessary resources to implement the protocol (for example: administrative coordinator time).

Examples of implementations or projects in progress

▶ **FFMPS [French Federation of Healthcare Clinics and Cluster]:** In June 2012, the FFMPS asked MSP teams to send HAS examples of the multidisciplinary protocols that they implement. Eight teams submitted 64 documents. These documents are in the following forms:

- Memos (16): short documents of 0.5 to 1 page corresponding to a list of items to discuss in a consultation concerning the characterisation of a condition or prescription;
- Checklists (15): longer than the previous documents giving an overview of a disease or clinical situation

focusing on important components for practice during consultation;
- Shared care protocols (25): documents from 0.5 to 7 pages describing who does what and when, for a given situation.
- The topics common to several MSPs were: management of AVKs (5 MSPs), vaccinations (4 MSPs), cardiac arrhythmia (2 MSPs), COPD (2 MSPs), diabetes (2 MSPs), wounds (2 MSPs), home liaison binder (2 MSPs).

▶ ***The Réseau Sphères [Spheres Healthcare Network] has developed shared care protocols in Paris*** for managing outpatient crisis situations as an alternative to avoidable hospitalisations. Protocols are developed by a local scientific committee from science-validated data and drawn up on an A4 sheet. The network provides logistics for patient follow-up, and uses a computer system for this. Current topics for protocols are: treatment of acute community-acquired pneumonia, deep thrombophlebitis, febrile urinary infections, chest pain and transient ischaemic accident. The health economics assessment of the Réseau Sphères was the subject of two general medicine theses and a study by CNAMTS [National Salaried Workers' Health Insurance Fund] that demonstrated a significant reduction in avoidable hospitalisations. Réseau Sphères 10 rue Ledion 75014 Paris FRANCE T + 33 953100296 amospheres@mac.com

▶ ***Association des Pôles et Maisons de Santé Libéraux [Association of Health Clusters and Clinics] (APMSL)*:** The Pays de la Loire APMSL has developed a guide for supporting the development of a shared care protocols in the patient-centred medical home. This guide was prepared by the multidisciplinary team of the administrative council in response to the methodological expectations of patient-centred medical homes (MSP). It comprises a proposal for a method to develop a protocol, an identity sheet, watch points, documentary sources, etc. It has been validated by a reading committee of MSP representatives. APMSL-PDL (Association des Pôles et Maisons des Pays de la Loire), Le carré de Couëron - 57 rue des Vignerons – Bureau 17, 1er étage - 44220 Couëron, FRANCE

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What you need to know

- A protocol describes who does what, when, how, why, for whom and with whom. It may take the form of a text, a table, a flowchart, etc.
- It relies on both scientific data and on the experience of professionals. The experience of patients and informal caregivers is also taken into account.
- It is developed by a team, as part of its working environment: the team may be already formalised at the level of a health or medical social facility or a primary care facility (multidisciplinary clinic, cluster or centre) or be put together ad hoc for a project. The protocol may concern both primary and secondary care, both the community and institutions, and the health, medical social or social sectors. Some teams may prefer to be limited to the first circle of proximity before integrating other professionals, but this may limit the scope of use of the protocol.
- A team may have multiple reasons for developing a protocol: repeated perception of a complex situation or a major risk of error, multiple diseases that are difficult to manage, multiple health and social participants, lack of continuity observed during transitions among healthcare levels and settings, need to harmonise practices in view of major variations in treatment procedures, discrepancies in the information transmitted by various professionals to patients, etc.
- Protocols can be used as checklists, reminders, prescription aids, training materials or even tools for dialogue and encouragement with patients.
- It has been demonstrated, with a generally low to moderate level of certainty, that the development and implementation of multidisciplinary protocols:
  - improve compliance with good practice recommendations and the quality of patient care, for example by reducing the mean duration of hospital stays and complications during hospitalisation;
  - reduce practice variations among professionals;
  - improve the working climate and organisation of professional teams and reduce the risk of burnout;
  - improve the quality of information collected in medical records.
- These studies were conducted for the most part in hospitals, but the prospect of multidisciplinary protocols is open to outpatient care due to the evolution of a traditional "individual" practice towards a "multidisciplinary team" approach already acquired within healthcare organisations.
- Positive effects have been described for a variety of acute or chronic diseases, such as treatment for vein thromboses, pneumonia, certain orthopaedic or digestive surgical procedures, HTN, depression, asthma and diabetes in a hospital environment and in general medicine. It has also been shown that shared care protocols can reduce the intra-hospital mortality of patients hospitalised for heart failure (moderate level of certainty).

- Share care protocols are more effective when they relate to predictable pathways, when there are cooperation and management shortfalls or when professionals are experimenting with new roles. They have a better chance of changing clinical practices when they are developed in concert by the members of a team, developing their own rules.
- The application context of the protocols influences the extent to which they are used and therefore determines their effectiveness. A protocol has a better chance of being used in a truly multidisciplinary team where tasks are shared among doctors and other caregivers, which opens to new professionals and which experiments with new services (Focus 3). However, professionals may perceive risks with the use of protocols (Appendix 3).
- The economic impact of shared care protocols has not been assessed. It is necessary be attentive so that their development and implementation costs are justified by the expected benefits.

Focus 1. Means for making the protocols accessible during consultation

- Integration with business software for professionals
- Electronic document available from a computer, tablet or smart phone
- Poster displayed in healthcare settings
- Binder assembling the various team protocols and available in healthcare settings
- File in an abbreviated format that can be consulted even from patients' homes

Focus 2. Procedures for documenting protocol deviations

- Monitoring indicators created from information documented in patient records in standard practice: lab work, prescriptions, appointments, critical clinical data, etc.
- Collecting information relating to the last 5 to 20 patients concerned by the protocol
- Questioning healthcare professionals regarding their use of the protocol with the last patient or last two patients concerned
- Organising team feedback meetings about their use of the protocol

Focus 3. Factors promoting the use of shared care protocols

Factors related to their development

- Development by a group including members belonging to all the professions concerned
- Extension of the validation to all the professionals concerned in the area

Factors related to their contents

- Support for innovation: by facilitating the implementation of new services or management of projects, by promoting extension of the role of certain professionals, mostly non-doctors
- Confidence building and security for professionals who are experimenting with new practices or new roles

Factors related to their usage context

- Strengthening existing team practices
- Quick and easy accessibility at the time of care
- Easy follow-up and documentation of protocol deviations
- Association with a financial valuation
- Active process for implementation: identifying obstacles, professional leadership, providing training and assistance for implementation thereof

Appendix 1: HAS Resource Centre

In the absence of recent French recommendations, it is not always easy for healthcare professionals who are not experienced with literature searches to find evidence-based components for good practice.

So a pilot project by the primary care Resource Centre has been in place since September 2013 to help teams in the field to develop a multidisciplinary protocol. In this context, the Resource Centre (CdR) provides evidence-based components for good practice, or "bricks", that are used to build this protocol.

Professional partners (URPS [Regional Healthcare Professional Unions], Regional Multidisciplinary Federations of Health Clinics and Clusters, National Union of Health Networks) can provide support to the teams in developing their protocol. In this context, they:

- Inform and mobilise teams;
- Help teams to formulate their questions in regard to the goals and methods of the CdR;
- Set up the connection with the CdR;
- Support teams in developing or appropriating protocols;
- Hold feedback and experience-sharing sessions with a view to both facilitating professional procedures and assessing the relevance of the plan.

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Appendix 2: Example of an identity sheet of a protocol

Adapted from the APMSL Pays de la Loire template

Creation date	mm/YY
Change date	mm/YY
Facility holding the protocol	MSP, health cluster, etc.
Protocol title	
Contact	Name and email address
List of professions or services and facilities involved in management	Within and outside the holding facility
General objective	What it is hoped that the protocol or new service provided will change
Secondary objectives	The other aspects affected by the protocol
Target population	Public concerned
Assessment	Criteria for assessing whether objectives are attained
List of associated documents	Tools facilitating implementation of the protocol
List of literature sources or references	Recommendation or recommendations on which the protocol is based. Alternatively, indication of a team consensus
Place where the protocol is consulted	Binder, computer file, smart phone
List of professionals following the protocol	May refer to an electronic list
List of professionals or facilities informed of the protocol	May refer to an electronic list
Working group (WG)	Name of WG participants who developed the protocol
Protocol validation method	Validation committee or meeting
Scheduled update	mm/YY

Appendix 3: Risks related to the use of the protocols

Risks	Prevention
Failure to follow the protocol.	Make the protocol easily accessible and visible when care is provided. Plan for a financial valuation. Note: following the protocol principles may be implicit.
Loss of connection with patients due to the standardisation of practices.	Following a protocol does not change the doctor-patient relationship as long as it is adapted to the patient's situation (professional consensus). Protocols can be used as tools for dialogue with the patient.
Clarification of the role of each professional rather than promotion of teamwork.	Make time for working together and coordination in the protocol.
Question existing boundaries for expertise and responsibility.	Emphasise the expected benefits of shared responsibility among professionals with regard to the risks of a lack of continuity in patient care pathways.
Providing a false sense of security.	Foster the possibility of professional exchanges when in doubt.