BPM+ Clinical Practice Guideline Adoption

Readiness Assessment and Maturity Model ): BPM+ Adoption

Suggest scheduled review-quarterly/semi-annual (organizationally determined), adoption of tool and the processes the tool is used to support-they are intimately connected-no use in having a tool that does not result in performance improvement and value to the users/benefactors

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|  | **Domain (?)** | **Level 1** | **Level 2** | **Level 3** | **Level 4** | **Level 5** |
| **Row #** |  | **Initial**  **Inconsistent** | **Repeatable**  **Stabilized** | **Defined**  **Standardized** | **Quantitatively Managed** | **Learning Health System** |
| **1** | **Definition (adapted from COBIT)** | Ad Hoc/iterative   * Adoption of clinical pathways is inconsistent. | Regular pattern  Adoption processes are repeatable within a work unit (ward, lab, etc.) as more pathways are adopted into use. | Defined and documented process capable of achieving process outcomes  Adoption processes are standardized across the organization and adoption support (training, change management, conformance discipline, and governance), is provided to work units. | Measured, monitored and controlled  Ability to consistently and quantitatively measure and improve adoption processes across the enterprise | Continuous process improvement  When optimized adoption processes meet objectives, innovative adoption practices are evaluated and implemented when identified as effective in production |
| **2** | **Description** | * Little preparation, inconsistent adoption and use. | * Local adoption of clinical pathways within work units (wards, labs, etc.), but no consistent adoption process across the organization. | Standard adoption processes with tailoring guidelines for introducing clinical pathways to different types of work units). (Configuration vs customization) | * Adoption process is measured and analyzed to identify factors that aid or hinder adoption and thresholds for evaluating adoption success. | Organic understanding and use of BPM+  Innovative adoption techniques employed when adoption speed or effectiveness does not meet measured expectations. |
| **3** | **Institutional Standards/ Guidelines / Policies** | * Limited or no structured advocacy * Reactive vs proactive * Individual proponents advocate adoption of clinical guidelines with no institutional commitment * Early leadership buy in and implementation of change management efforts (should be here or somewhere else in early efforts to lead change) | * Executive management commits the organization to adopt clinical pathways and develops appropriate policies * Executive management funds effort and resources required to adopt clinical pathways * Institution recognizes the need for clinical guidelines in certain situations with certain stakeholder groups * Adoption is audited to ensure compliance with adoption policies | Documented, standard approach (including policies) for evaluation and acceptance of clinical guidelines by designated clinical experts   * Policy requiring identification of associated metrics for each new clinical guideline * Governance to ensure a consistent approach to organizational change management as well as adoption * Policies for organization-wide training, knowledge management, measurement, and security implemented * Central approach to documenting clinical guideline adoption and implementation * Consistent approach to localization of clinical guidelines across disciplines/parts of the organization | * Governance to ensure quantitative analysis of adoption outcomes that result in recommendations for continual improvement of adoption processes. * Governance also applied to product improvement/optimization-feedback to users to inform of training improvements/system corrections to build trust and confidence in the products and the leadership’s commitment to support continuous improvement | * Guidelines are agiley adjusted and adapted to particular projects with a focus on quality, efficiency and a goal of minimizing deviations * Organizational support for identifying and evaluating innovative adoption techniques. Identified source for captureing innovative ideas |
| 4 | Adoption Processes | * Patchy and inconsistent adoption of practices across the organization * Implementation approaches vary by work area with primarily undocumented processes | * Adoption Processes are repeatable with limited rigor though the beginnings of being proactive * Adoption processes differ across work units and patterns of use may differ * Work units have the staff and resources necessary to meet their work commitments, and time is available for adopting clinical pathways | * Standard adoption processes used across the organization and supported by organizational resources. * Documented, standard approach for localization of clinical guidelines and pathways including mapping of clinical data and adapting workflows * Formal process for regular review and adapting to updates of clinical guidelines * Central approach to documenting clinical guideline adoption and implementation * Consistent approach to localization of clinical guidelines across disciplines * Strategic, tactical and technical needs are identified, formally addressed and fulfilled in a multi-disciplinary processes * Guidelines are agilely adjusted and adapted to particular projects with a focus on quality, efficiency and a goal of minimizing deviations, (maximizing outcomes too?) | * Adoption processes are measured and analyzed quantitatively to identify opportunities for improvement. * Performance improvement based on quantitative analysis is embedded into change management and changes in guidelines * Dedicated team captures information needed to evaluate pathway implementation and use * Automation is continually improved to support the end to end patient care process. | * When adoption processes do not achieve expected results, innovations in adoption methods and support processes are identified and evaluated. * Successful innovations are adopted through the standard adoption processes * Also-optimize use of the tool, system improvements and training proper use will enhance adoption, trust in the organizational commitment not just to adopting a tool, but linking it to accountability for use as well as support |
| **5** | **Privacy, Security, Confidentiality**  The preservation of confidentiality, integrity and availability of information, assets, and processes that support and enable its acquisition, storage, use, protection and disposal in order to prevent compromise (loss, disclosure, corruption, etc.) | * Has no plan or action in place to prevent compromise resulting in loss, disclosure or corruption of information, assets and processes. Gaps exist in the protection of confidential information | * Each work unit identifies the information under its control that must be protected. * Each work unit applies organizational information security policies independently | * Implementation of pathways consistently considers and incorporates security, privacy, and access permissions as required by policy * Assign access to physical and logical assets and associated facilities to enable and support the requirements of the pathway * Access/permissions will support the adoption processes including but not limited to localization. | * Optimized sharing of data across organizations needed to implement pathways * Management of permissions to provide visibility into the patient care and care processes and corresponding needed to effectively realize collaboration and care transitions * Implications of pathway adoption are considered and added to organizational cybersecurity training. * Evaluate the impact of pathway adoption on security key performance indicators and effect appropriate change. | * S Innovative techniques such as machine learning/advance analytics are used to identify novel security threats and (e.g. combining of data fields/sources) * Apply predictive techniques to determine emerging vulnerablilites associated with pathway adoption and corresponding remediations. |
| **6** | **Skills and Expertise  (education component)** | * Ability to hire people with knowledge of BPM exists but no formal plan is in place * Interview and onboarding procedures are patchy and inconsistent | * Understand and document the needs to support BPM adoption and the needed tool set within the organization * Ability to hire the right people to meet the short-term goals * Interview procedures provide a strong and candid evaluation of each candidate’s capabilities. * Training in job skills needed for adopting clinical pathways is available to staff * Hire/support the right people as an essential component of the workforce (team approach for ongoing integration of BPM+) | * Defined standard competencies developed that support BPM+ programs and evaluation of impact * Documented commensurate skills and knowledge incorporated into hiring procedures * A standard internal skills training and career pathway has been established for those using clinical pathways * Recognition of the need to develop and support technical and clinical skill set changes to meet the needs of future advances in medical practice * Consistent evaluation of skill and expertise available within the workforce * Establishment of learning skills pathway and succession planning * Integration of skills needed to support BPM+ as a core component of in house training; HR processes; strategic planning and continuous // (assessment) * Support for continuous development of required skills * Ability to respond to new skills needed for successful integration, adoption, proactive use, and evaluation | * Consistent evaluation of skill and expertise available within the workforce * Hire/support the right people as an essential component of the workforce ( team approach for ongoing integration of BPM+) * Establishment of learning skills pathway and succession planning * Dedicated team captures information needed to evaluate pathway implementation and use | * When the skills and performance of those using clinical pathways are not sufficient to meet objectives, identify and evaluate innovative training and development methods, and if successful, deployed through standard adoption processes. * Support workforce development of the BPM+ skill (career pathway) along with cross training to embed a network of support to bring the opportunities to improve to the right resource(s) to address them |
| **7** | **Stakeholder Management**  **(patient/caregiver(s), clinical staff, allied health professionals, payors external)** | * Entity has limited understanding of stakeholders needs and goals | * Work units identify the the roles and responsibilities/ between stakeholders and staff , and how they interact withclinical pathways with respect to a specific project or program * Work unit recognizes patients/caregivers as stakeholders | * Iterative gap analysis - identify, document, and implement the change management needed to incorporate stakeholders into the clinical pathway process * Starting to develop standardized tools/templates/processes * Patient needs explicitly included in the BPM tooling and process design | * Development of enterprise-wide program office to oversee/apply stakeholder management; management of standard templates * Growing awareness of value across entity and ‘baking in’ the need for stakeholder management at all levels * Expansion of standardization tools, templates and processes to new domains and stakeholder groups * Routine Inclusion of patient priorities in activity and decision planning * Direct and consistent advocacy participation | * Entity has established processes that are used for impact, predictive risk assessment and management * Entity proactively engages with stakeholders to continuously improve process * Applies across the organization * Inclusion of ‘ patient centered care * Constant monitoring/review/ improvement cycle * Impact of patient efficacy consistently included in outcomes |
| **8** | **Knowledge Assets, Tools and Automation** | * Minimal availability; Minimal use (K,T,A??) * Uncoordinated and inconsistent use of tooling (T) * Institutional knowledge is informally shared by word of mouth (K) | * Defined and endorsed minimal tool set (T) * Adoption, but Inconsistent use and/or customization of the tooling (T) across work units * Institutional knowledge sharing is recognized as critical to success (K) * Knowledge captured within work units and documented as checklists, quick guides, etc. * KM is endorsed throughout the institution and is on leadership team agendas (K) | * Multiple technologies endorsed, available and installed (T, A) * Clinical decision support available at the point of care, choices can be repeatable (order sets, alerts, reminders, etc) (K,T,A) * Human centered design has been considered in the formulation of CDS (K) * Initial process formalisms (e.g. workflow diagrams) drive IT solutions (T, A) * Knowledge management introduced to inventory and manage CPG (K) * KM is endorsed throughout the institution and is on leadership team agendas (K) * Consistent process formalisms (K,T,A( * KM exists that supports management of CPG (K) | * Rubric available and utilized to support consistent approach and use (K, A) * CDS available at POC (K,T,A) * Increased replicability and repeatable (A) * KM is automated and transparent (K,T,A) * Multidisciplinary organizational structure exists for managing knowledge assets, tools and information (K, T, A) * Capture and use of knowledge is evaluated quantitatively and improvements are identified. * Formal knowledge management system tracking implementation artifacts (order sets, rules, executable pathways, etc) and linking them to the source clinical guideline | * Standardardized tool suite of content delivered across care settings (T,A( * Integrated and effective (K,T,A) * Tooling identifies best practices through HCD process (K,T,A) * Continuous monitoring and updating/modification based on identified needs and usage (K,T) * Consistent process formalisms (K,T,A( * KM exists that supports management of CPG (K) * Self organizing communities of practice meet regularly and inform a learning health system (K,A) * When knowledge management does not meet objectives, innovative solutions are identified and evaluated, and if successful, deployed through standard adoption processes. |
| **9** | **Goals and Measurement**  **(adoption of clinical pathway; organizational)** | * Inconsistent or no measurement of adoption process and goals | * Measurable organizational goals for deployment are established and progress towards goals is measured and reviewed * Each work unit measures and reports its adoption progress * Routine adjustment of processes to advance outcomes | * Adoption of quality measures, dashboards, goals and quality reporting at an institutional level * Use of these at POC (appropriate use of tools) * Measure outcomes but not advanced process * Consistent review of efficacy of adoption processes in impacting goals * Defined KPI / OKR and ongoing and consistent measuring and reporting of progress | * Implementation of scaled, consistent tooling and processes to support improved and consistent outcomes and measurement of pathway process * There is an opportunity to distinguish between nominal measurements (e.g. low, medium, high quality) and interval measurements (e.g. numerical values that represent the degree of difference between measures) * Continuous improvement and feedback loop through routine data collection and modifications in guidelines * Process metrics are used to effectively control the process as well as outcomes | * Consistent review of efficacy of processes in impacting goals; Routine adjustment of processes to advance outcomes * Defined KPI / OKR and ongoing and consistent measuring and reporting of progress * Innovative measures and analyses are identified and implemented as needed |

Stakeholder management-- can vary based on multidimensional and engagement of stakeholders

Level 5- organic and integrated into the practice; EMBEDDED and used ( muscle memory within the clinical team)

Tools and automation

1. Is this for end user and.or organization
2. Are we creating new tools
3. Execution and delivery of tools into the clinical practice