HIMSS Analytics
Continuity of Care Maturity Model
An Introduction

Model Information
http://himssanalytics.org/CCMM
Agenda

• Target Audiences
• The Industry Challenge
• Introducing the Continuity of Care Maturity Model – CCMM
  – Design
  – Stages
  – Methodology
  – Scoring
• Value Proposition of a CCMM Engagement
• Questions and Next Steps
Continuity of Care Target Audiences

• Those responsible for a community
  – Regional & National Health Authorities/MoH
  – Integrated Delivery Networks (IDN)
  – Regional Health Authorities
  – Other communities of care

• Solution Providers
  – System providers, integrators, consultants…
  – Technology Partners
The Industry Challenge

Providers of care and patients do not have access to all relevant information required to make the most informed decisions at the right time in the care delivery process…

Silo’ed health information and uncoordinated services
CCMM - Continuity of Care Maturity Model

CCMM measures the degree to which an organization or a regional or national health authority provides an environment and services supporting a care community with a continuum of information about a patient’s history and care…

– Health Information Exchange
– Coordinated patient care
– Patient engagement
– Advanced analytics

A Care Community is defined as the patient population that is being cared for.
CCMM 9 Key Pillars of Focus
## CCMM Stages

<table>
<thead>
<tr>
<th>STAGE 0</th>
<th>Limited to No E-communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAGE 1</td>
<td>Basic Peer-to-Peer Data Exchange</td>
</tr>
<tr>
<td>STAGE 2</td>
<td>Patient Centered Clinical Data using Basic System-to-System Exchange</td>
</tr>
<tr>
<td>STAGE 3</td>
<td>Normalized Patient Record using Structural Interoperability</td>
</tr>
<tr>
<td>STAGE 4</td>
<td>Care Coordination based on Actionable Data using a Semantic Interoperable Patient Record</td>
</tr>
<tr>
<td>STAGE 5</td>
<td>Community Wide Patient Record using Applied Information with Patient Engagement Focus</td>
</tr>
<tr>
<td>STAGE 6</td>
<td>Closed Loop Care Coordination Across Care Team Members</td>
</tr>
<tr>
<td>STAGE 7</td>
<td>Knowledge Driven Engagement for a Dynamic, Multi-vendor, Multi-organizational Interconnected Healthcare Delivery Model</td>
</tr>
</tbody>
</table>

*Continuity of Care Maturity Model*
CCMM Methodology

**Project Kickoff**
Define client's objectives, scope of measurement, project team/ responsibilities, program deliverables, and timelines

**Assessment**
Data collection Interviews

**Quality Assurance and Validation**
Validate data Resolve discrepancies

**Analysis and Results Generation**
Compile and processes data and findings
Produce deliverables such as scores, roadmap, GAP analysis, findings summary

**Presentation Delivery**
Expert interpretation of results is shared with project sponsors and leadership.
 Deliverables are presented and reviewed.
Actionable items are identified and discussed.
## CCMM Assessment and Scoring

<table>
<thead>
<tr>
<th>Category</th>
<th>Primary/Outpatient</th>
<th>Acute Inpatient</th>
<th>Rehabilitative Care</th>
<th>Patient</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage Achieved</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>2.6</td>
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<tr>
<td>Overall % of Stage Achievement</td>
<td>10%</td>
<td>46%</td>
<td>58%</td>
<td>19%</td>
<td>32%</td>
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<tr>
<td>ICT System Capabilities</td>
<td>11%</td>
<td>76%</td>
<td>59%</td>
<td>24%</td>
<td>42%</td>
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<tr>
<td>Organization Strategy</td>
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<td>90%</td>
<td>100%</td>
<td>32%</td>
<td>66%</td>
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<tr>
<td>Standards &amp; Interoperability</td>
<td>12%</td>
<td>57%</td>
<td></td>
<td>55%</td>
<td>46%</td>
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<tr>
<td>HIE - provider-to-provider</td>
<td>28%</td>
<td>65%</td>
<td>58%</td>
<td>52%</td>
<td>54%</td>
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<tr>
<td>HIE - provider-to-authority</td>
<td>0%</td>
<td>27%</td>
<td>0%</td>
<td>0%</td>
<td>5%</td>
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<tr>
<td>Care Coordination</td>
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<td>40%</td>
<td>53%</td>
<td>22%</td>
<td>27%</td>
</tr>
<tr>
<td>Patient &amp; Citizen Empowerment/Engagement</td>
<td>3%</td>
<td>28%</td>
<td>35%</td>
<td>24%</td>
<td>19%</td>
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<tr>
<td>Advanced Analytics</td>
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<td>31%</td>
<td>72%</td>
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<td>Pan-Organizational Capability Facilitation</td>
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<td>48%</td>
<td>60%</td>
<td>0%</td>
<td>26%</td>
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<tr>
<td>Policy-level Initiatives</td>
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<td>63%</td>
<td>56%</td>
<td>0%</td>
<td>40%</td>
</tr>
</tbody>
</table>

**GREEN = Strengths**  **RED = Opportunities**
CCMM Results

- Multi-dimensional across care settings and pillars
- Opportunity identification

Continuity of Care Maturity Score: 2,6130

- Overall
- Primary / Outpatient Care
- Acute Inpatient Care
- Rehabilitative Care
- Patients

- ICT System Capabilities
- Policy-level Initiatives
- Organization Strategy
- Standards & Interoperability
- Business / Financial Information Exchange
- Pan-Organizational Capability Facilitation
- Advanced Analytics
- Patient & Citizen Empowerment/Engagement
- Care Coordination
- Health Information Exchange (provider-to-provider)
- Health Information Exchange (provider-to-authority)
CCMM Value Proposition

• Baseline education about continuity of care
  – Common language, terminology, and a starting point for capability discussion
  – Well thought out maturity model and scoring system
• Gap analysis demonstrates strengths and opportunities
  – Identification of baseline and target opportunities
  – Understand your strengths and opportunities
  – Maximize value from resources (ROI)
• A staged and paced roadmap for future progress
  – Improved patient engagement, population health, and overall care coordination
Thank you

• Questions
• Next Steps

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