A Continuity of Care Maturity Framework: A reference tool for Ontario Health Teams to assess and guide their journey to connected care

By Todd MacCallum

These are exciting times in healthcare. Don't get me wrong there are a ton of pressures facing our healthcare system and more complexity than you can shake a stick at. Some days I feel discouraged about the seeming lack of progress we have made (#axethefax), but when I take a step back it is clear that we are in the midst of disruption in our industry. This disruption refers to changes hitting us from a technological perspective, but also in the areas of system (re)design and the ongoing maturity of and migration to (common) standards – both clinical and technological. We are collaborating on a global scale and that is starting to accelerate innovation at a regional level though not as fast as some of us would like.

Integrated health service delivery is defined by the World Health Organization (WHO) as "an approach to strengthen people-centred health systems through the promotion of the comprehensive delivery of quality services across the life-course, designed according to the multidimensional needs of the population and the individual and delivered by a coordinated multidisciplinary team of providers working across settings and levels of care".

A local example of system re-design in Ontario is the formation of Ontario Health Teams (OHTs). This is not new concept and similar models have been implemented around the world – for example, Integrated Delivery Networks, Integrated Care Delivery Systems, and Accountable Care Organizations. Gone are the days when health care providers could operate independently across a patient population and deliver anything resembling Value-Based Care. Most healthcare systems around the world have realized this and our current situation in Ontario is forcing us to look at things differently.

Okay, so let's talk about OHTs. We don't know the KPIs yet and there is definitely no one model that suits every catchment area. What we do know is that for an OHT to be effective it needs to be patient centred. This is a good thing for patients but it represents a ton of potential complexity. Yes, the technological complexity is large. But governance, funding and privacy are foundational pillars that will require strong leadership to overcome. Once these barriers are overcome, we will hopefully begin seeing successful OHT's across the province who are delivering seamless transitions of care, effective population health management, and better-informed care delivery though insights from advanced analytics.

How can HIMSS help in the journey to achieve such a lofty vision? HIMSS is generally well-known in the acute care sector for its EMRAM maturity model, but there are more frameworks which have been developed over recent years. In the case of OHTs, the HIMSS' Continuity of Care Maturity Model (CCMM) would be the most relevant. It does not encompass everything required to deliver integrated care, but it could serve as a useful foundation and roadmap to get there. According to a 2018 study by Kneck et al. (2019) published in the International Journal of Integrated Care entitled Information Flow in a Healthcare Organisation with Integrated Units,

> "Integration of care in terms of delivering continuous, comprehensive and coordinated care across organisations and professionals along a patient's care trajectory is closely related to continuity of care, i.e., continuity in management, relations and information. Continuity of care has been associated with reduced utilization of healthcare and mortality, as well as increased patient satisfaction. One important aspect is information continuity. How information is captured, processed, communicated and applied will affect how the information is received by patients, relatives and the multidisciplinary teams of healthcare professionals. Accessible information and transparent information flow, within care and between all the partners in care, is thus necessary for shared decision-making and responsibility, and co-production of care."

Essentially, CCMM is a strategic framework to guide continuity of care implementation. It is a seven (7) stage model that demonstrates the evolution of communication between clinicians in different settings with limited or no electronic communication to an advanced, multiorganizational, knowledge driven community of care.

The stages of the CCMM are:

STAGE **6**

Closed Loop Care Coordination across Care Team Members

STAGE **5**

Community-Wide Patient Records Using Applied Information with Patient Engagement Focus

STAGE **4**

Care Coordination Based On Actionable Data Using a Semantic Interoperable Patient Record

STAGE **3**

Normalized Patient Record Using Structural Interoperability

STAGE **2**

Patient Centered Clinical Data Using Basic System-To-System Exchange

STAGE **1**

Basic Peer-To-Peer Data Exchange

STAGE **0**

Limited or No E-Communication

OHTs would likely need to achieve stage 6 or 7 by maturity. Of course, funding incentives for performance as the OHT program matures will be essential to encouraging continued investment to reach a mature, fully integrated, patient centred systems. Hopefully with data standards that allow for an integrated approach to care delivery across the province as well.

Additional details on the Maturity Model can be found at: https://www.himssanalytics.org/ccmm

While none of the above explicitly identifies programs related to social determinants of health and wellness, the model lays a foundation enabling all of it. It is important that we never lose sight of the fact that healthier populations and more effective use of system resources are the ultimate goals here. These incremental innovations are part of the process…hopefully.

If you are interested in finding our more information on the HIMSS CCMM model visit www.himss.org. I encourage you to also get involved with the local Ontario Chapter of HIMSS for additional insight and learning opportunities.