




Maturity Framework for New Care Models/Risk-sharing Arrangements

Hospitals are in the midst of navigating significant changes in how they operate and deliver care. Each organization can use the maturity framework to assess its current capabilities to determine the best type of value-based care for the organization. All providers need to rethink where they are on the risk continuum, where they will be in the future and whether they have the infrastructure systems needed to manage risk.

CAPABILITY	MATURITY LEVEL		
	BASIC	FOUNDATIONAL	ADVANCED
 <p>Care Continuum and Provider Network Management</p>	<ul style="list-style-type: none"> ● NETWORK Significant gaps in assets across care continuum (outpatient — inpatient — post-acute) ● AFFILIATION REQUIREMENTS Limited criteria for affiliation ● QUALITY IMPROVEMENTS No link to quality/value 	<ul style="list-style-type: none"> ● NETWORK Robust network (either owned or affiliated). Health systems can address most patient care needs across continuum through owned or affiliated providers. ● AFFILIATION REQUIREMENTS Contracts require commitment to shared quality/utilization metrics ● QUALITY IMPROVEMENTS Portion of payment to physicians tied to performance/value 	<ul style="list-style-type: none"> ● NETWORK Comprehensive, clinically integrated network ● AFFILIATION REQUIREMENTS Affiliation relationship contingent on meeting quality and cost-management objectives ● QUALITY IMPROVEMENTS Strong alignment of physician compensation with clinical objectives through use of incentives
 <p>Clinical and Care Management</p>	<ul style="list-style-type: none"> ● CLINICAL PROTOCOLS No standardization of clinical protocols ● CARE MANAGEMENT Limited, if any ● QUALITY IMPROVEMENTS Quality-improvement and disease-management programs exist but are not coordinated across different parts of the health system 	<ul style="list-style-type: none"> ● CLINICAL PROTOCOLS Shared clinical protocols and standards of care ● CARE MANAGEMENT Integrated care teams, including nonphysician providers; dedicated care managers for high-risk patients ● QUALITY IMPROVEMENTS Shared quality measures 	<ul style="list-style-type: none"> ● CLINICAL PROTOCOLS Process for updating protocols with latest evidence and monitoring adoption ● CARE MANAGEMENT Population-health and disease-management programs, including use of telehealth and new technologies, where appropriate; assessment of social determinants of health and referrals to community-based organizations ● QUALITY IMPROVEMENTS Culture of continuous process improvement with progressively evolving performance standards
 <p>IT Infrastructure and Analytics</p>	<ul style="list-style-type: none"> ● ELECTRONIC HEALTH RECORD Functional EHR but little interoperability with affiliates ● POPULATION HEALTH MANAGEMENT TOOLS Use of disease registries/reporting ● PERFORMANCE ANALYTICS Some ability to track performance against quality/utilization benchmarks 	<ul style="list-style-type: none"> ● ELECTRONIC HEALTH RECORD Strategy in place to integrate EHR and analytics platforms across network, though not necessarily common platform ● POPULATION HEALTH MANAGEMENT TOOLS Population health-management system to identify high-risk patients ● PERFORMANCE ANALYTICS Integration of clinical, administrative and care management data at patient-level; practice-level dashboards to track performance against quality/utilization targets 	<ul style="list-style-type: none"> ● ELECTRONIC HEALTH RECORD Common EHR, analytics and care management platform used across network ● POPULATION HEALTH MANAGEMENT TOOLS Ability to identify defined subpopulations for targeted interventions; use of predictive modeling to identify at-risk members; ability to facilitate and track closed-loop referrals to community-based organizations ● PERFORMANCE ANALYTICS Near real-time visibility into quality and cost performance

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