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Educational Webinar Series

Think like a

Value-Based Care Consultant

Karen Burke

August 12, 2026

Introduction

Karen Burke

By the Numbers:

20+ years in Healthcare

- 12 years Management Consulting
- 5 years Healthcare Executive

- 17 Value Based Care Teams
- 56 Value Based Care Projects
  - 8 Provider Groups
  - 5 Payers
  - 2 Integrated Health Systems
  - 2 State Health Agencies

Objectives

Create a practice that accelerates implementation of value-based care initiatives while keeping an eye on success

- Provide a framework for rolling out any value-based care initiative
- Walk through a sample VBC use case
- Provide VBC KPI/metric accelerator
- Discuss keys to success
- Q&A

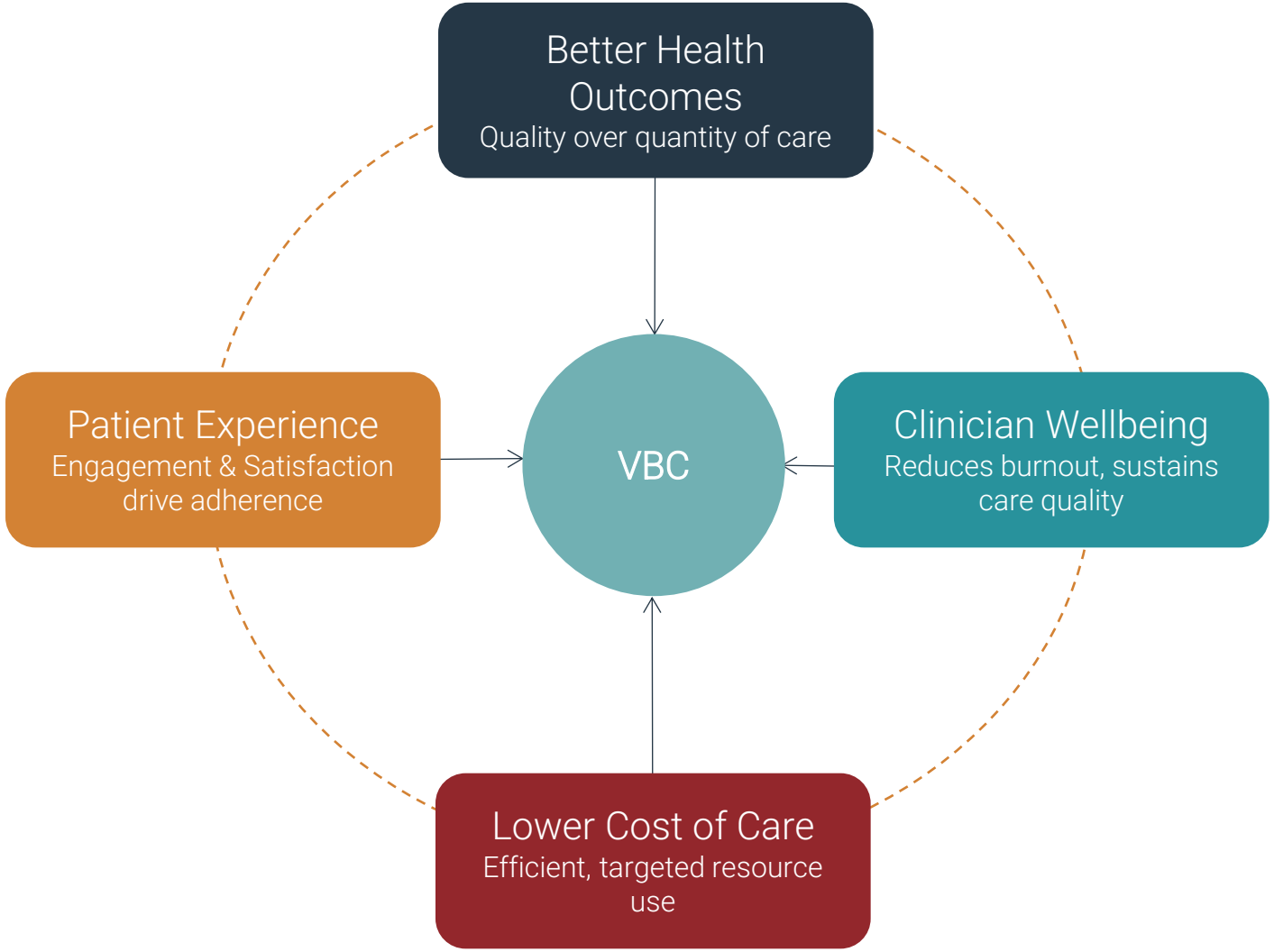
Poll Question

Which category best describes your organization's role in the healthcare ecosystem?

- **A.** Payer / Health Plan
- **B.** Provider Group / Physician Practice Organization
- **C.** Integrated Health System / Integrated Delivery Network (IDN)
- **D.** Post-Acute / Home Health / Community-Based Provider
- **E.** Healthcare Consulting / Technology Partner / Other

Understanding the opportunity

Framing the VBC problem in terms of the **Quadruple Aim** provides structure to apply the framework



Better health outcomes reduce unnecessary utilization, which lowers cost

A **better patient experience** improves adherence and engagement, which drives better outcomes

Lower cost of care frees resources to invest in prevention and population health

Clinician wellbeing reduces turnover and errors, protecting both quality and cost

Apply an Actionable Framework

The **VBC Strategic Framework** serves as the guardrails to build a roadmap for where you want to go

Where you are today

Current State Assessment

- Contract Portfolio
  - FFS vs. VBC revenue mix
  - Downside/Upside Risk
- Quality & Outcomes
  - HEDIS, STAR, CAHPS gaps
  - Avoidable utilization rates
- Care Team Readiness
  - Care Management Capacity
  - Attribution & Panel Clarity
- Data & Technology
  - EMR/EHR, Analytics, interoperability gaps, Claims & ADT Feed Access

Where you want to go

VBC Vision and Goals

- VBC North Star
  - % revenue at risk by year 3-5
  - Target Population Served
- Clinical Outcomes
  - Reduced ED & Readmits
  - Chronic disease control rates
- Financial Targets
  - Shared savings capture rate
  - Total Cost of Care Benchmark
- Contract Model Goals
  - ACO Reach, MSSP, Capitation bundle and episode targets

How to get there

The Roadmap

1. Build Infrastructure
   - Analytics, Care Management, Registry
2. Stratify Populations
   - Risk scoring, Rising Risk ID
3. Redesign Care Models
   - Transitions, CCM, Team-Based
4. Launch Contracts
   - Payer Agreements, attribution
5. Measure & Scale
   - KPIs, Savings, Expand Risk

Continuous performance loop

Reassess utilization & quality → refine interventions → renegotiate contracts → repeat

Measuring Performance

Key Performance Metrics for each Quad Aim in value-based Care

Quadruple Aim — VBC Metrics Rubric

Key performance metrics for each aim in Value Based Care

Aim Summary

Quadruple Aim	Key Metric Focus	Primary Data Source	VBC Contract Link
Better Health Outcomes	HEDIS, readmissions, HbA1c control	EHR, claims, registry	Star ratings, quality bonuses
Lower Cost of Care	TCOC vs. benchmark, avoidable admits	Claims, payer reports	Shared savings, risk corridors
Patient Experience	CAHPS, access, care continuity	Patient surveys, CMS	Star ratings, P4P contracts
Clinician Wellbeing	Burnout, turnover, satisfaction index	Staff surveys, HR data	Network stability, contract renewal

Health Outcomes

Quadruple Aim — VBC Metrics Rubric

Metric	Definition / What It Measures	Target / Benchmark	Frequency	VBC Relevance
All-cause readmission rate	% of patients readmitted within 30 days of discharge	< 15% (CMS benchmark); aim for bottom quartile	Monthly	Core MSSP/ACO quality measure; tied to shared savings eligibility
HbA1c control (diabetes)	% of diabetic patients with HbA1c < 8.0%	> 70% of attributed diabetic panel	Quarterly	HEDIS measure; included in Medicare Advantage Star ratings
Blood pressure control	% of hypertensive patients with BP < 140/90	> 70% of hypertensive panel	Quarterly	High-weight HEDIS measure; affects Star ratings and quality bonuses
Preventive care completion	% of eligible patients receiving recommended screenings (mammogram, colorectal, etc.)	> 75% completion by care gap type	Annually / rolling	HEDIS-driven; closing care gaps improves quality score tier
Avoidable hospitalization rate	Admissions for ambulatory-sensitive conditions (CHF, COPD, asthma, UTI)	< state/regional average; year-over-year reduction	Quarterly	Direct driver of TCOC; primary cost lever in risk contracts
ED utilization rate	ED visits per 1,000 attributed members	Trending down; payer benchmark varies by market	Monthly	High-cost setting; avoidable ED drives benchmark overage in risk arrangements
Care gap closure rate	% of open HEDIS/quality care gaps closed within measurement year	> 80% closure rate annually	Ongoing / annual closeout	Directly tied to quality score used for bonus calculations

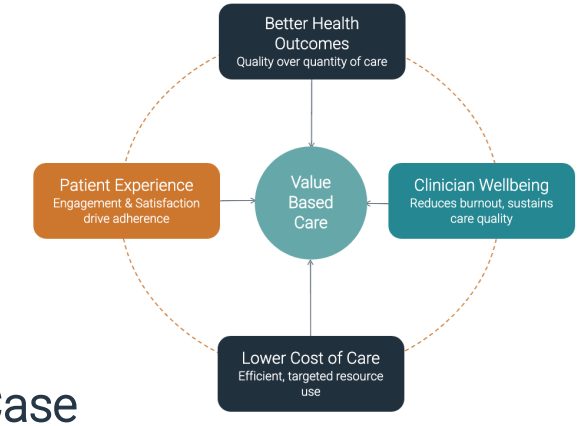
Cost of Care

Quadruple Aim — VBC Metrics Rubric

Metric	Definition / What It Measures	Target / Benchmark	Frequency	VBC Relevance
Total Cost of Care (TCOC)	Total spend per member per year across all settings vs. risk-adjusted benchmark	Below benchmark; payer-set; CMS publishes regional targets	Annually (contract); Monthly (internal tracking)	Primary financial performance metric in ACO, MSSP, and risk-based contracts
Per member per month (PMPM) spend	Average monthly cost per attributed member including inpatient, outpatient, Rx	Trend < medical inflation (CPI-M); below regional average	Monthly	Operational metric for managing toward annual TCOC benchmark
Inpatient admission rate	Inpatient admissions per 1,000 attributed members	< regional market average; year-over-year reduction	Monthly	Single largest cost driver; most sensitive lever in risk arrangements
Length of stay (LOS)	Average inpatient days per admission by DRG/condition	At or below CMS geometric mean LOS by DRG	Monthly	Excess LOS signals care coordination failure; drives cost above benchmark
Generic drug prescribing rate	% of prescriptions written as generic vs. brand when generic available	> 85% generic dispensing rate	Quarterly	Pharmacy cost lever; relevant in full-risk and capitation models
Specialist referral rate	Specialist visits per 100 primary care encounters	Trending down; benchmarked to similar panels	Quarterly	High referral rates signal PCP care gaps; drives downstream specialty cost
Shared savings / (deficit)	Difference between actual spend and risk-adjusted benchmark; positive = savings	Positive variance; track against minimum savings rate (MSR)	Annually (CMS settlement); Quarterly (projections)	Core VBC financial outcome; determines bonus or repayment obligation

Implement > Execute > Measure

Use the framework to build the use case and plan to execution



Value-based care Strategic Framework

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Value-based care Metrics

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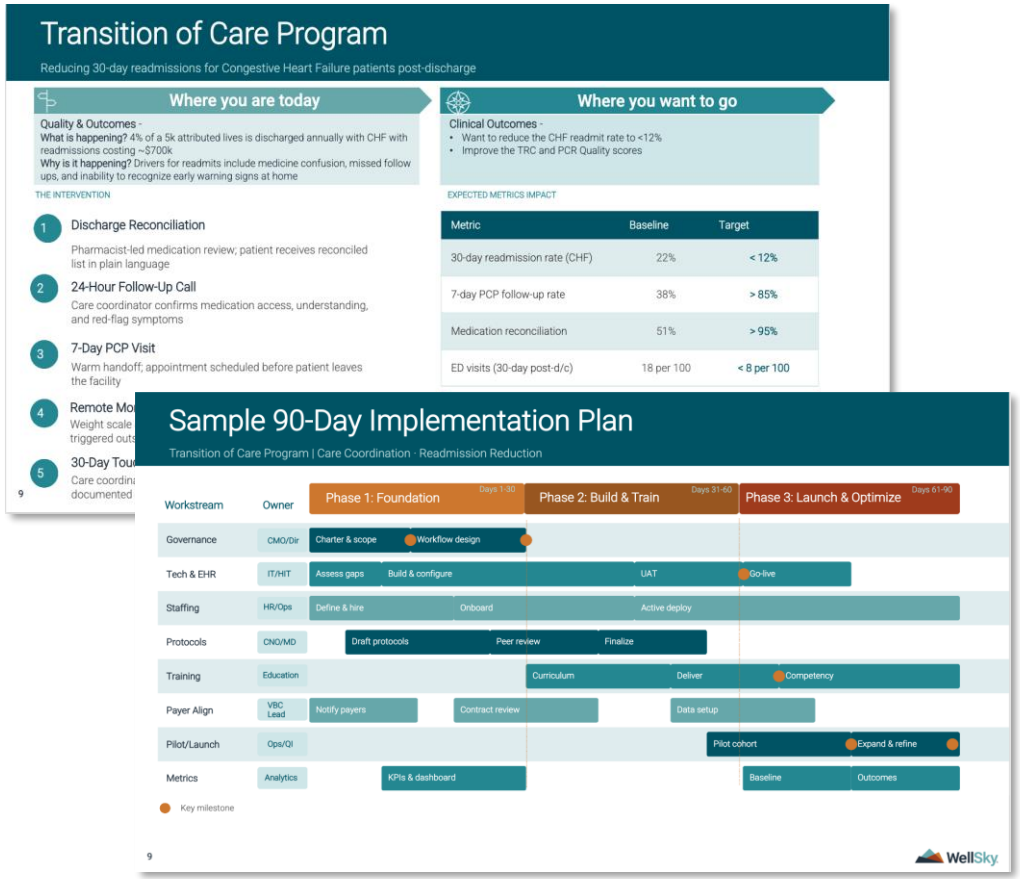
Value-based care Use Case



Implementation Plan

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Poll Question

What is the single biggest bottleneck preventing your organization from hitting its VBC contract milestones?

A. Staffing & Capacity Constraints: We don't have enough care managers or clinicians to perform proactive patient outreach.

B. Data Silos & Interoperability: We cannot easily exchange CCDs or real-time attribution data with our payer/provider partners.

C. Clinician Buy-in & Burnout: Our frontline clinicians are overwhelmed by administrative burden and EHR inbox overload.

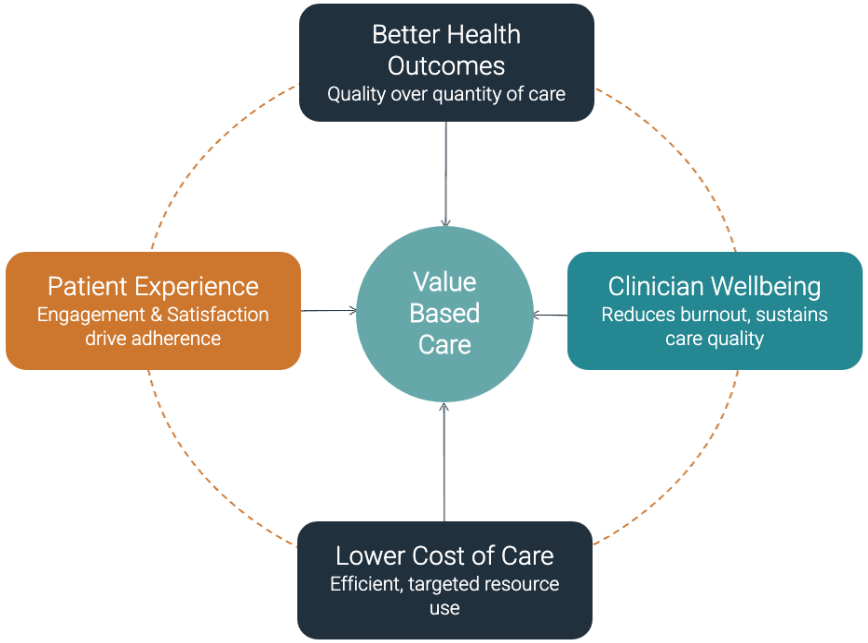
D. Lack of collaboration between key partners

VALUE BASED CARE

Care Coordination

Sample VBC Use Case

Transition of Care - evidence-based intervention to reduce 30-day readmissions and improve VBC quality score performance



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Transition of Care Program

Reducing 30-day readmissions for Congestive Heart Failure patients post-discharge

Where you are today

Quality & Outcomes -

What is happening? 4% of a 5k attributed lives is discharged annually with CHF with readmissions costing ~$700k

Why is it happening? Drivers for readmits include medicine confusion, missed follow ups, and inability to recognize early warning signs at home

THE INTERVENTION

1. **Discharge Reconciliation**
   Pharmacist-led medication review; patient receives reconciled list in plain language
2. **24-Hour Follow-Up Call**
   Care coordinator confirms medication access, understanding, and red-flag symptoms
3. **7-Day PCP Visit**
   Warm handoff; appointment scheduled before patient leaves the facility
4. **Remote Monitoring**
   Weight scale & BiPAP monitoring for CHF patients; alerts triggered outside parameters
5. **30-Day Touchpoints**
   Care coordinator check-ins at day 7, 14, and 30 with documented care plan updates

Where you want to go

Clinical Outcomes -

- Want to reduce the CHF readmit rate to <12%
- Improve the TRC and PCR Quality scores

EXPECTED METRICS IMPACT

Metric	Baseline	Target
30-day readmission rate (CHF)	22%	< 12%
7-day PCP follow-up rate	38%	> 85%
Medication reconciliation	51%	> 95%
ED visits (30-day post-d/c)	18 per 100	< 8 per 100

VBC OUTCOME

~24 prevented readmissions/yr on a 5K-life panel -> $380K in avoided spend

Feeds directly into shared savings performance & TRC quality score

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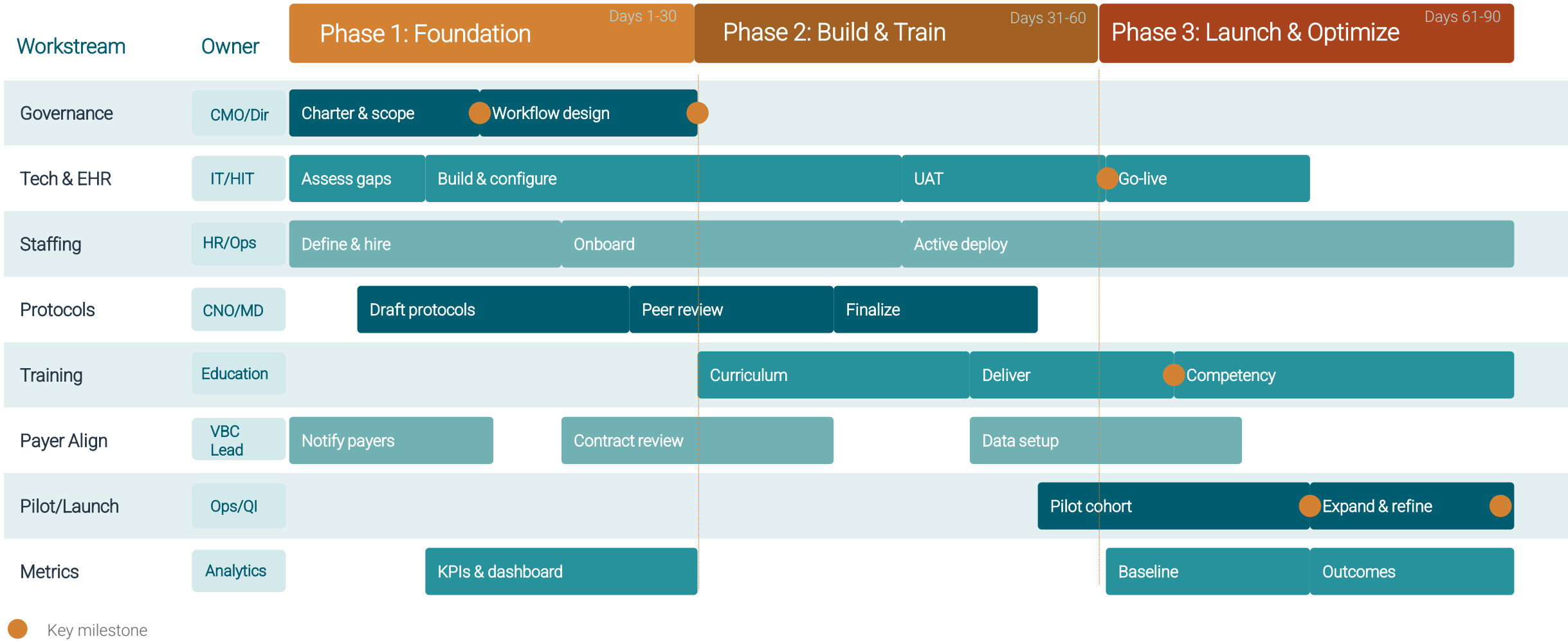
Sample 90-Day Implementation Plan

Transition of Care Program | Care Coordination · Readmission Reduction



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Keys to Success

What drives VBC execution success in organizations?

Large Organization

Grassroots-driven success

Front-line clinician buy-in
Champions embedded in care teams drive adoption from the floor up

Department-level data ownership
Teams trust & act on data they helped define and validate

Workflow integration by role
EHR workflows, care protocols fit each team's daily routine

Peer recognition & local wins
Small-team wins are celebrated and amplified across the org

Bottom-up protocol design
Clinicians co-design the TOC, care gap, and risk protocols

Shared Success Factors

Present in both contexts

Clear VBC vision & why it matters
All staff understand the outcome goal, not just the process

Defined metrics with shared targets
Quality scores, cost benchmarks, and timelines are visible to all

Payer & partner alignment
Contracts, attribution, and data flows confirmed before launch

Technology that supports the work
EHR workflows, dashboards, and alerts match real care processes

Regular feedback loops
Progress reviewed monthly; course corrections made quickly

Small Organization

Leader-championed success

Visible executive sponsorship
CEO/CMO publicly owns the VBC strategy and removes barriers

Fast decisions from the top
Leader authority compresses approval cycles and unblocks issues

Leader as VBC storyteller
The why is told repeatedly in all-hands, huddles, and 1:1s

Top-down resource allocation
Budget, FTEs, and vendor decisions flow from leadership mandate

Leader accountability for outcomes
Named leader owns the P&L impact of VBC contract performance

The most resilient VBC rollouts combine both — a leader who opens the door and front-line champions who hold it open.

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Q & A

Stop by our VBCExhibitHall.com Virtual Booth:

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Thank you

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Next Webinar

Stop Boiling the Ocean: Delivering Small Wins That Drive Big Value in VBC

October 1st 12 pm ET/ 11 am CT