

Stop boiling the ocean: Delivering small wins that drive big value in VBC

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In partnership with



Educational Webinar Series

Our presenter



Darcie Goodman is a healthcare executive and former ER/Trauma registered nurse with 20+ years of international healthcare experience.

Her experience spans private equity, large multi-state health systems, payers, managed service organizations, rural and community providers, government agencies, and healthcare start-ups.

Her areas of expertise include:

- Value-based care strategy
- Clinical transformation
- MSO implementation
- Quality management
- Care & utilization management
- Technology enablement & clinical informatics

<https://slingshot-health.com/>

Agenda



1. VBC webinar attendee background
2. VBC continuum (FFS – Capitation)
3. Financial mechanics and levers for VBC success
4. Common pitfalls and an approach to improvement
5. Getting started



Poll Question

Which category best describes your organization?

- A. Payer / Health Plan
- B. Integrated Health System / Physician Practice Organization
- C. Managed Service Organization (MSO)
- D. Post-Acute / Home Health / Community-Based Provider
- E. Healthcare Consulting / Technology Partner / Other

The value-based care (VBC) journey



Fee-for-Service

Volume-driven reimbursement without accountability for costs

NO PROVIDER RISK

Performance Pay

Upside bonuses linked to HEDIS and clinical quality benchmarks

PAY-FOR-PERFORMANCE

Bundled Payments

Fixed episode-based spend

EPISODE ACCOUNTABILITY

Shared Savings / Risk

Two-sided financial risk against total cost of care budgets

SHARED RISK MODELS

Capitation

Global PMPM budget with total attribution risk

TOTAL RISK TRANSFER

Provider Financial Accountability

Poll Question

Which level of VBC risk makes up the majority of your organization's contracts?

- A. Fee-for-Service
- B. Pay for Performance
- D. Shared Savings Risk
- E. Capitation
- F. Not Sure

Aligned case for transition to value-based care

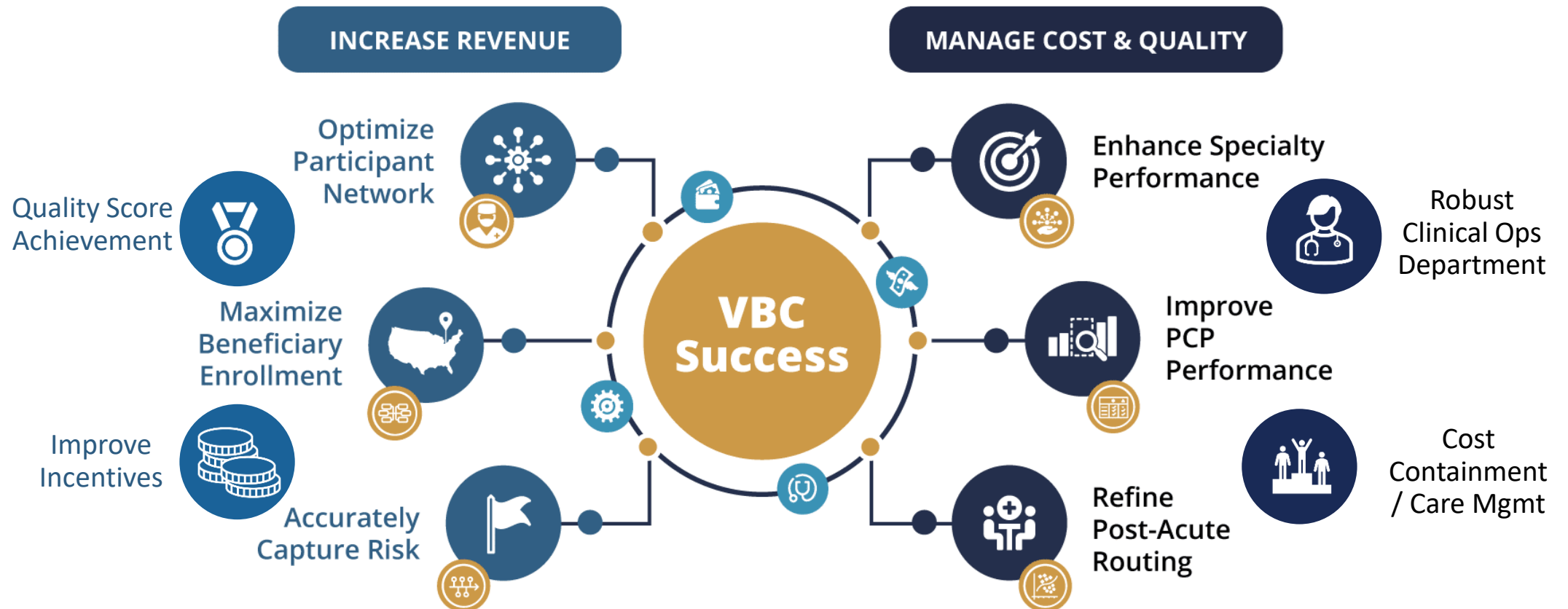


Traditional fee-for-service (FFS) models often incentivize quantity over quality, encouraging the number of services delivered rather than the outcomes or long-term benefits for patients.

FFS models can result in fragmented care, and higher costs, which impacts health outcomes.

Insurance company	Provider	Patient/Member
• Grow and retain membership • Maximize premium revenue • Transfer financial risk	• Maximize reimbursement • Exceed insurer performance • Deliver effective care	• Obtain access to high value care • Reduce frustration with navigation issues • Limit financial burden

VBC client success



Value-based payment scenario 1

SCENARIO 1



Savings achieved

Actual total population spend is kept below benchmark targets through proactive acute care coordination.

Projected budget: \$50,000,000

Actual spend: \$46,000,000

Outcome: +\$4,000,000



Budgeted
Spend



Total
Projected
Healthcare
Spend for
Population

Scenario 1:
**Savings
Achieved**

Shared
Savings

Healthcare
Spend for
Population



Value-based payment scenario 2

SCENARIO 2

Cost overruns

Unmanaged and/or fragmented handoffs lead to avoidable hospital and specialty spend exceeding budget caps.

Projected budget: \$50,000,000

Actual spend: \$53,500,000

Outcome: **-\$3,500,000**

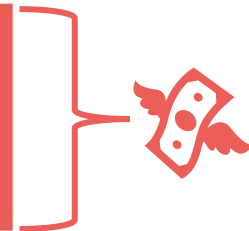
Budgeted
Spend



Total
Projected
Healthcare
Spend for
Population

Scenario 2:
**No Savings
Achieved**

Actual
Spend Over
Budget



Healthcare
Spend for
Population

Value-based payment scenario 3

SCENARIO 3

Quality & coding optimization

Accurate HCC risk capture plus top-tier Star/HEDIS quality scores trigger maximum contract payout multipliers.

Adjusted budget: \$50,000,000

Actual spend: \$46,000,000

Coding Optimization & Quality Bonus: **+\$3,500,000**

Outcome: **+\$9,500,000**



Budgeted
Spend



Total
Projected
Healthcare
Spend for
Population

Scenario 3:
Coding Accuracy and
Quality Performance

Coding

Quality

Shared
Savings

Healthcare
Spend for
Population



Common VBC implementation pitfalls



Data

- Not understanding your data or leveraging your payor partners
- Not looking at baseline data – you need directional, not perfect
- Not stratifying populations and lacking patient attribution to individual providers

Providers

- Siloed providers, without venue for individual performance reporting
- Lack of alignment and understanding between clinicians and contracting team

CM

- Implementing high risk CM as a first strategy
- Creating CM that is too specialized

Operations

- Assigning a single team responsible for VBC
- Chasing quality at the end of the year
- Front Desk and RCM functions siloed from clinical teams

Targeting incremental wins



High-Yield Focus Areas

Post-utilization Engagement: Leverage ADT feeds and partners for rapid engagement following inpatient discharges and acute ED visits.

Focused Support: Establish structured workflows for managing patients with Diabetes and Heart Failure.

Pre-visit Planning: Proactively identify quality metric gaps, utilization history, and social, condition, and medication needs.

Structured Check-in/out: Correct demographics, billing, and consents upfront, formalize medication reconciliation and referral and follow-up scheduling at departure.

Documentation & RCM: Optimize clinical documentation improvement (CDI), coding and risk capture.



Following the funds sustains impact



Expected outcomes

Lower avoidable utilization: Eliminate high-cost recidivism through targeted, effective follow-up and support.

Elevated patient and provider experience: Enhance patient trust and engagement through coordinated, smooth, person-centered care that maximizes provider efforts.

Maximized shared savings: Achieve quality and cost thresholds to capture full financial incentives to providers.

Reduced waste & friction: Streamline administrative burden across clinical and back-office teams.

Lowered no-show: Improve arrival rate at primary and specialty care appointments.



Starting your improvements: Focus on small wins



1

ATTRIBUTION

Clarify attribution

Define exactly which patients you are held financially accountable for and establish refresh cycle from payer rosters to internal data.

- Create provider specific attribution
- Establish internal attribution schedule
- Match clinical patient rosters against payer claims

Step 1: Unify provider attribution modeling

2

STRATIFICATION

Stratify population risk

Focus first on contracts with the highest downside exposure and segment patient cohorts by avoidable utilization risk.

- Stratify patients to prioritize frequent ED visits and acute utilization/readmission
- Create chronic disease and quality gap cohorts

Step 2: Simplify internal stratification methodology

3

EDUCATION

Educate the team

Focus VBC education by role to ensure an understanding of individual contribution and responsibilities to VBC success (improved condition management, and patient and team experience).

- Outline ownership by roles and intervention phase
- Celebrate wins, and create feedback loop for questions

Step 3: Embed VBC education into regular meetings

4

INTERVENTION

Execute 2–3 strategies

Determine focuses and map concise workflows from patient identification through intervention completion, understanding information flow and assigning clear individual ownership.

- Outline clear workflows, team roles, and intervention milestones
- Establish rapid review cycles at 30-day intervals

Step 4: Implement and Track Results

Next steps: high-yield implementation playbook



Next step: Identify 1-2 high yield opportunities for your organization

- ✓ **Post-utilization engagement:** Rapid engagement following inpatient discharges and acute ED visits.
 - Leverage partners/orgs that can deliver real-time data and/or understand your highest utilizing patients
 - Outline a simple intervention and determine who will be responsible
 - Capture successful visit rate and future utilization rate

OUTCOME: 30% reduction in R/A and PCR from 1 -> 4 star increase within 1st 10 months

- ✓ **Focused support:** Establish structured workflows for managing patients with Diabetes and Heart Failure.
 - Identify highest utilizing patients with IDDM and CHF, prioritizing those with open care gaps
 - Outline a simple intervention for screening, specialty collaboration, and regular monitoring, and determine who will be responsible
 - Capture successful visit rate and future utilization rate

OUTCOME: Reduction in overall avoidable utilization, improved specialty integration, and triple weighted HEDIS increase within 1st 10 months

- ✓ **Pre-visit planning:** Proactively identify quality metric gaps, utilization history, and social, condition, and medication needs.
 - Leverage data to stratify your highest utilizing patients and ID care gaps
 - High needs receive a reminder call prior to appointment (bring in medications, transportation needs, diagnostics completed, MD questions)
 - Low needs receive a slip to complete in waiting room (current meds, recent testing/other provider visits, chief concern)
 - MA (or other team member) pulls collected information to prime the MD chart for open care gaps, new information, and chief concern to support visit

OUTCOME: More effective MD visit, increased care gap closure rate, coding optimization, improved medication reconciliation rate, improved patient experience due to prepping for appointment

Next steps: high-yield implementation playbook



Continued - Next step: Identify 1-2 high yield opportunities for your organization

✓ **Structured check-in/out:** Correct demographics, billing, and consents upfront, formalize medication reconciliation and referral and follow-up scheduling at departure.

- Assign one team member to complete structured check in & out with each patient
 - Ensure information is correct and consents for SMS, Email and phone contact are completed
 - Billing information correct and prior auth and applicable payments/co-insurance received
 - Discharge summary, visit notes, prescriptions and follow ups are received by patient and understood
 - Complete follow-up appointment and referrals scheduling, and ensure prescriptions/service referrals sent to correct pharmacy/location/vendor
 - Determine if pre-visit reminder support is needed and schedule outreach

OUTCOME: Improved payment capture, reduction in no-shows (20%), decreased network leakage, improved patient experience due to coordination and engagement

✓ **Documentation & RCM:** Optimize clinical documentation improvement (CDI), coding and risk capture.

- Link with check in/out process above
- Map the end-to-end RCM process and ensure each step has a clear owner with documented responsibilities, turnaround time and clear escalation process

OUTCOME: Improved turnaround time, cash on hand, risk capture. Reduction in admin waste and bad debt with denials and appeals. More meaningful patient interventions.

**STEP 1
Identify**

ADT / Data Feed

**STEP 2
Engage**

Call Within 48h

**STEP 3
Schedule**

PCP Within 7 Days

**STEP 4
Reconcile**

Meds, Supplies, Plan

**STEP 5
Clinic Visit**

HRA & Check-in

**STEP 6
Measure**

Readmission Rate

STAKEHOLDER ROLES & RESPONSIBILITIES

Data analytics: Surfaces ADT alert of diabetic discharge within 12 hours.

Care coordinator: Completes telephonic engagement and schedules PCP visit and performs pre-visit screening.

Front desk & back office: Greets patient, verifies demographics, insurance & co-pay, accurately codes conditions and submits timely.

Physician & MA: Reconcile meds, close HEDIS screening gaps, ensures referrals scheduled, and fully documents conditions.

FRONTLINE CLINICAL ACTION STEPS

Engage and schedule within 48 Hours: Verify patient safety, symptoms, and transportation barriers.

Review meds, supplies & plan: Confirm patient has medications/DME on hand, services have arrived and understands plan.

Escalation protocol: Establish management procedure and contact plan, if condition destabilizes before visit.

Clinic pre-planning: Ensure discharge summary and complete pre-visit checklist are available to appointment front desk and clinical teams.

Next steps for client teams



1

Identify 1 target risk contract

Focus first on contracts with the highest downside financial exposure

2

Audit baseline data to focus intervention

Leverage Payor analytics to segment patient cohorts by avoidable utilization risk

3

Define the intervention and owner

Engage team to understand goal map workflow from patient identification through intervention completion, understanding information flow and assigning clear individual ownership.

4

Launch intervention and monitor

Establish rapid review cycles at 30-day intervals to celebrate wins, and create feedback loop for questions

Poll question

Would you be interested in a follow up?



Q & A



Stop by our VBCExhibitHall.com Virtual Booth:



VBCExhibitHall.com



Thank you

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