



Mindtree

A Larsen & Toubro Group Company



# Role of population health management in a value-based care framework



# The need for population health initiatives

With the shift in focus from a fee-for-service to a value-based model, population health has moved to the forefront of health policy formulation. With more and more payers advocating risk-sharing payment models and the emergence of innovative and non-traditional payer-provider partnerships, the focus has shifted from health services provided at the point of care and paid for at an individual level to holistic health care management for a discrete or defined population—an approach known as population health management.

## The challenges of population health

The shift of focus from individual care to the care of a population brings with it unique challenges for providers, especially in value-based contracts with downside financial risk.

### Understanding the population

A population attributed to a provider can vary significantly in numbers and diversity. Providers need to transition from a reactive mode of caring for patients at the point-of-service to a model that is predicated on a comprehensive risk stratification at the population and the patient level using demographics, clinical, social, and other sources of data.

### Shifting patient populations

Shifting patient populations and transient groups can hamper visibility into the attributed patient population and skew providers' performance metrics. Data sharing and transparency, care coordination, and transition management are important tools to manage risk and visibility in attributed members and their health needs and outcomes.

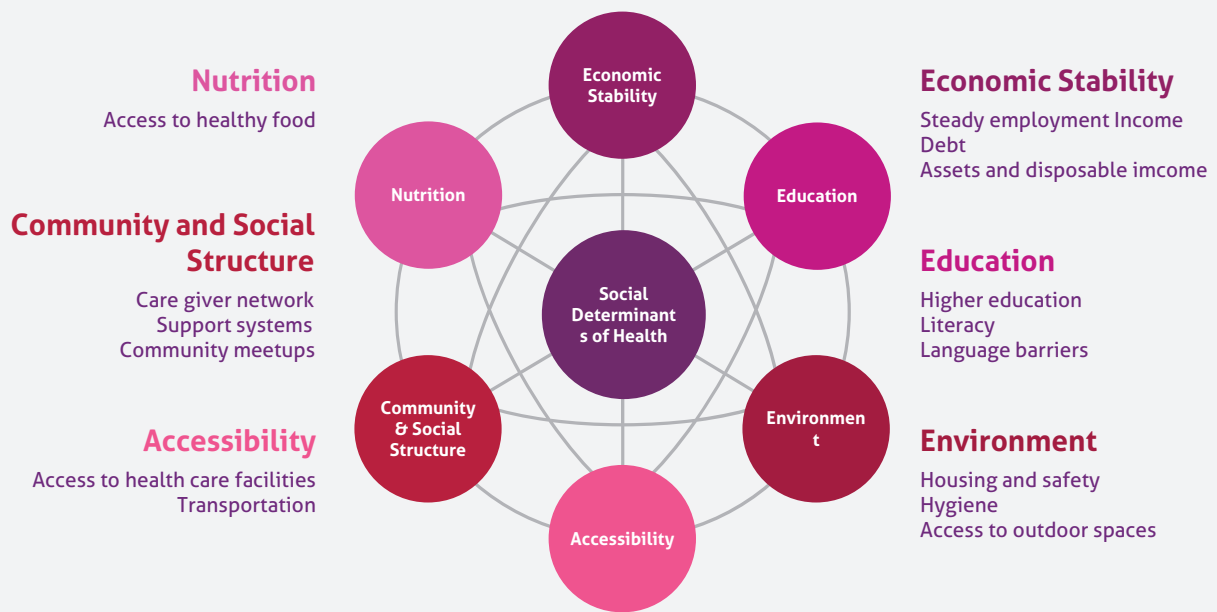
### Migration towards personalized health management

A proactive reach out to the members of the population, a focus on preventive medicine, regular follow-ups for treatment compliance, and chronic care and remote monitoring tools and devices have become essential tools for providers to manage the health outcomes of their assigned groups.

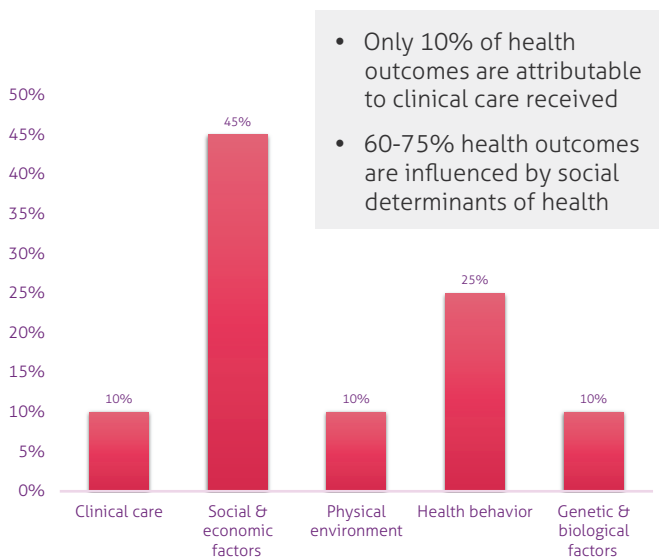
### Focus on social determinants of health

A critical part of population health management includes addressing Social Determinants of Health (SDoH) to advance the concept of whole-person health.





SDOH and it's effect on health outcomes



Social determinants of health

It is estimated that **only 10%** of outcomes are associated with medical interventions, whereas **up to 60%** of health outcomes are associated with Social Determinants of Health (SDoH)<sup>1</sup>. Providers need to conduct a proactive reorganization of health care delivery around the anticipated needs of the population, enabled by risk stratification and collaboration with entities such as payers, other providers, healthcare service providers, and the community.

## The alignment of quality and outcome measures

Navigating multiple value-based contracts with multiple payers can be time-consuming and complex. There is a real need to develop standardized quality metrics across payers to achieve efficiency and develop processes and workflows.

## Elements of a robust population health management program

The bedrock of an effective population health program is based on holistic health and wellness management leading to lower costs, generating value through better health outcomes, reducing readmissions and recurrences of episodes that need urgent and expensive medical attention.

The various elements of a robust population health management program include:

## 1. Risk stratification

Healthcare organizations need to consider that a typical population comprises patients belonging to different payment model groups (Medicare, Medicaid, commercial payers, and uninsured) with differing FFS or value-based contractual requirements and protocols. It is neither sustainable nor conscionable for providers to provide differing health services and processes for the differing patient groups. The solution is to stratify the population into risk-based segments and tailor the health service offerings to the specific health needs of each group. Structured and unstructured data from various sources such as EHRs, claims data, pharmacy benefit systems, and patient portals are aggregated, cleansed, normalized, and analyzed, using AI/ machine learning and predictive analytics. Based on this data, the population can be stratified into risk groups, and targeted protocols and treatment modalities applied to the groups as per their health needs.

## 2. Data-driven insights and clinical decision-making

Health organizations need to base their population health initiatives on actionable insights derived from data collected by various health systems. Data can also be used to derive actionable insights that can be applied during the clinical workflow to identify care gaps, opportunities for improvement and provide personalized and specific care to each patient at the point of care. Dashboards and metrics help organizational leaders identify resource utilization and view the care, quality, and financial metrics that matter most to their organization, thus driving operational efficiency and cost savings.

## 3. Patient engagement and care coordination

Having identified the risk-stratified groups and care gaps, providers need to conduct targeted and personalized outreach efforts based on digital strategies and patient preferences, to improve health, satisfy quality measures for value-based payment contracts, and support revenue generation. Proactive patient engagement helps organizations attract and retain patients, securing their loyalty and taking ownership of their health, as well as track patients entering or leaving the population group. Care coordination and collaboration among health teams and other stakeholders can be supported by technological and digital tools. Additional resources such as care coordinators, nurse navigators, and care transition nurses play a big role in provider engagement and health management.

## 4. Patient medical home

With multiple stakeholders and clinical teams involved in the care delivery process, processes and communications with the patient can be duplicated or missed, giving rise to an unsatisfactory experience for the patient. The Patient-Centered Medical Home (PCMH) is a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand<sup>1</sup>. The idea is to have a centralized hub that facilitates partnerships among various care teams facilitated by health information exchange and other digital tools.

## 5. Collaboration and partnerships

A key component of population health is a collaboration among health care agencies and the community. Providers, payers, government, and community agencies all play a major role in providing a seamless continuum of care for the community. Hence partnerships, data exchange, and aligned priorities are the cornerstones of a successful population health initiative.

## How can Mindtree help?

Mindtree helps healthcare organizations design and execute their population health and value-based programs with robust consulting and technology solutions. Our strength and expertise in the following areas help support your activities at various points along the care spectrum.

**Key enablers:**  
Interoperability AI/ML  
analytics automation

**Sources of data and LIS.**  
EHR, benefit data, admissions data,  
patient profile, SDoH data HIE, LIS

**Platform implementation**  
Data aggregation  
data cleanup Care  
coordination and  
Telehealth services

### Population health management platform

#### Risk stratification

- Patient segmentation based on risk profiles
- Analysis of risk profiles, including SDoH
- Personalized and targeted health care services based on risk stratification

#### Data-driven insights

- Actionable insights at POC
- Identification of care gaps, opportunities for improvement
- Dashboards and metrics for resource and utilization management
- collaboration between care teams, payers

#### Engagement and care coordination

- Targeted and personalized outreach efforts
- Patient engagement initiatives
- Care coordination and collaboration
- Follow up or screening reminders

#### Patient medical home

- Patient treatment is coordinated through primary care physician
- Advanced analytics and real time care mapping
- Enablement of robust and timely regulatory reporting
- Centralized hub that facilitates partnerships

*Our population health solution*

### • Data and intelligence

Our data and intelligence solutions can support the acquisition, aggregation, standardization, and normalization of data across systems and lines of business to provide a line of sight into risk-stratified population segments. Additionally, AI/ML-based analysis of data for cost, utilization, quality, SDoH, and other parameters can help generate actionable insights, identify gaps in care and support innovative and transformative initiatives.

### • Care coordination and digital engagement

In collaboration with our partners, we provide care management and care coordination services backed by a longitudinal view of the patient at all steps of the patient journey. Our solutions and

platforms can support all digital touchpoints with patients and the community. We provide targeted reach out, personalized communication, resource sharing, and remote monitoring services with a host of patient engagement solutions.

- **Interoperability and integration**

Our interoperability offerings not only help you meet key compliance goals but also help leapfrog competitors by dissolving barriers, enabling better access to health information and interoperability among systems, fostering innovation.

## Conclusion

With the emergence of value-based contracts and the shift of risk to providers associated with these programs, the healthcare industry is taking a long hard look at its existing processes and identifying ways to address the gaps and disparities in care for the community and population. Population health management is an essential part of healthcare reform that involves participation and collaboration among stakeholders such as providers, payers, the government, and the community. Implementing a robust and effective population health management program requires technology and digital tools that can not only support this transition but also help sustain the program through the realization of the “value” in value-based care.

## References


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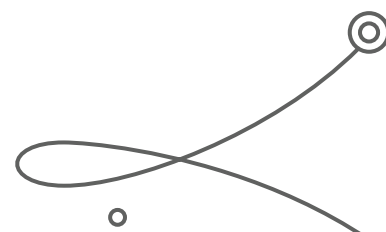


**Contact Mindtree**

**Amar Prasad,**  
Healthcare Industry Solutions Leader, Mindtree

 [Amar.Prasad@mindtree.com](mailto:Amar.Prasad@mindtree.com)

 [www.mindtree.com/industries/health](http://www.mindtree.com/industries/health)



## About Mindtree

Mindtree [NSE: MINDTREE] is a global technology consulting and services company, helping enterprises marry scale with agility to achieve competitive advantage. “Born digital,” in 1999 and now a Larsen & Toubro Group Company, Mindtree applies its deep domain knowledge to 270 enterprise client engagements to break down silos, make sense of digital complexity and bring new initiatives to market faster. We enable IT to move at the speed of business, leveraging emerging technologies and the efficiencies of Continuous Delivery to spur business innovation. Operating in 24 countries across the world, we are consistently regarded as one of the best places to work, embodied every day by our winning culture made up of over 23,800 entrepreneurial, collaborative and dedicated “Mindtree Minds.”