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WHITE PAPER

From measurement to execution: Why population health has reached a structural inflection point

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Executive perspective

Population health has been a strategic priority in healthcare for more than a decade. Organizations have invested heavily in analytics platforms, data aggregation, and quality reporting, expecting that greater visibility would lead to better outcomes. While these efforts have improved measurement, they have not fundamentally changed execution.

As a result, many healthcare organizations have extensive insight into performance but limited ability to act in time to influence outcomes. Population health initiatives remain largely retrospective, labor-intensive, and disconnected from day-to-day operational decision-making.

This gap between visibility and action has become untenable as value-based care expands. Under risk-based reimbursement models, measurement alone does not improve outcomes, reduce costs, or mitigate financial exposure—execution does.

This paper makes the case that population health has reached a structural inflection point. The historical model—measurement-first, execution-later—is no longer sustainable. It examines why this shift is occurring now and how Infor™ Population Health Analytics (IPHA) was designed in response to it, allowing population health to function as a core operating capability rather than a retrospective reporting function.

The measurement trap in population health

Historically, population health initiatives have centered on answering a single question: How are we performing? Dashboards, scorecards, and registries were built to track quality measures, utilization trends, and risk stratification across defined populations.

While these tools increased transparency, they also reinforced a fundamentally reactive operating model:

- **Performance gaps are identified after measurement periods close**
- **Quality teams rely on manual chart review to validate results**
- **Care teams receive insight too late to intervene meaningfully**
- **Leadership reviews outcomes rather than steering execution**

In this model, population health becomes an exercise in explanation rather than prevention. Organizations can describe what happened, but they struggle to change what happens next.

This approach persisted because it was sufficient in a fee-for-service environment and tolerable in early value-based experiments. It is no longer sufficient today.

Why value-based care changes everything

Value-based care fundamentally reshapes the role population health plays. As organizations assume greater accountability for outcomes, cost, equity, and utilization, population health can no longer function as a reporting layer alone.

Under risk-based models supported by the Centers for Medicare & Medicaid Services and commercial payers, organizations must continuously understand:

Which patients and populations are at risk

Which interventions will have the most meaningful impact

Where limited clinical and care management resources should be deployed

Quality frameworks governed by organizations such as the National Committee for Quality Assurance, including the Healthcare Effectiveness Data and Information Set (HEDIS), increasingly emphasize longitudinal outcomes and equity rather than point-in-time compliance.

In this environment, population health insights that arrive too late or require manual remediation for validation create risk rather than value.

The structural inflection point

Population health has reached a structural inflection point. The traditional, measurement-first operating model simply cannot support the level of execution that value-based care now requires. Three structural constraints explain why:

Scale and complexity
Organizations now manage multiple value-based programs simultaneously, each with distinct measures, attribution models, and reporting requirements. Manual, measure-by-measure execution does not scale.

Workforce constraints
Persistent shortages across clinical, quality, and care management roles make labor-intensive models economically unsustainable. Chart chasing is not a workaround; it is a bottleneck.

Accountability without control
Leadership is increasingly accountable for outcomes yet lacks an operating model that enables timely intervention. Visibility without control is not leadership; it is exposure. These forces expose a core truth: Population health cannot succeed as an analytics-only discipline. It must operate as an execution capability.

Population health is entering a new phase. Success will no longer be defined by how comprehensively organizations can measure performance, but by how reliably they can act on insight under real-world constraints.

As value-based care expands, population health maturity will be judged by execution capability, specifically the ability to identify risk early, prioritize intervention effectively, and operationalize action across clinical and organizational boundaries. Platforms that support execution, rather than retrospective reporting alone, will increasingly define the standard for population health performance.

Rethinking population health as an operating capability

To move beyond the measurement trap, population health must be reframed. The question is no longer **"What do we know?"** but **"What can we do now?"**

This shift requires three foundational capabilities:

Trusted data

Execution depends on confidence. If data must be manually validated before action can occur, intervention will always lag. Population health platforms must be designed to normalize, validate, and contextualize real-world healthcare data so teams can act without rechecking every signal.

Meaningful prioritization

Insight without prioritization overwhelms limited resources. Population health must help organizations focus their efforts where interventions will have the greatest impact, rather than addressing every possible gap equally.

Timely intervention

Outcomes change only when action occurs early enough to matter. Population health systems must support in-cycle intervention, not end-of-period explanation. Together, these capabilities transform population health from a reporting function into an operating capability.

How Infor Population Health Analytics was designed in response

Infor Population Health Analytics (IPHA) was designed explicitly around this reframing.

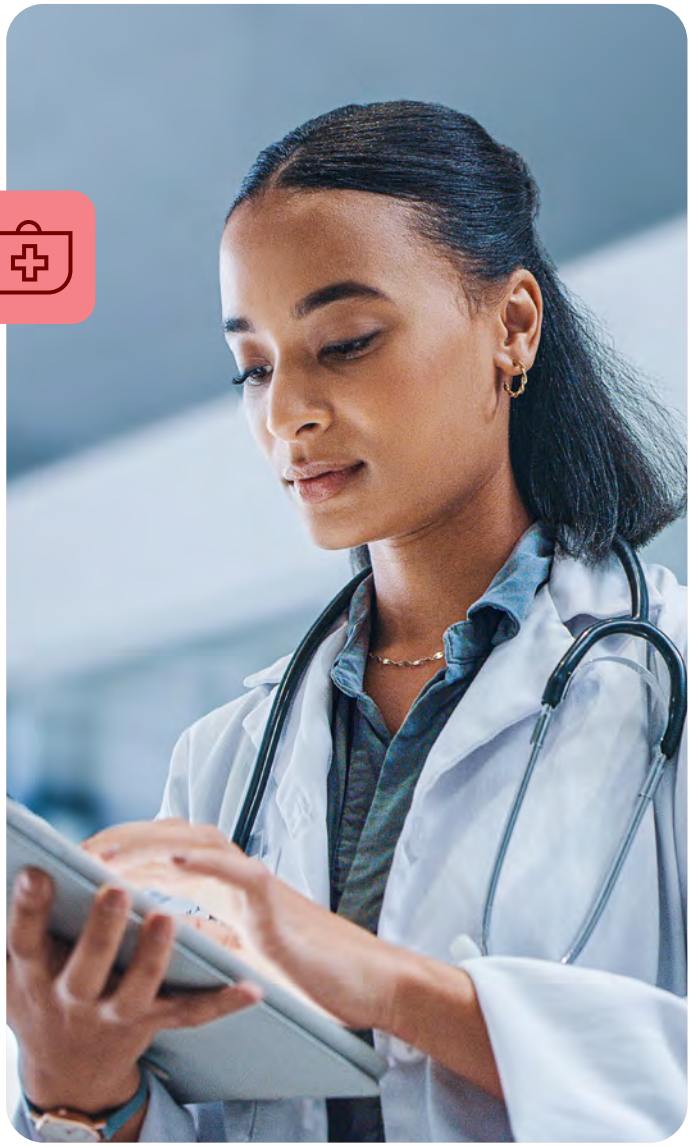
IPHA is not intended to be another analytics dashboard or quality reporting tool. It was built to address the structural limitations of traditional population health models by enabling large-scale execution.

At a high level, IPHA functions as an execution layer between fragmented healthcare data and operational action. It assumes real-world conditions—delayed claims, incomplete feeds, and inconsistent mappings—and focuses on creating sufficient trust and context to support timely decision-making.

By emphasizing trusted data, meaningful prioritization, and timely intervention, IPHA enables population health to operate as infrastructure rather than an after-the-fact reporting process.

Importantly, IPHA does not eliminate complexity, rather, it makes complexity manageable. This approach does not suggest that measurement, analytics, or reporting are no longer necessary. These capabilities remain foundational to population health.

However, insight without execution does not improve outcomes. Without infrastructure designed to support trusted data, meaningful prioritization, and timely intervention, population health efforts remain retrospective and labor-intensive. IPHA was designed to complement measurement by enabling execution, allowing organizations to act on insight early enough to influence outcomes.



Real-world evidence: Population health execution in practice

Evidence 1: Operationalizing eCQM submission at scale

(Large, multi-state integrated delivery network)

A large, multi-state integrated delivery network operating across multiple hospitals and ambulatory sites faced increasing pressure to improve electronic clinical quality measure (eCQM) performance while reducing the manual burden associated with measure validation and submission.

Historically, the organization relied on a retrospective quality reporting model. Gaps were identified late in the performance cycle, manual chart reviews were required to validate results, and submission timelines were compressed into high-effort reporting periods. While performance visibility existed, opportunities to intervene during the measurement period were limited.

By adopting an execution-oriented population health approach supported by IPHA, the organization shifted from retrospective reporting to in-cycle performance management.

Measured outcomes included:

- Earlier identification of eCQM gaps by approximately 4–8 weeks, enabling remediation during the measurement period rather than after close
- 30–45% reduction in manual chart review effort required for eCQM validation, driven by improved data normalization and trust
- Improved first-pass eCQM submission success, reducing resubmission cycles and rework

As a result, quality teams redirected effort from post hoc validation toward proactive performance management. Population health evolved from a reporting obligation into an operational capability that supported timely action and repeatable execution at scale.

Evidence 2:
Daily gaps-in-care execution across a payer-provider ecosystem

(Academic health system and regional health plan collaboration)

An academic health system serving a diverse patient population partnered with a regional health plan to address persistent gaps in care across preventive and chronic condition measures. Prior to this initiative, gaps were identified through retrospective, batch-oriented reports, often weeks after patient encounters had already occurred.

Using IPHA as an execution layer, the organizations shifted to a daily population health operating model, aligning clinical and claims data into a shared, trusted view that refreshes continuously.

Measured outcomes included:

- Reduction in gap-in-care identification latency from multiple weeks to less than 24 hours, enabling same-day or next-day intervention
- 15–25% improvement in gap closure rates for targeted preventive and chronic condition measures within the first performance cycle
- Increased proportion of gaps addressed at the point of care, reducing reliance on downstream outreach and manual follow-up

By operationalizing gaps in care regularly, the collaboration moved population health from retrospective reporting to continuous execution embedded in day-to-day clinical workflows.

Leadership implications

This shift has implications far beyond technology.

Treating population health as a core operating capability requires leaders to rethink ownership, accountability, and governance. Execution cannot remain confined to analytics teams, quality departments, or services organizations. It must be elevated to an executive-owned, cross-functional responsibility with clear accountability for outcomes.

IPHA enables this shift by making performance risk visible early, tradeoffs explicit, and timely intervention possible. IPHA strengthens leadership judgment by providing trusted data, meaningful prioritization, and in-cycle insight, allowing leaders to steer performance proactively rather than explain results after the fact.

Population health has reached a structural inflection point. Organizations that continue to treat it as a retrospective reporting function will experience escalating costs, increased volatility, and diminishing returns on analytics investment. Organizations that adopt IPHA as execution infrastructure position population health as an operating capability that can scale under risk, workforce constraints, and regulatory pressure.

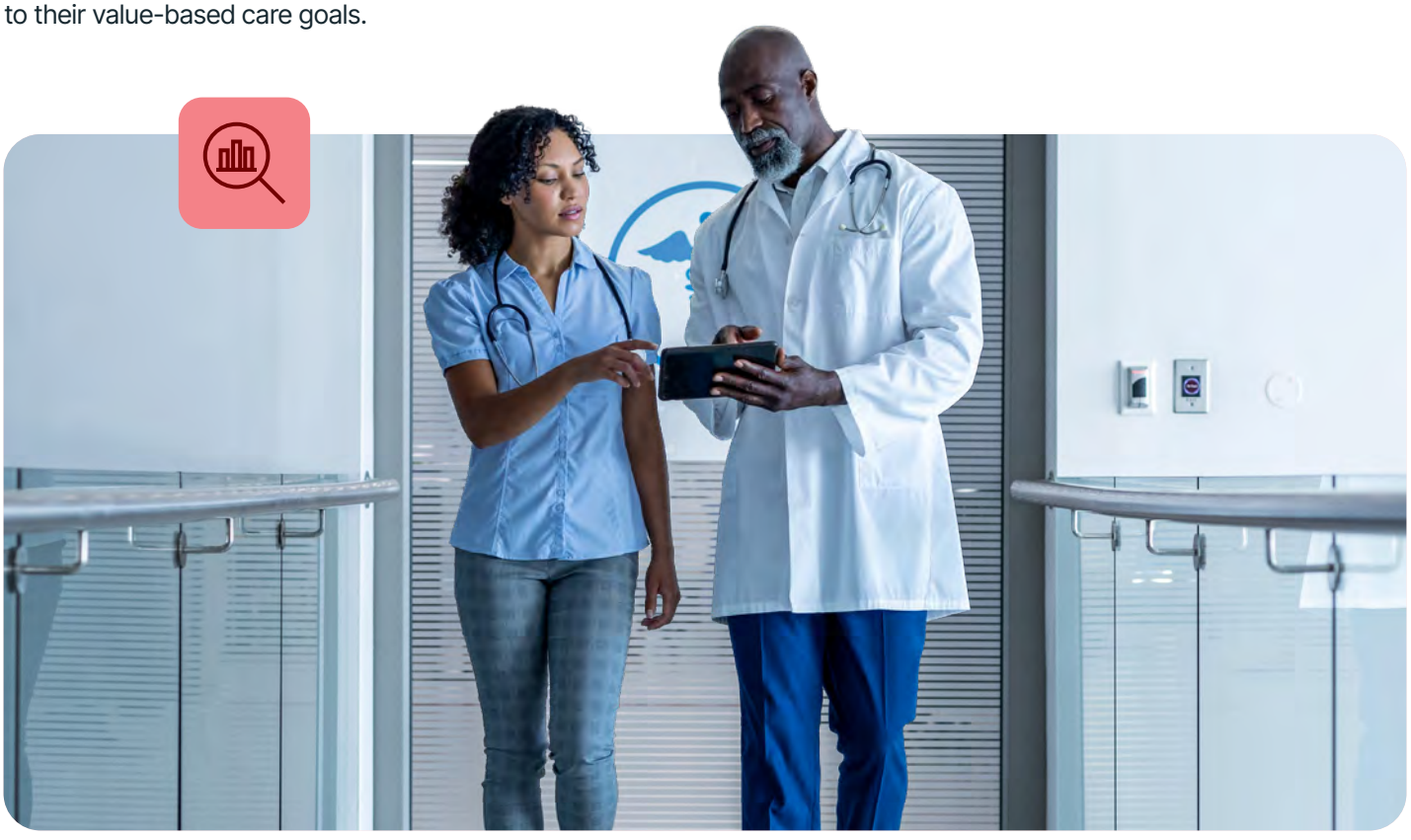
The future of population health will not be defined by who measures the most. It will be defined by who can execute consistently, reliably, and at scale.

Advancing population health execution

Incremental improvements to reporting and analytics are no longer sufficient. Organizations operating under value-based care must now assess whether their population health approach enables timely action, clear prioritization, and execution at scale.

Healthcare leaders and partners are encouraged to evaluate their population health operating model and identify where execution breaks down, whether due to data trust issues, manual intervention, or delayed insight. The most productive next step is a focused discussion on how to operationalize population health as a core capability within existing clinical and operational environments.

Infor Population Health Analytics was designed specifically to meet this need. Organizations interested in exploring how IPHA supports trusted data, meaningful prioritization, and timely intervention are encouraged to engage their Infor Customer Success Executive or Account Executive to schedule a follow-up discussion and demonstration tailored to their value-based care goals.



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