

Your Wish List for MACRA Performance Improvement Technology

written by Theresa Hush | October 26, 2016



Even as CMS has eased the transition to MACRA with the [Final Rule](#) published on October 14, managing under Risk remains a core goal. The best way to prepare your organization? Develop MACRA Improvement Activities (formerly CPIAs), the training ground for managing under Risk. The MACRA Improvement Activities cover all of the processes and root causes of health care cost increases, and Medicare wants you to address them. Hint: they're scoring your work.

While the MACRA requirements are now superficially easy to meet—attest to at least one Performance Improvement Activity—the reality will be very different if you are really [preparing for Risk](#): initiatives across multiple provider subgroups, many patient populations and different goals. Engineering will be essential.

With that in mind, it's time for a reality check on what's really required to make MACRA

Improvement Activities in large multi-specialty groups and health systems fulfill their intent. And now is the best time to assess what you'll need, since the clock will run faster in the future.

Make a List, Check it Twice

First, let's focus on the [technology you'll need to improve performance](#). Many organizations, having invested heavily in their EMR systems, want to get the most out of those systems. That's understandable. Here's the essential question: Can Improvement Activities be performed through EMRs?

As a general rule, EMRs may be very helpful in many aspects of performance improvement. This includes:

- Identifying and reaching out to patients who have gaps in care;
- Following up with patients who have labs or tests with poor intermediate outcomes (requires EMRs that can sort and track outcomes, not only services);
- Reaching out to patients with educational needs (requires EMR population health modules);
- Organizing patients into high risk registries for use in tracking results (requires EMRs with customizable registry capability and/or population health);
- Setting up coordination of care or referrals for patients who were admitted or visited the emergency room (requires EMRs with required customized template for coordination, plus integration between hospital and physician EMRs, preferably linked to physician or referral scheduling).

There may certainly be other functionalities and innovations at point-in-care services to patients that will improve performance.

But the missing ingredient in this array of possibilities is [project management](#), as well as a strategic and operations center for Improvement Activities that both guides the development of Improvement Activities but performs these functions:

- Embeds the priorities for Performance Improvement through an organizational inventory and classification of Improvement Activities that are being pursued;
- Evaluates the progress of all Improvement Activities and each Improvement Activity individually;
- Compares results across several Improvement Activities;
- Keeps historical detail of all Improvement Activities with populations, provider participation, interventions and goals;

Links Improvement Activities with current MACRA requirements as they evolve, much like quality measures;

Directs implementation for Improvement Activities centrally, permitting multiple roles (both practice and organization) to contribute to Improvement Activity development;

Includes functionalities for managing innovative projects, data sharing and social exchanges among providers in Improvement Activities, to engage providers in Performance Improvement.

Improvement Activities will constantly evolve in a dynamic Performance Improvement process, and these strategic, evaluative and execution functions will be essential to driving organizational change.

Real Change Requires Leadership AND Physicians

MACRA Improvement Activities will be one of two things to health care systems and organizations: simple activities designed to meet the basic MACRA requirements and “check the box” for attestation, or substantive plans to engineer changes in both clinical and cost performance. The latter will prepare providers for taking on Risk, and is the focus of this discussion.

Change takes people. If the organization pursues Improvement Activities in the traditional Quality Assurance way—setting up a department whose job is to implement Improvement Activities—even the very best staff will not have the ability to get enough results to move the organization to Risk.

Real change will require the leadership to facilitate change, plus collaborators to spread it throughout the large organization. Dedicated staff will be necessary for inventing, executing and evaluating Improvement Activities. But a kingpin (or more) in organizational leadership with the authority and vision to make it a go is essential, and the organization must be developed from the top down to reflect the priority on Performance Improvement. Provider involvement is essential; they must participate and collaborate on the design and implementation of Improvement Activities.

What tools do leaders, collaborators and providers need to make real change?

Analytics that view not just performance metrics, but the Improvement Activities and the changes in performance over time;

Mechanisms to communicate and share results of Improvement Activities;

Centralized as well as distributed improvement Activity project development, including defining populations and interventions, validating patients and adding data;

Feedback capabilities, to contribute observations and recommendations.

Without functionalities to view data and run discrete projects (even experiments) to improve performance, Improvement Activities will be even more cumbersome and difficult to undertake. The organization can easily sink under the weight of multiple complex Improvement Activities, or default to minimizing the Performance Improvement activity to make it manageable with less functionality and fewer resources.

The Wish List for Performance Improvement

Performance Improvement activities that are significant enough in scope to change costs and outcomes will demand specialized technology and other resources. You won't find these capabilities in EMRs or most current Registries, but you are likely to see them being developed in [Qualified Clinical Data Registries \(QCDRs\)](#), which are favored by MACRA:

1. Project Management Functionalities

- Define and organize Performance Improvement projects by population criteria, participation of providers, data and interventions;
- Set project schedules, deadlines and measurement points;
- Validate patients for inclusion or exclusion, with reasons (with distributed functions to clinicians and/or practices);
- Add patients into the project as defined;
- Measure results of interventions;
- Compare Improvement Activity progress and implementation criteria;
- Renew or tailor projects.

2. Broad Performance Improvement Capabilities

- Go beyond traditional population health and patient outreach or process measurement to enable deeper Performance Improvement projects focusing on clinical outcomes and cost, not just processes;
- Allow for experimentation and evaluation of interventions used for Performance Improvement;
- Have flexibility for innovative project design, such as creation of small pre-populated registries for physician collaboration and feedback;
- Enable both centralized and physician-led projects to improve results, especially clinical.

3. Communication and Data Sharing Options

- Allow project communication among clinicians, with secure social network communications and measurement of engagement;

Foster project manager communiqués;
Comparative analytics for patient outcomes and costs.

4. Wide Range of Non-traditional Data Sources

Database built with demographic, claims and clinical data, but only as a starting point for performance measurement;
Use of patient-reported outcomes, clinician input and feedback to explain root causes of events or outcomes, and external data sources;
Extensive use of data, such as CMS claims and practice QRURs, to establish baseline measurements for cost and quality, and beginning points for Improvement Activities;
Data prowess, reflected by patient-centric system that allows for better monitoring of per patient risks, costs and outcomes over time.

For provider organizations or health care technology firms that are buried in work just to manage the basics, some of these capabilities are too new to envision. But in order to really [make substantial gains](#) in health care Performance Improvement, everyone will need to incorporate fresh thinking on change management and be open to innovation. In the current environment, incremental gains are not only unsuccessful; they are destructive to long term tactics. It's time to generate excitement over Performance Improvement throughout the organization and have the tools to support smaller, innovative projects that will bring clinicians on board.

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