Improve Your Risk Readiness With Physician-Driven MACRA CPIA Innovation

written by Theresa Hush | October 5, 2016

CMS is pushing providers to accept Risk under Alternative Payment Models (APMs), and they're sweetening the pot with incentives. But for the vast number of providers who will participate in MIPS because they *don't* participate in risk-based APMs, the path to reward is murky. That's because many Health Systems have a hard time visualizing how Performance Improvement with CPIAs can create savings under ACOs, the biggest APM model. Here's the key: innovation that engages physicians.

Historical Performance Improvement Often Leaves Out Physicians

For most Health Systems, it's rare for physicians to actively participate in Performance Improvement initiatives. There are two common categories of this approach to Performance Improvement: first, those that target physicians but expect passive improvement. This includes many initiatives in which physicians receive scores or data that direct them to fix performance (without clarifying *how* to fix it):

Admission and Readmissions reports;
Comparative metrics on various internal or external performance targets, or measures;
Core Measure reports;
Cost breakdowns and targets provided by commercial health plans or Medicare /Medicaid.

Each of these initiatives shines a negative light on performance. The message to the physician: "It's your problem. Do better."

A second category of common Performance Improvement initiatives includes those intended to work *around physicians, not with them,* to fix the problem. In hospital-based systems, this can include care redesign or better coordination between service units. These are logical strategies, but the fact is that physicians are usually more than peripherally involved and can't be skirted.

More problematic are activities that are intended to support practices, but are perceived by physicians as hostile. This can include intensive case management of chronically ill or high-risk patients, using a centralized panel of nurses who have no direct reporting to the practice. The physician may not have a choice about which patients fall into the case management program, and may in fact disagree with the entire effort or feel defensive about its encroachment into patient communications. Sometimes the patient communication also occurs without closing the communication loop with the practice through reporting, feedback or discussion.

Pre-MACRA Quality Reporting Off-loaded as Administrative

Under pre-MACRA programs—PQRS Reporting, Meaningful Use, and Value Modifier—most Health Systems undertook these efforts as compliance activities, at best using the data for passive Performance Improvement communication with physicians. Physicians themselves, even in small practices, tended to view these as administrative and not clinical efforts. They were uninspired by the process measures and did not see them as pertinent to their clinical work.

The bottom line is that Performance Improvement activities—designed and implemented without the physician's involvement—cannot produce results under MACRA and *will not lead to the successful undertaking of Risk*. Physicians' active engagement will be critical to improvement of outcomes.

Changing Focus through CPIAs Essential for Risk Preparation

If MIPS is the segue to APMs, as proclaimed by CMS, the CPIAs are where all the action takes place. Because MIPS has a scoring focus, Health Systems will be tempted to choose convenience and ease when creating the activities and attesting to them. But that is a poor choice. Before Risk is a mandated reality for Health Systems and their providers, using MIPS

CPIAs is the best venue for testing and implementing substantive Performance Improvement.

Here's the real issue: It does no good to lament the lack of provider engagement while taking baby steps in Performance Improvement. Clinical Outcomes and Cost Efficiency cannot reach your targets without your clinicians. They are the game changers, along with patients.

Empowering your physicians, however, will require a different structure to your Performance Improvement activities. It will mean that you give them the freedom to explore, make decisions and interact with other clinicians in a process that is designed as an inquiry, rather than a formulaic response to Performance Improvement.

This doesn't mean that Health Systems should abandon efforts to better coordinate care, or redesign care paths, or to evaluate the numbers. But it does mean that none of those initiatives will matter enough without also engaging providers in an active discovery of improving outcomes and efficiency.

Ten Principles for Innovation in Clinicians' Performance Improvement

As any physician will tell you, the overwhelming reason why traditional Performance Improvement feels like the enemy is that it involves more work, and much of it is not smart work. So the cardinal principle of innovative Performance Improvement activities is to embrace the idea of small populations and testing. This serves as a platform for a model to engage physicians:

> Use small populations to lay the groundwork in CPIAs initially, building the initiatives after testing results. For example, let's say your target is to improve the outcomes and costs associated with patients having Congestive Heart Failure (CHF). The results may include admissions and readmissions, along with clinical outcomes, perhaps some patient-reported outcomes. By pre-populating a limited Registry of patients meeting certain criteria, you can allow physicians to experiment with interventions and trade information about what is working. A larger group of patients would make this impossible and work-heavy— and the work would be assigned to a nurse.
> Focus on the positive, not just negative. Using the CHF example, you could ask physicians to differentiate interventions or reasons for why patients in their small populations did well, rather than focus on the patients who did not.
> Provide freedom of choice. One of the problems with many Performance Improvement programs is that they are top-down. If you structure a program with multiple CPIA clinical categories or initiatives, you can set up a rotation where physicians can focus on certain outcomes, or certain areas of Performance Improvement. This gives a greater sense of control over the starting point and lessens the barrier to physician involvement.

Help physicians contribute through sharing information and stories. Physicians need to tell their stories and share them with others in order to promote group change. A Registry of shared, de-identified patients with physicians outlining their interventions and results will incorporate two important elements into the program: Competition and Shared Enthusiasm. You can induce competition by simple metrics for shared views, postings of information and so on. No one wants to be in a lower tier! And you can structure the Registry forums in a way that is more typical of online courses and social media than health technology, making it interesting for physicians to view others' contributions and collaborate.

Let physicians determine the interventions to test. The actual solutions to problems should come out of sharing and collaboration. After all, we don't always know what will work to improve performance—that's why it's a test!

Add data as the CPIA progresses. It's a fact that we do not often know the reasons for stalled progress on outcomes, or poor outcomes, or high costs. Let physicians identify and request data needed to add to the picture.

Find a way to reward innovation and participation. Moving outcomes and costs, even in a small group, should get a reward. Let the clinicians help define what that is, because only they can determine what is motivating.

Figure out how to get patients energized, too. Obviously patients are a huge part of the Performance Improvement process. Ask physicians to determine how to best incorporate patient feedback—and trial different methods of seeing what will work to engage patients in their results. However, get agreement for unfiltered patient feedback as well as that coming through physicians, since patients are not always willing to share with their physicians.

Test, retest, rotate, evolve. If you rotate your CPIAs among clinicians across time, each physician will be able to have experience with more than one type during the year. You can help them change assumptions and change the model to build from what is working. Performance Improvement is not a single solution. It is evolutionary. We don't know what will work until it goes through the process.

Use technology that is targeted to Performance Improvement of patient outcomes and costs. A Qualified Clinical Data Registry (QCDR) is designed to improve performance. To be innovative, the QCDR should support project management, multiple customized initiatives, data-sharing and posting, in addition to tracking outcomes and risk over time.

Performance Improvement under MACRA will be a totally new process, if it is to succeed in helping provider organizations transform themselves to Risk-bearing systems. We haven't seen this kind of innovation typically happen in health care before, but we have seen it in Tech and other industries. Innovation is a product of excitement and energy, and to unleash it means giving people freedom to invent. What better way than to engage the stakeholders of our Health Systems, the physicians?

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