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Part III Four categories defined by MIPS Correlate with Four Strategies SETMA Defined in 2000-2005
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Additionally, the MIPS artificial assumption that performance on nine, or six, or any number of isolated, unconnected, arbitrarily metrics chosen by a practice, often on the basis of how easy it is to perform the requirements of the metric, is not going to change the quality element of practice. This was always the flaw of PQRI in 2006 and subsequently PQRS in 2011, although "comprehensive metric sets" for a particular condition were an option in both programs. The design flaw was that the comprehensive metric sets were not required. Now the same mistake is being made in MIPS.

An alternative is that just as National Committee Quality Assurance (NCQA0 recognition as a Level 2 Patient-Centered Medical Home meets the MIPS' Clinical Practice Improvement Activities, so a practice or provider meeting NCQA standards for Diabetes Recognition and for Heart/Stroke Recognition could be given credit for the metric side of the Quality Category of the MIPS Scoring System.

In addition to an recognized and established standard which represents excellence in complex, chronic care settings, the data base generated by this change to MIPS would allow for statistical analysis of the kinds of practices which are meeting standards of excellence which would allow for further public policy observations about how to improved population health. Other accreditation agencies for quality healthcare performance can also be included in this option, such as the Accreditation Association for Ambulatory Healthcare, URAC and the Joint Commission.

Ultimately, the real flaw of MACRA and MIPS is that like any legislated standard it was created to be measurable when what it needs to be is scalable and elastic to support healthcare delivery transformation rather than at best having a system which promotes compliance without necessarily improving care quality. This is the very nature of reform.

The Ultimate Hope of the Future of Healthcare is Transformation

To be successful, the implementation of new polices and initiatives witch will produce the future we imagine, must be transformative which comes from within. Transformation results in change which is not simply reflected in shape, structure, dimension or appearance, but transformation results in change which is part of the nature of the organization being transformed. The process itself creates a dynamic which is generative, i.e., it not only changes that which is being transformed but it creates within the object of transformation the energy, the will and the necessity to sustain and expand that change and improvement. Transformation is not dependent upon external pressure (rules, regulations, requirements) but is sustained by an internal drive which is energized by the evolving nature of the organization.

While this may initially appear to be excessively abstract, it really begins to address the methods or tools needed for reformation, or for transformation. They are significantly different. The tools of reformation, particularly in healthcare administration are rules, regulations, and restrictions. Reformation is focused upon establishing limits and boundaries rather than realizing possibilities. There is nothing generative - creative - about reformation. In fact, reformation has a "lethal gene" within its structure. That gene is the natural order of an organization, industry or system's ability and will to resist, circumvent and overcome the tools of reformation, requiring new tools, new rules, new regulations and new restrictions. This becomes a vicious cycle. While the nature of the system actually does change, where the goal was reformation, it is most often a dysfunctional change which does not produce the desired results and often makes things worse.

The tools of transformation may actually begin with the same ideals and goals as reformation, but now, rather than attempting to impose the changes necessary to achieve those ideals and goals, a transformative process initiates behavioral changes which become self-sustaining, not because of rules, regulations and restrictions but because the images of the desired changes are internalized by the organization which then finds creative and novel ways of achieving those changes.

It is possible for an organization to meet rules, regulations and restrictions perfunctorily without ever experiencing the transformative power which was hoped for by those who fashioned the external pressure for change. In terms of healthcare administration, policy makers can begin reforms by restricting reimbursement for units of work, i.e., they can pay less for office visits or for procedures. While this would hopefully decrease the total cost of care, it would only do so per unit. As more people are added to the public guaranteed healthcare system, the increase in units of care will quickly outstrip any savings from the reduction of the cost of each unit.

Transformation of healthcare would result in a radical change in relationship between patient and provider. The patient would no longer be a passive recipient of care given by the healthcare system. The patient and provider would become an active team where the provider would cease to be a constable attempting to impose health upon an unwilling or unwitting patient. The collaboration between the patient and the provider would be based on the rational accessing of care. There would no longer be a CAT scan done every time the patient has a headache. There would be a history and physical examination and an appropriate accessing of imaging studies based on need and not desire.

This transformation will require a great deal more communication between patient and provider which would not only take place face-to-face, but by electronic or written means. There was a time when healthcare providers looked askance at patients who wrote down their symptoms. The medical literature called this la maladie du petit papier or "the malady of the small piece of paper." Patients who came to the office with their symptoms written on a small piece of paper where thought to be neurotic.

No longer is that the case. Providers can read faster than a patient can talk and a well thought out description of symptoms and history is an extremely valuable starting point for accurately

recording a patient's history. Many practices with electronic patient records are making it possible for a patient to record their chief complaint, history of present illness and review of systems, before they arrive for an office visit. This increases both the efficiency and the excellence of the medical record and it part of a transformation process in healthcare delivery.

This transformation will require patients becoming much more knowledgeable about their condition than ever before. It will be the fulfillment of Dr. Elliot Joslin's (The founder of the Diabetes Center of Excellence in Bosom, which is affiliated with Harvard Medical College) dictum, "The person with diabetes who knows the most will live the longest."

It will require educational tools being made available to the patient in order for patients to do self-study. Patients are already undertaking this responsibility as the most common use of the internet is the looking up of health information. It will require a transformative change by providers who will welcome input by the patient to their care rather seeing such input as obstructive.

This transformation will require the patient and the provider to rethink their common prejudice that technology - tests, procedures, and studies - are superior methods of maintaining health and avoiding illness than self discipline, communication, vigilance and "watchful waiting." In this setting, both provider and patient must be committed to evidence-based medicine which has a proven scientific basis for medical-decision making. This transformation will require a community of patients and providers who are committed to science. This will eliminate "provider shopping" by patients who did not get what they want from one provider so they go to another.

This transformation will require the reestablishment of the trust which once existed between provider and patient to be regained. The restoration of trust between the provider and patient cannot be created by fiat. It can only be done by the transformation of healthcare in to system which we had fifty to seventy-five years ago. With that trust relationship coupled with modern science, healthcare can produce a new dynamic which we call patient-centered medical home. In this setting the patient must be absolutely confident that they are the center of care but also they must know that they are principally responsible for their own health. The provider must be an extension of the family. This is the ultimate genius behind the concept of Medical Home and it cannot be achieved by regulations, restrictions and rules.

The transformation will require patient and provider losing their fear of death and surrendering their unspoken idea that death is the ultimate failure of healthcare. Death is a part of life and, in that, it cannot forever be postponed, it must not be seen as the ultimate negative outcome of healthcare delivery. While the foundation of healthcare is that we will do no harm, recognizing the limitations of our abilities and the inevitability of death can lead us to more rational end-of- life healthcare choices.

Conclusion

MIPS is a good thing; it could be better and the ideas contained in this series would help make it better.