Blue Cross Blue Shield Michigan’s Hospital Collaborative Quality Initiatives:
Achieving Transformative Performance and Improved Relations through Collaboration

Presentation to:
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Tom Leyden, MBA
Director II, Value Partnerships
Blue Cross Blue Shield Michigan
Our Goal: Improve Care for Members and Increase Value for our Customers

Value = Patient Experience + Quality Cost
Premise: Uncomplicated Surgical Procedures are More Profitable to Hospitals and Less Costly to Payers than those with Complications

- For example, the Michigan Surgical Quality Collaborative saw an absolute 2.5% drop in surgical morbidity rates across 33 hospitals, equating to 2,500 fewer patients with surgical complications annually. Payments associated with these cases were reduced by more than $49M from 2009-2010.

Reimbursement for patients without complications ($14,266) exceeded hospital costs ($10,978), generating an average hospital profit of $3,288 and a profit margin of 23%. When complications occurred, hospitals still received reimbursement in excess of their costs, but the profit margin declined: reimbursement ($21,911) exceeded hospital costs ($21,156), yielding an average profit of $755 and a profit margin of 3.4%. Complications were always associated with an increase in costs to health-care payers: Complications were associated with an average increase in reimbursement of $7,645 (54%) per patient.
Value Partnerships Program Overview

- Partnerships with physicians/surgeons, physician groups and hospitals to create strong collaboration and reward systems for the transformation of health care
- Encompasses 50+ statewide clinical improvement initiatives
- Impacts the lives of nearly two million Blues members
- Works collaboratively with the majority of the acute-care hospitals in the state and with over 18,500 primary care physicians and specialists
- Value Partnerships initiatives are enhancing clinical quality, decreasing complications, managing costs, eliminating errors and improving health outcomes, through collaboration and data sharing
Value Partnerships – From 30,000 Feet

Value Partnerships programs (e.g. CQIs) incentivize providers to alter the delivery of care by encouraging responsible and proactive physician/surgeon behavior, ultimately driving better health outcomes and financial impact.

BCBSM provides the financing, tools and support…

so physicians can engage in transformative initiatives…

that change the way healthcare is delivered…

and drive meaningful impacts for you and your members.

Efficient Utilization of Resources

Improved Quality of Care (i.e. reduced mortality, morbidity)

Enhanced Member Experience
BCBSM View of the Health Plan Role

- Convene and catalyze; not engineer and control
- Assemble competitive hospitals/physicians and offer neutral ground for collaboration
- Provide resources to reward infrastructure development and process transformation – often includes provision of financial support for data gathering to participants
- Share data at facility, physician organization (PO), physician practice and physician level
- Reward quality and cost results (improvement and optimal performance) at the population level
- Leave management of individual patient care to providers
- A heavy hand prompts the provider community to do the least necessary. Empowerment encourages the provider community to do the most possible
Collaborative Quality Initiatives (CQI)

- CQIs are **statewide quality improvement initiatives**, developed and administered by Michigan physicians and hospital partners, with funding and support from BCBSM and our HMO subsidiary, Blue Care Network.

- In most cases, a CQI project relies on a comprehensive **clinical registry** which includes patient risk factors, processes of care and outcomes of care. The registry is usually focused on a complex area of practice.

- Goal of CQIs is to empower providers to **self-assess** and optimize their care by identifying **best practices** and to disseminate information about them.

- This leads to **improved quality** and **lower costs** for selected, high cost, high frequency, and highly complex procedures.
CQIs: Underlying Assumptions

Cross-group/institution collaboration yields more than competition on quality:
- Improvement catalyzed by sharing best practices
- More can be learned from variation in care processes and outcomes across groups
- Allows more robust analyses of link between processes and outcomes of care than can be achieved by examining one group

Valid, evidence-based, nationally accepted performance measures cover a narrow slice of health care generally, and hospital care in particular

Simple performance measures don’t address areas of care which are highly technical, rapidly-evolving and associated with scientific uncertainty

These areas best addressed through collaborative, inter-institutional, clinical data registries, with coordinated QI programs
Overall Goals of the CQI Program

- Examine the link between care processes and outcomes in complex, highly technical areas of care to continually generate new knowledge contributing to understanding of which care processes lead to optimal outcomes
- Measure the quality of care within and across systems of care
- Create a feedback loop to participating institutions to facilitate continuous quality improvement at their own facility
- Identify “clinical champions” at each participating hospital
- Implement fast-track quality improvement initiatives targeted at specific, high-leverage procedures
- Continue to demonstrate to consumers and purchasers of care that CQIs positively impact systems of care and help optimize the quality and outcomes of care
BCBSM Hospital CQI Program Framework

- Contribute to All-Payer registry
- Share and learn best practices
- Implement Quality Improvement opportunities

- Offer neutral ground for collaboration
- Program funding and incentive payment design
- Clinical and administrative support to Coord Ctrs

- Clinical Leadership – develop and executes the QI agenda
- Explore links between process and outcomes
- Analytic and QI support

Participating Hospitals

Coordinating Centers

BCBSM

Consortium

Data collection

Data Analysis

Continuous Quality Improvement

Develop Best Practices

Data Reporting

CQI
CQIs as Key Component of Value Partnerships

Physicians

Physician Group Incentive Program
PGIP includes 27 initiatives aimed at improving quality, utilization and costs. Initiatives include following Professional CQIs:
- **Condition-Focused**
  Oncology practice/treatment
  Urology
- **Clinical Process-Focused**
  Lean transformation
  Transitions of care

Hospital CQIs Addressing:
- Angioplasty
- Anticoagulation services
- Bariatric surgery
- Breast cancer
- Cardiac surgery
- General surgery
- Radiation oncology
- Surgery related processes
- Total knee and hip replacement
- Trauma
- Vascular interventions
- VTE prevention
- Hospital efficiency (new in 2013)
- Spine surgery (new in 2013)

Hospitals

Hospital P4P Incentive Program
P4P program consists of
- Quality Measures
  - CQIs
  - Quality Indicators
- Efficiency Measures
  - Cost-per-Case

BCBSA Best of Blue & BlueWorks Awards
- 2006 – PGIP and CQI program
- 2011 – MSQC, MBSC and MOQC (also received BlueWorks Awards for MSQC and MBSC)
- 2012 – Fee for Value and BMC2-PCI
Other Awards and Recognition
- 2008 - NBCH eValue8 Health Plan Innovation Award
- 2011 - Michigan Cancer Consortium Spirit of Collaboration Award
# Current Hospital CQIs

<table>
<thead>
<tr>
<th>CQI Name</th>
<th>Inception Date</th>
<th>Cases in Registry (since inception):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan Cardiovascular Consortium - Percutaneous Coronary Intervention</td>
<td>July 1997</td>
<td>325,000</td>
</tr>
<tr>
<td>(BMC2 - PCI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michigan Society of Thoracic and Cardiovascular Surgeons (MSTCVS)</td>
<td>Sept 2005</td>
<td>84,000</td>
</tr>
<tr>
<td>Quality Collaborative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michigan Bariatric Surgery Consortium (MBSC)</td>
<td>Oct 2005</td>
<td>41,000</td>
</tr>
<tr>
<td>Michigan Surgical Quality Collaborative (MSQC)</td>
<td>Nov 2005</td>
<td>334,000</td>
</tr>
<tr>
<td>Michigan Breast Oncology Quality Initiative (MiBOQI)</td>
<td>Apr 2006</td>
<td>26,700</td>
</tr>
<tr>
<td>BCBSM Cardiovascular Consortium - Vascular Interventions Collaborative</td>
<td>Oct 2006</td>
<td>30,193</td>
</tr>
<tr>
<td>(BMC2 - VIC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michigan Anticoagulation Quality Improvement Initiative (MAQI2)</td>
<td>Sept 2009</td>
<td>8,000 new patients 207,000 follow up</td>
</tr>
<tr>
<td>Hospital Medicine Safety (HMS) Consortium</td>
<td>Oct 2010</td>
<td>53,000</td>
</tr>
<tr>
<td>Michigan Trauma Quality Improvement Project (MTQIP)</td>
<td>Jan 2011</td>
<td>51,000</td>
</tr>
<tr>
<td>Peri-Operative Outcomes Initiative (POI)</td>
<td>Apr 2010</td>
<td>43,000</td>
</tr>
<tr>
<td>Michigan Radiation Oncology Quality Consortium (MROQC)</td>
<td>Feb 2012</td>
<td>1757</td>
</tr>
<tr>
<td>Michigan Arthroplasty Registry Collaborative for Quality Improvement</td>
<td>Mar 2012</td>
<td>13,901</td>
</tr>
<tr>
<td>(MARCQI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michigan Spine Surgery Improvement Collaborative (MSSIC)</td>
<td>Sept 2013</td>
<td>N/A</td>
</tr>
<tr>
<td>Michigan Value Collaborative (MVC)</td>
<td>Oct 2013</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Hospital CQI Map by County as of April 2013

Single Facility Locations
Multiple Facility Locations
Total Participants 2013
Total Participants 2012
BCBSM/BCN Collaborative Quality Initiative (CQI)

- Angioplasty (BMC2-PCI) 33
- Cardiac CT Angiography (ACIC) 43
- Arthroplasty (MARCOI) 12
- Bariatric Surgery (MBSC) 37
- Breast Oncology (MIBOQI) 25
- Cardiac Surgery (MSTCVS) 33
- General & Vascular Surgery (MSQC) 52
- Anticoagulation Clinics (MAQI2) N/A
- Hospitalist Care (HMG) 36
- Peri-Operative Outcomes (POI) 18
- Radiation Oncology (MROQC) 9
- Trauma (MTQIP) 23
- Vascular Interventions (BMC2-VIC) 42

2013: 134 hospitals and 3 physician locations
2012: 138 hospitals and 5 physician locations
Participating Hospital Perceptions: CQI Participation

Fall 2013 Quarterly Meeting
Overall Average by Question

Value in the Collaborative: 4.60
Participation only with BCBSM Incentive: 4.22
Value in Coordinating Center: 4.53
BCBSM considered a reliable CQI partner: 4.52

Scale is 1-5 (strongly disagree - strongly agree)
Examples of Success: Michigan Bariatric Surgery Collaborative (MBSC)

Year Launched: 2005
Physician Leaders: Nancy Birkmeyer, PhD, John Birkmeyer, MD
Number of Participants:
  40 Michigan hospitals
  77 physicians

Size of Registry:
As of October 2013, over 41,000 cases entered into data registry since inception
CQI Achievements –
1st Example of Improving Quality of Care

**Michigan Bariatric Surgery Collaborative:** From 2007 to 2013, decreased the pre-operative IVC filter placement rate from 7.56% to 0.31%.

- The inferior vena cava (IVC) filter is a device that is inserted into a patient prior to surgery as a means to prevent a blood clot from forming in the lungs. Bariatric patients are at a higher-than-average risk of suffering from these clots; IVC filters are frequently used in patients with high risk of PE. Through analysis of data in the clinical registry, MBSC identified significant variations in IVC filter usage prior to surgery as an effort to prevent a blood clot in the lungs after surgery. It was discovered that IVC filter use was not always preventing blood clots, but at times contributing to increased complications – and even death. These findings were presented at a collaborative wide meeting.
CQI Achievements – 1st Example of Improving Quality of Care

Consider: It typically takes ~ 15 years to fully implement evidence based medicine. MBSC did this in less than 1 years time.
Impact of CQIs on Medical Policy: The Evolution of Sleeve Gastrectomy as a Payable Service

Sleeve gastrectomy is a surgical weight-loss procedure in which the stomach is reduced to about 25% of its original size by surgical removal of a large portion of the stomach along the greater curvature. Although it is now widely acknowledged and accepted as an established procedure, previously, sleeve gastrectomy was indicated as a first stage procedure (the second stage was gastric bypass) for super obese (BMI >50 kg/m²), high-risk patients only.

• Input from MBSC (bariatric surgery CQI) influenced BCBSM’s initial decision to cover sleeve gastrectomy as part of a phased procedure long before it was being recommended for coverage by BCBSA Medical Policy nationally.
  – This procedure yields substantial weight loss with lower complication rates compared to more complex procedures.

• Later, input from MBSC led to BCBSM’s removal of a “phased treatment” approach and consideration of sleeve gastrectomy as an equal option to other established bariatric surgery procedures.

Additionally, MBSC feedback also contributed to BCBSM’s decision to waive the six month non surgical intervention requirement for super obese individuals.
Background
• Efforts to reduce variation in surgical results have focused primarily on improving peri-operative care.
• There is little evidence to support the relationship between technical skill and the variation in outcomes.

Methods
• 20 surgeons submitted a videotape of themselves performing bariatric surgery and were rated for technical skill by at least 10 peer surgeons
• Peer reviewers were unaware of identity of surgeon

Conclusions
• Surgical skill is a strong predictor of clinical outcomes.
• Bottom quartile of surgical skill associated with higher complication rates and higher mortality, longer operations, higher rates of reoperation and readmission.
• Greater skill was associated with fewer postoperative complications and lower rates of reoperation, readmission, and visits to ED.
Examples of Success:  
Michigan Society of Thoracic and Cardiovascular Surgeons Quality Collaborative (MSTCVS)

Year Launched: 2005
Physician Leader: Richard Prager, MD
Number of Participants:
   33 Michigan hospitals
   96 physicians

Size of Registry:
As of October 2013, over 84,000 cases have been entered into MSTCVS registry since program inception
CQI Achievements – 2nd Example of Improving Quality of Care

**Michigan Society of Thoracic and Cardiovascular Surgeons (MSTCVS):** From 2005 to 2012, increased Internal mammary artery (IMA) use from 82.0% to 97.8%.

- Coronary artery bypass grafting (CABG) is a type of surgery that improves blood flow to the heart for those who have severe coronary heart disease.

- Internal mammary artery (IMA) use during coronary artery bypass grafting (CABG) is an important process measure associated with improved outcomes.

- In 2005, variation in IMA use rates was noted. Seven out of thirty-one adult cardiac surgery programs in Michigan had IMA use rates less than 90%.
CQI Achievements –
2nd Example of Improving Quality of Care

Internal Mammary Artery (IMA) use in the low IMA programs significantly increased from 82.0% to 97.8% from 2005-2012. (p < 0.0001)
CQIs: Perspective from a Surgeon Leader

Dr. Richard Prager, Physician
Director
MSTCVS Quality Collaborative

http://www.youtube.com/watch?v=QLo3YVEwZ4Y&feature=youtu.be
Examples of Success: Michigan Surgical Quality Collaborative

Year Launched: 2005
Physician Leader: Darrell “Skip” Campbell Jr., MD

Number of Participants (as of October 2013):
  • 52 Michigan hospitals
  • 52 Clinical Champions (one per hospital)
  • Over 3,000 surgeons /physicians contributing data

Size of Registry:
As of October 2013, Over 334,000 general and vascular surgical cases have been entered into the MSQC registry since inception
CQI Achievements:
An Example of Improving Quality of Care

Colon surgery has a high infection rate; analysis of which antibiotics should be used after surgery.

Surveyed hospital participants and learned over 120 different combinations were being used for the same operation.

MSQC analyzed which worked best, narrowing it down to three that worked superbly well (the rest were not so good).

All of the hospital participants benefited from this information, and learned about it simply by attending the quarterly meeting.

View the video: Improving Surgical Care in Michigan through MSQC
CQI Achievements –
The Consortium Difference

An analysis published in Health Affairs (April 2011) reviewed hospital performance for 30 day surgical morbidity rates. From 2005-2009, hospitals participating in the Michigan Surgical Quality Collaborative (MSQC) and Michigan Bariatric Surgery Collaborative (MBSC) were compared to those outside of Michigan, participating in the National Surgical Quality Improvement Program (NSQIP).

**Risk-adjusted morbidity with general and vascular surgery:** Hospitals in Michigan versus hospitals outside of Michigan, 2005-09

**30-day mortality after bariatric surgery:** Hospitals in Michigan versus hospitals outside of Michigan, 2007-09

-Difference is the presence of the consortium, not just the registry alone
CQI Achievements –
Additional Examples of Improved Quality of Care

Dramatic reductions in complications and death

- **BMC2-PCI (angioplasty):** Reduced vascular complications by 52% (2008-2013)
- **BMC2-VIC (PVI & vascular surgery):** Reduced blood transfusions by 45% (2008-2013)
- **MSTCVS (cardiac surgery):** Observed/Expected (O/E) death ratio for coronary artery bypass graft (CABG) was 0.77 in 2012, compared to the National STS in-hospital O/E death rate of 1.0 in 2012
- **MSQC (general and vascular surgery):** Reduced morbidity and mortality of non-trauma emergency surgery operations by 40% (2006-2012)
- **MBSC (bariatric surgery):** Reduced complication rates by 25% (2007-2010)
CQIs: Impact on Many Fronts

Collaborative Quality Initiatives

- Improve quality (reduced morbidity and mortality)
- Reduced overall spend
- Reduce costs
- Hospital profitability
- Practice transformation
- Development of national best practices
- Physician satisfaction
- Recognition of value through awards, grants
- Influence and improve medical policy
Hospital CQI Savings - Bending the Benefit Cost Trend and Impacting our Social Mission

Over a 3-4 year period, five programs sponsored by Blue Cross Blue Shield of Michigan to improve the quality of common medical procedures performed in Michigan hospitals have produced $403 million in health care cost savings and have lowered complication and mortality rates for thousands of patients.

Cost savings for the five programs studied break down as follows:

<table>
<thead>
<tr>
<th>CQI Name</th>
<th>Timeframe</th>
<th>Statewide Savings</th>
<th>BCBSM Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan Surgical Quality Collaborative (general surgery)</td>
<td>2008-2011</td>
<td>$174.7 million</td>
<td>$71.0 million</td>
</tr>
<tr>
<td>Michigan Society of Thoracic and Cardiovascular Surgeons (cardiac surgery)</td>
<td>2009-2011</td>
<td>$50.9 million</td>
<td>$3.9 million</td>
</tr>
<tr>
<td>Michigan Cardiovascular Consortium – Percutaneous Coronary Intervention (angioplasty)</td>
<td>2008-2011</td>
<td>$145.5 million</td>
<td>$18.8 million</td>
</tr>
<tr>
<td>Michigan Cardiovascular Consortium – Vascular Interventions Collaborative (vascular surgery)</td>
<td>2009-2011</td>
<td>$10.9 million</td>
<td>$744 thousand</td>
</tr>
<tr>
<td>Michigan Bariatric Surgery Collaborative (bariatric surgery)</td>
<td>2008-2011</td>
<td>$21.0 million</td>
<td>$6.9 million</td>
</tr>
</tbody>
</table>
## Funding Support for Hospitals Participating in CQIs

### Participation and Performance

<table>
<thead>
<tr>
<th>Participation Payment</th>
<th>Pay-for-Performance Incentive</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Annual Full-Time Equivalent (FTE) payment to support costs of a nurse data abstractor</td>
<td>• Hospitals have an incentive to participate via the BCBSM Hospital Pay-for-Performance (P4P) Program</td>
</tr>
<tr>
<td>– Intended to cover a portion of costs for BCBSM, BCN, government and uninsured cases (projected to be approximately 80% of total cases)</td>
<td>• Payment tied to score received on the CQI Performance Index based on previous year’s performance</td>
</tr>
<tr>
<td>• Payment tied to annual case volume (e.g. one FTE per X number of cases)</td>
<td>• Each CQI is weighted at 4.0% of a hospital’s P4P score; the number of CQIs that will be included in the index for P4P scoring purposes will not exceed 10</td>
</tr>
<tr>
<td>• Support for registry costs, if applicable</td>
<td>• A hospital can earn up to 40% of their P4P payment as a result of their performance on the CQIs</td>
</tr>
</tbody>
</table>

*Note: There can be many approaches to participation and incentive payments*
Incentivizing CQI Hospital Participants through P4P

*The CQI Performance Index*

- Scorecard criteria developed by each CQI’s Coordinating Center, the consortium and BCBSM
  - Measures related to active engagement and performance improvement
  - Administered by Coordinating Center
  - Score incorporated into the P4P CQI allocation
  - Measures expected to shift over time to focus more on QI
    - Bariatric Surgery CQI example provided

<table>
<thead>
<tr>
<th>Measure #</th>
<th>Weight</th>
<th>Measure</th>
<th>Points Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>15%</td>
<td>Grade 1 complication rate&lt;br&gt;• ≤5% rate&lt;br&gt;• &gt;5% to ≤7% rate&lt;br&gt;• &gt;7% rate</td>
<td>15 0 0</td>
</tr>
<tr>
<td>2</td>
<td>15%</td>
<td>Serious complication rate&lt;br&gt;• &lt;2% rate&lt;br&gt;• 2.1% to &lt;2.5% rate&lt;br&gt;• &gt;2.5% rate</td>
<td>15 10 0</td>
</tr>
<tr>
<td>3</td>
<td>15%</td>
<td>Improvement in grade 1 complication rate&lt;br&gt;• Major improvement (z-score less than -1)&lt;br&gt;• Moderate improvement/maintained complication rate (z-score between 0 to -1)&lt;br&gt;• No improvement/rates of grade 1 complications increased (z-score &gt;0)</td>
<td>15 10 0</td>
</tr>
<tr>
<td>4</td>
<td>15%</td>
<td>Improvement in serious complication rate&lt;br&gt;• Major improvement (z-score greater than -1)&lt;br&gt;• Moderate improvement/maintained complication rate (z-score between 0 to -1)&lt;br&gt;• No improvement/rates of serious complications increased</td>
<td>15 10 0</td>
</tr>
<tr>
<td>5</td>
<td>10%</td>
<td>Patient satisfaction (very satisfied, %)- is based off the 1-year annual follow-up survey question “Overall how satisfied are you with your bariatric surgery”&lt;br&gt;• &gt;85% very satisfied&lt;br&gt;• 80-84% very satisfied&lt;br&gt;• ≤79% very satisfied</td>
<td>10 5 0</td>
</tr>
<tr>
<td>6</td>
<td>5%</td>
<td>Meeting attendance- surgeon&lt;br&gt;• Attended 3 out of 3 meetings&lt;br&gt;• Attended 2 out of 3 meetings&lt;br&gt;• Attended in fewer than 2 meetings</td>
<td>5 3 0</td>
</tr>
<tr>
<td>7</td>
<td>5%</td>
<td>Meeting attendance- abstractor/coordinator&lt;br&gt;• Attended 3 out of 3 meetings&lt;br&gt;• Attended 2 out of 3 meetings&lt;br&gt;• Attended in fewer than 2 meetings</td>
<td>5 3 0</td>
</tr>
<tr>
<td>8</td>
<td>5%</td>
<td>Timely data submissions&lt;br&gt;• On time 3 of 3 times&lt;br&gt;• On time 2 of 3 times&lt;br&gt;• On time fewer than 2 of 3 times</td>
<td>5 3 0</td>
</tr>
</tbody>
</table>
# CQI Program Costs and Participation Stats

## Approximate CQI Related Costs (2012)

<table>
<thead>
<tr>
<th></th>
<th>Coordinating Center</th>
<th>FTE Site Payments</th>
<th>Facility P4P CQI Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Per Individual CQI</strong></td>
<td>$500,000 - $3 million</td>
<td>$2,000 - $200,000</td>
<td>$700,000 (Average Per Hospital)</td>
</tr>
<tr>
<td><strong>CQI Program Overall</strong></td>
<td>$13 Million</td>
<td>$19 Million</td>
<td>$ 52 Million</td>
</tr>
</tbody>
</table>

## CQI Program Stats

<table>
<thead>
<tr>
<th>Stat</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Hospitals that participate in the CQI program</td>
<td>75 (88%)</td>
</tr>
<tr>
<td>Percentage of hospitals that participate in 100% of CQIs that their site is eligible for (excludes new CQIs requiring substantial recruitment)</td>
<td>91%</td>
</tr>
</tbody>
</table>
BCBSM in the National Spotlight: Improving Quality of Care Through CQIs

“The CQI Projects effectively put the workings of Comparative Effectiveness Research in the hands of the Provider Community in real world situations empowering them to use sophisticated scientific methods to rigorously assess and improve care affecting the entire population making hospitals self-optimizing institutions” – David Share, Assistant CMO, BCBSM

Regional collaborations between hospitals and physicians may be more effective than either selective referral or pay-for-performance in improving the quality of health care at the population level.

The improvement programs target clinical conditions and procedures that are relatively common and that are associated with high costs per episode.

The large sample sizes and statistical power associated with regional collaborative improvement program registries allow for more robust, rapid assessment of relationships between process and outcomes and of the effects of quality improvement interventions than can be achieved by hospitals examining their own practice in isolation.
**BCBSM Value Partnerships Receives Strong National Exposure Thru Recent Publications**

<table>
<thead>
<tr>
<th>Year</th>
<th>Journal Name</th>
<th>Author(s)</th>
<th>Publication Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>Diseases of the Colon and Rectum</td>
<td>Jan 2014</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>Journal of the American Geriatric Society</td>
<td>Jan 2014</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>Journal of the American College of Surgeons</td>
<td>Feb 2014</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>Annals of Surgery</td>
<td>Feb 2014</td>
<td></td>
</tr>
</tbody>
</table>

**CQIs have been profiled in peer reviewed literature more than 50 times in the last 4 years**

| 2013 | Journal of Thrombosis and Thrombolysis | Jan 2013 |
|      | BMC2 PCI | American Heart Journal | Feb 2013 |
|      | MSTCVS | The Annals of Thoracic Surgery | Mar 2013 |
|      | MSQC | Diseases of the Colon and Rectum | Apr 2013 |
|      | MSQC | Annals of Surgery | Apr 2013 |
|      | MSTCVS | The Annals of Thoracic Surgery | May 2013 |
|      | BMC2 PCI | JACC: Circulation | May 2013 |
|      | MSTCVS | The Annals of Thoracic Surgery | May 2013 |
|      | BMC2 PCI | Journal of the American Medical Association | May 2013 |
| 2012 | BMC2-PCI | Journal of the American College of Cardiology | May 2012 |
| 2012 | BMC2 PCI | American Journal of Cardiology | Jun 2012 |
| 2012 | BMC2 PCI | American Heart Journal | Aug 2012 |
| 2012 | BMC2 PCI | American Heart Journal | Aug 2012 |
| 2012 | BMC2 PCI | Journal of the American College of Cardiology | Aug 2012 |
| 2012 | BMC2 PCI | American Journal of Cardiology | Aug 2012 |
| 2012 | MSQC | JACC: Circulation: Cardiovascular Interventions | Aug 2012 |
| 2012 | BMC2 PCI | American Heart Journal | Aug 2012 |
| 2012 | MSQC | ISRN Surgery | Aug 2012 |
| 2012 | MSQC | Journal of Surgical Research | Sep 2012 |
| 2012 | MBSC | Journal of the American College of Surgeons | Oct 2012 |
| 2012 | BMC2 PCI | Annals of Internal Medicine | Nov 2012 |
| 2012 | MSQC | Journal of the American College of Surgeons | Nov 2012 |
| 2012 | BMC2 PCI | Circulation: Cardiovascular Interventions | Dec 2012 |
| 2012 | MSQC | Journal of the American College of Surgeons | Dec 2012 |
| 2012 | BMC2 PCI | Journal of American College of Cardiology | Dec 2012 |
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**CQIs have been profiled in peer reviewed literature more than 50 times in the last 4 years**
In June of 2012 the Agency for Healthcare Research and Quality (AHRQ) singled out BCBSM’s CQI program as a national best practice that improves health care quality. This article was published on AHRQ’s Health Care Innovation Exchange website.

Read the article, “Insurer Provides Financial Incentives, Infrastructure, and Other Support to Stimulate Provider Participation in Quality Improvement Collaborations” HERE

In January of 2013, AHRQ asked BCBSM to present on the CQI program, its successes, and lessons learned in a national webinar titled, “Innovative Policies: Using ACO Principles and Financial Incentives to Improve Health Outcomes.”

View the presentation HERE
CQIs in the Blogosphere

Clinical Curbside (http://curbsideconsult.tumblr.com/)

• A blog for physicians, by physicians, offering commentary on physician collaboration and diagnostic accuracy

MUSIC: A Concerted Effort to Improve Urology Care in Michigan by Brian Stork, MD

“MUSIC has turned out to be more than just an exercise in agreeing upon metrics and collecting data. It has been an opportunity for academic and private practice urologists to ask the questions and learn from each other in an effort to continuously improve urological care”
Value Partnerships: Award Winning Programs

**Best of Blue Clinical Distinction Award**: BCBSA, in partnership with Harvard Medical School Dept of Healthcare Policy has awarded multiple Best of Blue Awards to BCBSM for best practices that focus on reducing medical costs while improving quality, affordability and patient safety.

- In 2010, BCBSM received a Best of Blue Award and the Blueworks Award (premier award that goes to only one of the 38 Blues plans) for its Patient-Centered Medical Home model.
- BCBSM received three Best of Blue Awards in 2011:
  - Michigan Surgical Quality Collaborative
  - Michigan Bariatric Surgery Collaborative
  - Michigan Oncology Quality Consortium
- **NOTE**: MBSC and MSQC also received BlueWorks premiere award
- BCBSM received two Best of Blue Awards in 2012:
  - Blue Cross Blue Shield of Michigan Percutaneous Coronary Intervention
  - PGIP – “Reimbursement Transformation: Fee for Service to Fee for Value”
NIH awarded a three-year grant totaling $879,535 to Nancy Birkmeyer, PhD (Director of MBSC) to develop an ROI analysis for the following statewide BCBSM/BCN-sponsored surgical CQI projects:

- Michigan Breast Oncology Quality Initiative (MiBOQI)
- Michigan Surgical Quality Collaborative (MSQC)
- Michigan Society of Thoracic and Cardiovascular Surgeons Quality Collaborative (MSTCVS)
- BCBSM Cardiovascular Consortium (PCI and PVI)

This grant will fund the examination of the relationship between costs and quality by linking BCBSM claims cost data on improvements in quality from the CQI registries.
National Reviews and Grants: CQIs

Patient Centered Outcomes Research Institute (PCORI) awarded a three-year grant totaling $1.5M to develop a web-based interactive decision support tool to incorporate tailored information regarding risks and benefits of the treatment options for potential bariatric surgery patients.

The study involves early, more direct engagement of patients to:
  • Help them make the decision whether or not to have surgery
  • Determine which surgical procedure is most suitable
  • Provide information about maintaining weight loss after surgery

The Michigan Bariatric Surgery (MBSC) data registry will be used as a platform:
  • Information collected from approximately 40 hospitals participating in MBSC
  • Data collected on more than 35,000 patients

“Improving patient decisions about bariatric surgery,” was awarded to Dr. Nancy Birkmeyer, PhD, project director of MBSC.
National Reviews and Grants: CQIs

The Agency for Healthcare Research and Quality (AHRQ) awarded a four-year grant totaling $1.5M to the Michigan Society of Thoracic and Cardiovascular Surgeons (MSTCVS), in collaboration with the Society of Thoracic Surgeons (STS) and the Duke University Clinical Research Institute to study healthcare acquired infections.

The study will utilize:
• The 10-year experience and collaboration of the MSTCVS as a model setting for identifying and sharing best practices across its 33-member programs to reduce the rate healthcare acquired infections subsequent to adult cardiac surgery
• The Society of Thoracic Surgeons Adult Cardiac Surgery Database to compare rates of healthcare acquired infections across MSTCVS programs to rates in other areas of the country

If successful, the investigators will pursue efforts to share best practices more broadly throughout the country.

Dr. Richard Prager, project director, and Patty Theurer, project manager, of MSTCVS, are co-investigators on the grant, “Optimizing Prevention of Healthcare-Acquired Infections After Cardiac Surgery.”
Why are CQIs so Successful?

• Empowers provider community to self-optimize care for their population in “real world” circumstances
• Harness the power of continuous quality improvement – collect, analysis, share data and disseminate best practices
• Measure to improve – not to judge
• All patient/all payer – all patients regardless of coverage receive QI benefits
• Consortium identifies and disseminates best practices
• Collaborative, consortium-based QI catalyzes more rapid and dramatic practice transformation than independent provider improvement efforts
• Rapid change on evidence-based medicine – what typically takes a decade or longer is often accomplished in significantly condensed periods of time
• **Locus of control remains with the providers** – complete, accurate, risk adjusted, confidential, provider-owned data. BCBSM only has access to de-identified data
Why Does BCBSM Fund the CQI Program?

- Dramatically improves quality and outcomes
- Decreases cost of care
- Allows physicians to self-optimize
- Fast-tracks improvements in care
- Fosters strong relationships with providers (both for plan and member)
- Fulfills our social mission
- Results in coordinated, collaborative improvements

*It is a win for those who seek care, those who provide care, and those who pay for care*
Questions?

Tom Leyden, MBA
Director II, Value Partnerships
Blue Cross Blue Shield Michigan

tleyden@bcbsm.com
(313) 448-3306
www.valuepartnerships.com
Physician Community Views on CQI Participation and Testimonials
Comments from the Physician Community re: Cardiac CQI (BMC2)

“BMC2 has forged a unique and vital partnership with hospitals and interventional cardiologists across Michigan to continuously optimize practices, systems and outcomes of care. The Michigan Chapter of the American College of Cardiology is proud to be a collaborator with BMC2 in this ever-evolving culture of quality in Michigan.”

Claire Duvernoy, M.D. President Michigan chapter ACC
Chief, Cardiology Section
VA Ann Arbor Healthcare System
Associate Professor of Medicine
University of Michigan Health System
Comments from the Physician Community re: Hospitalist CQI (HMS)

“Hospitalists are uniquely positioned to lead and implement improvement and safety efforts in their hospitals. Innovative and large scale collaborative improvement efforts like the state-wide quality collaboratives (HMS and MTC2) led by BCBS in Michigan are good for their communities, their hospitals and the hospitalists. They leverage the practical front-line knowledge of the hospitalist, provide hospitalists with QI leadership opportunities, and enhance the likelihood of securing improved patient outcomes by providing QI infrastructure and shared tools and strategies.”

Greg Maynard, M.D.
Senior Consultant, SHM Center for Hospital Innovation and Improvement
Clinical Professor of Medicine, Division of Hospital Medicine
Director, Center for Innovation and Improvement Science
UC San Diego
Comments from the Physician Community re: Hospitalist CQI (HMS)

“As a hospitalist, it has been a true pleasure to be involved in the Blue Cross Blue Shield of Michigan sponsored Hospital Medicine Safety consortium. This consortium has the potential to markedly improve the care of patients in the state and to create new science that can be used outside of the participating hospitals. Knowledge gained to date has radically changed how many members of the consortium view which hospitalized patients should be treated to prevent blood clots. This information was judged to be one of the top 3 most important studies at the 2013 national meeting of the Society of Hospital Medicine, the clinical and academic “home” for hospitalists. These changes have the potential to decrease how often patients need injections of medication and to save hospitals costs without increasing risks; a win, win, win situation.”

Scott Kaatz, DO, MSc, FACP,
Chief Quality Officer, Chief, Hospital Medicine
Hurley Medical Center, Flint, MI
Clinical Associate Professor of Medicine
Michigan State University - College of Human Medicine
Comments from the Physician Community re: Cardiothoracic CQI (MSTCVS)

“The whole weekend was great with phenomenal speakers. Thank you for this learning opportunity. I am fortunate to be able to attend such a “High Level” conference. I am excited to share all this information with the rest of our health care team and use it to improve our quality patient outcomes.”

Participant at MSTCVS 2013 Summer Conference
Comments from the Physician Community re: Urology CQI (MUSIC)

“With support from Blue Cross Blue Shield of Michigan, establishment of the Michigan Urological Surgery Improvement Collaborative (MUSIC) created an unprecedented infrastructure for improving the quality and cost-efficiency of care provided to men with prostate cancer. The degree of engagement among Michigan urologists has been remarkable, and we have rapidly assembled a group of physician champions who are committed to improving patient outcomes through shared data collection, performance feedback, review of best practices, and collaborative learning. Already, MUSIC is recognized by the national urology community as a pioneering approach to improving the diagnosis and treatment of men with prostate cancer. By working collaboratively to tackle the big challenges in our field, we are making Michigan #1 in prostate cancer care.”

David C. Miller, MD, MPH – Associate Professor of Urology at University of Michigan; MUSIC Program Director
James E. Montie, MD – Professor of Urology at University of Michigan; MUSIC Program Co-Director
Comments from the Physician Community re: Urology CQI (MUSIC)

“My experience as a MUSIC champion has been fulfilling on many levels. The organization, positive attitude and integrity of the leadership in this collaborative is exceptional. I am honored to be included in a group of very intelligent and committed physicians, who are genuinely interested in improving patient care while compiling accurate data to bring to light new and better prostate cancer care. The collection of individual office practices is the first step in improving uniform treatment of prostate cancer. Our sharing of the vital information for patient care will only further enhance outcomes in our profession. This statewide model will be looked upon as a landmark study in the diagnosis and treatment of prostate cancer in Michigan as well as throughout the country. I can honestly say I am excited about the future of the efforts of this collaborative and am confident that prostate cancer patients of the future will benefit greatly.”

Brian R. Drabik, DO
Cadillac Urology Practice