

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

**Presentation to:
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**Our Goal: Improve Care for Members
and Increase Value for our Customers**

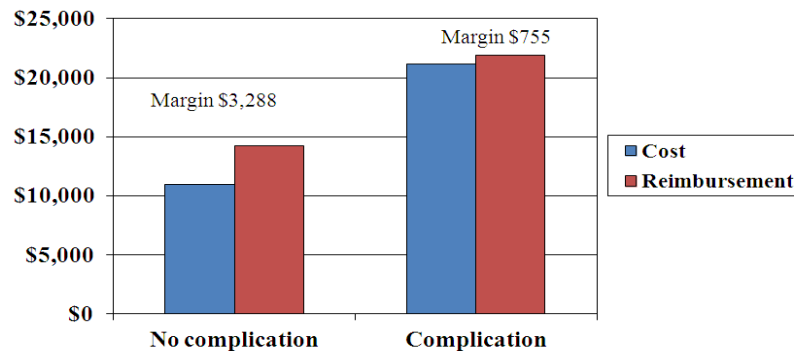
$$\text{Value} = \frac{\text{Patient Experience} + \text{Quality}}{\text{Cost}}$$



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.

Margins in patients with and without NSQIP complications,
University of Michigan Hospital



*Dimick et al. JACS 2006; 202(6): 933-937

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.

BCBSM/Provider Partnership

PGIP and CQI Initiatives

Delivery of Care

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

Participating Hospitals

CQI

BCBSM

Coordinating Centers

Consortium

Data collection

Data Analysis

Continuous Quality Improvement

Develop Best Practices

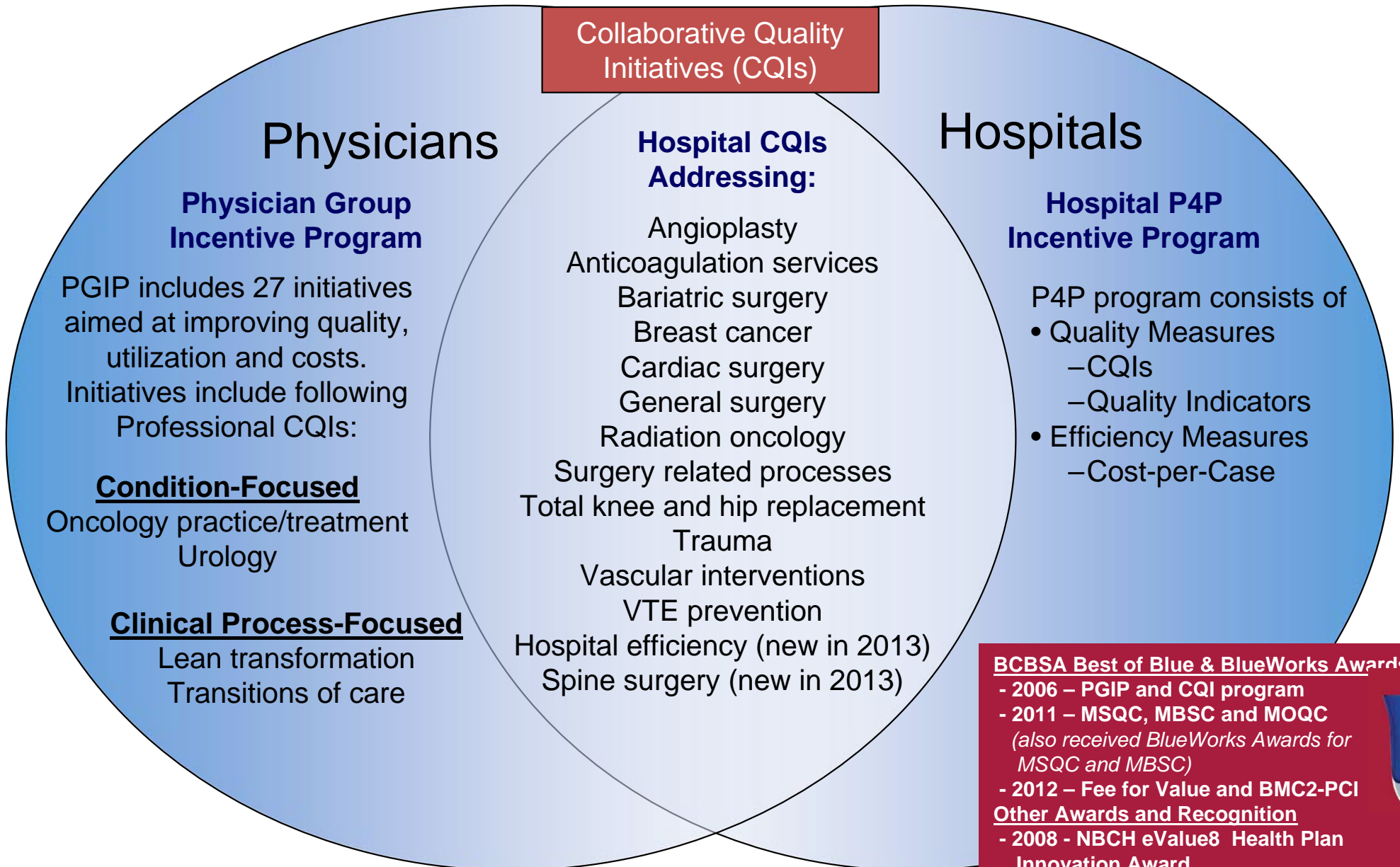
Data Reporting

- 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



CQIs as Key Component of Value Partnerships



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

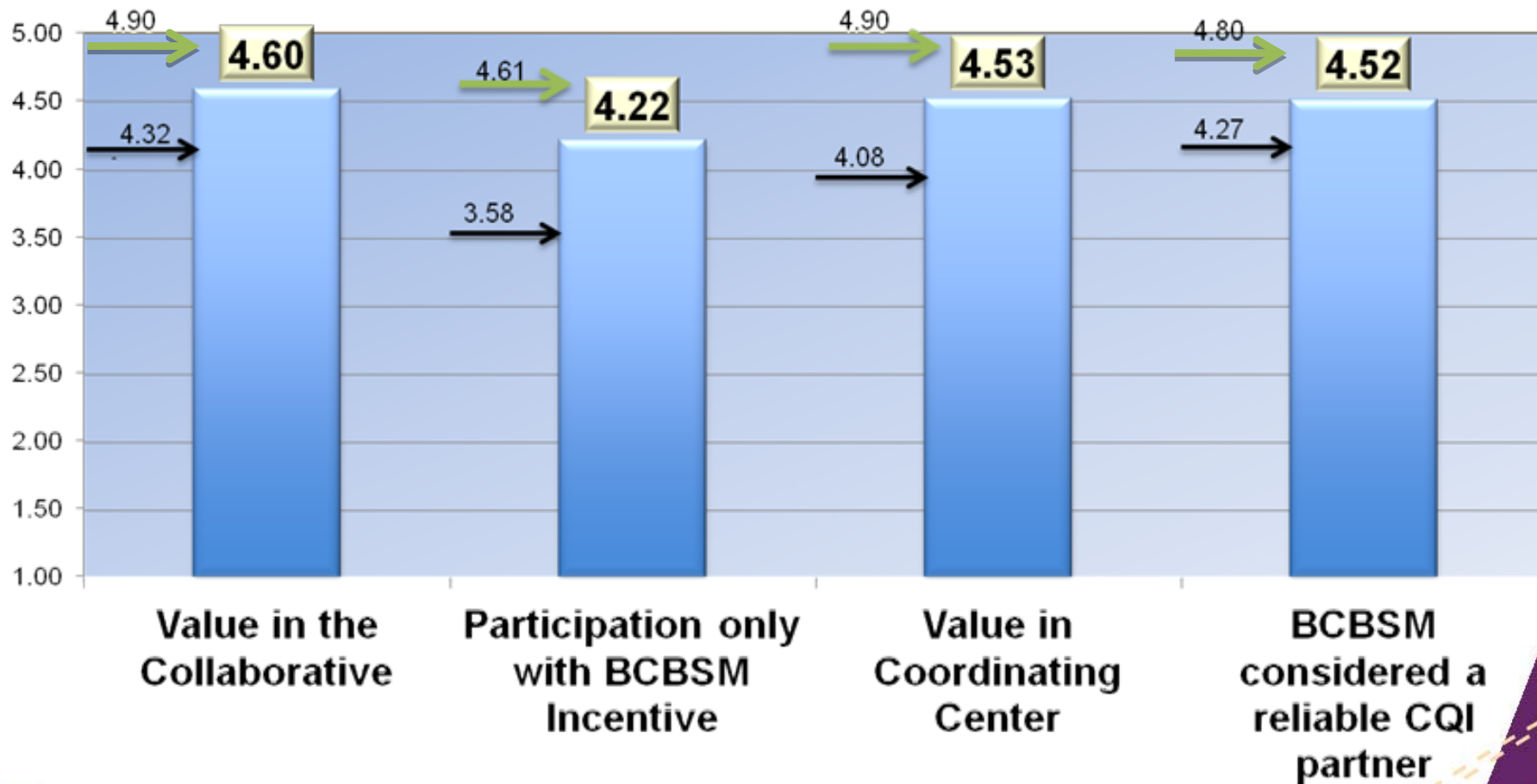


Current Hospital CQIs

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

Participating Hospital Perceptions: CQI Participation

Fall 2013 Quarterly Meeting
Overall Average by Question



High score →

Low score →

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



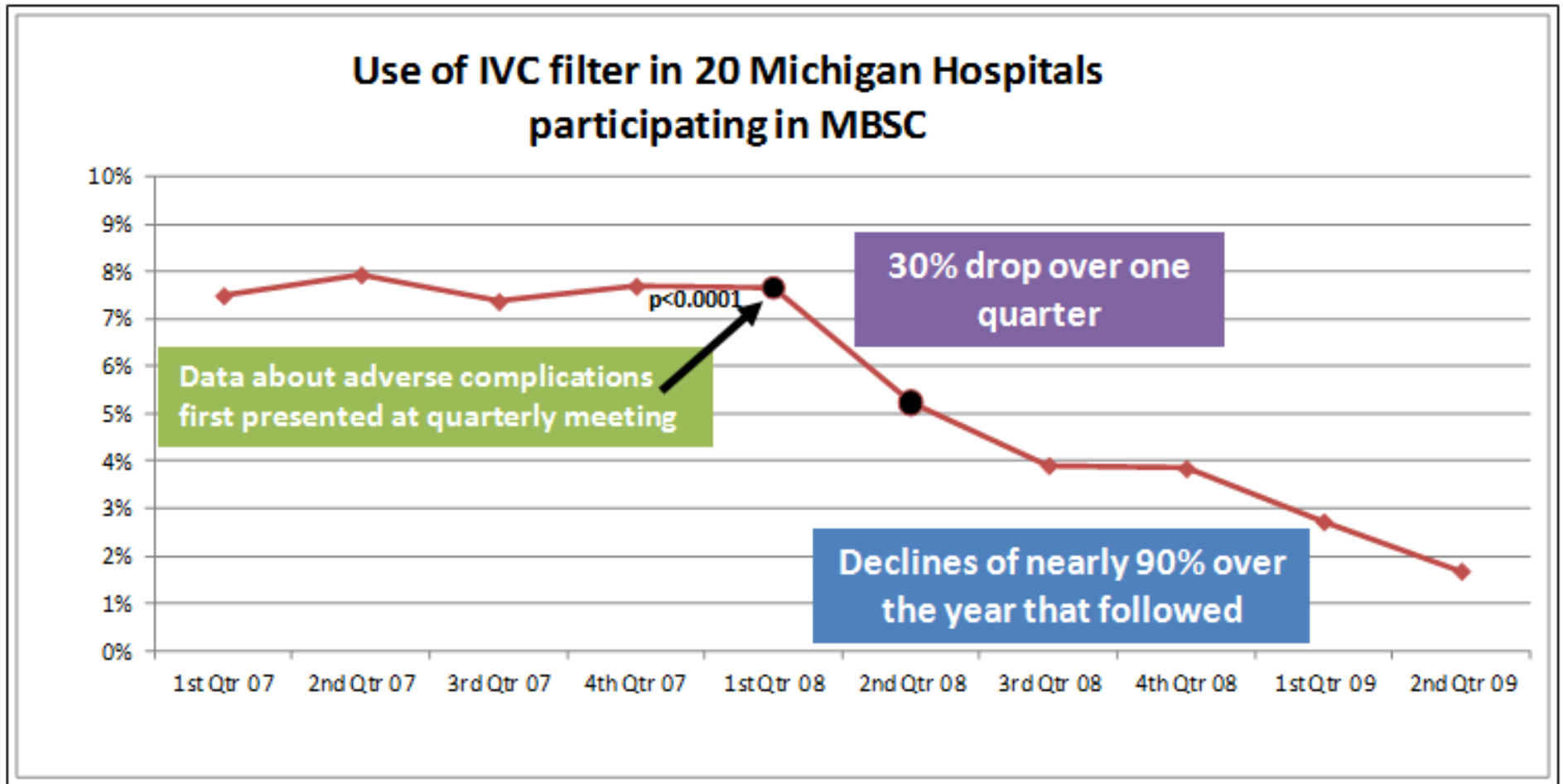
CQI Achievements – 1st Example of Improving Quality of Care

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.



Just Published in NEJM: Improving Bariatric Care in Michigan

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Surgical Skill and Complication Rates after Bariatric Surgery

John D. Birkmeyer, M.D., Jonathan F. Finks, M.D., Amanda O'Reilly, R.N., M.S., Mary Oerline, M.S., Arthur M. Carlin, M.D., Andre R. Nunn, M.D., Justin Dimick, M.D., M.P.H., Mousumi Banerjee, Ph.D., and Nancy J.O. Birkmeyer, Ph.D., for the Michigan Bariatric Surgery Collaborative

ABSTRACT

BACKGROUND

Clinical outcomes after many complex surgical procedures vary widely across hospitals and surgeons. Although it has been assumed that the proficiency of the operating surgeon is an important factor underlying such variation, empirical data are lacking on the relationships between technical skill and postoperative outcomes.

METHODS

We conducted a study involving 20 bariatric surgeons in Michigan who participated in a statewide collaborative improvement program. Each surgeon submitted a representative videotape of a bariatric procedure. Each videotape was rated in various domains of technical skill on a scale of 1 to 5 (with higher scores indicating more advanced skill) by at least 10 peer surgeons who were unaware of the identity of the operating surgeon. We then assessed relationships between these skill ratings and risk-adjusted complication rates, using data from a prospective, externally audited, clinical-outcomes registry involving 10,343 patients.

RESULTS

Mean summary ratings of technical skill ranged from 2.6 to 4.8 across the 20 surgeons. The bottom quartile of surgical skill, as compared with the top quartile, was associated with higher complication rates (14.5% vs. 5.2%, $P<0.001$) and higher mortality (0.26% vs. 0.05%, $P=0.01$). The lowest quartile of skill was also associated with longer operations (137 minutes vs. 98 minutes, $P<0.001$) and higher rates of reoperation (3.4% vs. 1.6%, $P=0.01$) and readmission (6.3% vs. 2.7%) ($P<0.001$).

CONCLUSIONS

The technical skill of practicing bariatric surgeons varied widely, and greater skill was associated with fewer postoperative complications and lower rates of reoperation, readmission, and visits to the ED. Although these findings are preliminary, they suggest that a strategy for assessing a surgeon's proficiency.

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.

Birkmeyer et al. New England Journal of Medicine, October 2013; 369:1434-42.

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

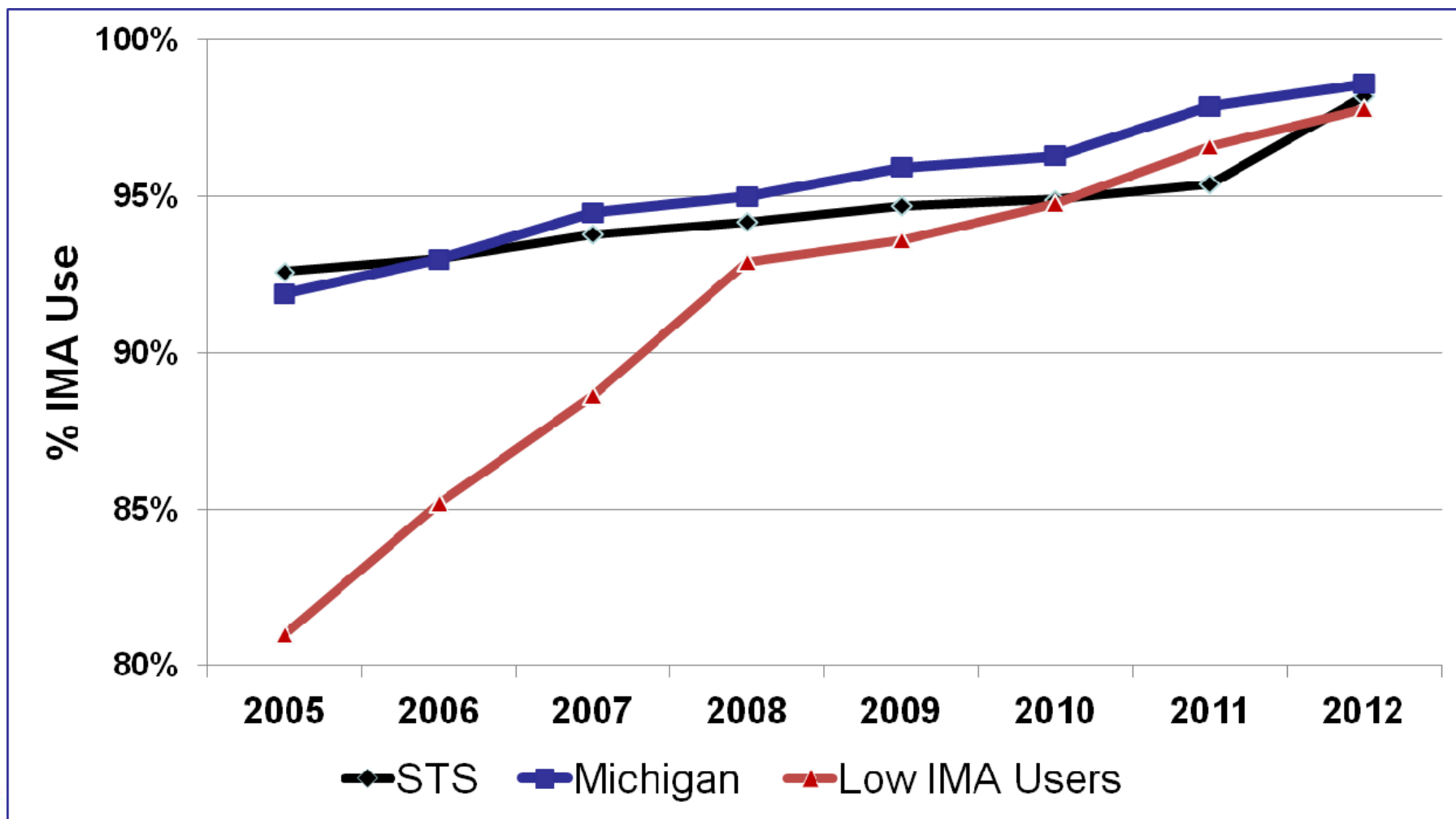
Michigan Society of Thoracic and Cardiovascular Surgeons (MSTCVS):
From 2005 to 2012, increased Internal mammary artery (IMA) use from 82.0% to 97.8%.

- 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

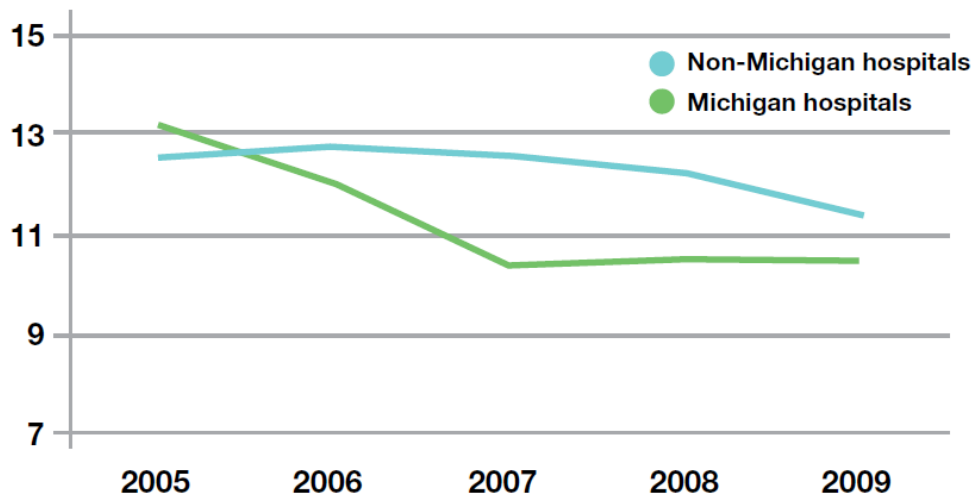
MSQC analyzed which worked best, narrowing it down to three that worked superbly well (the rest were not so good)

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

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).

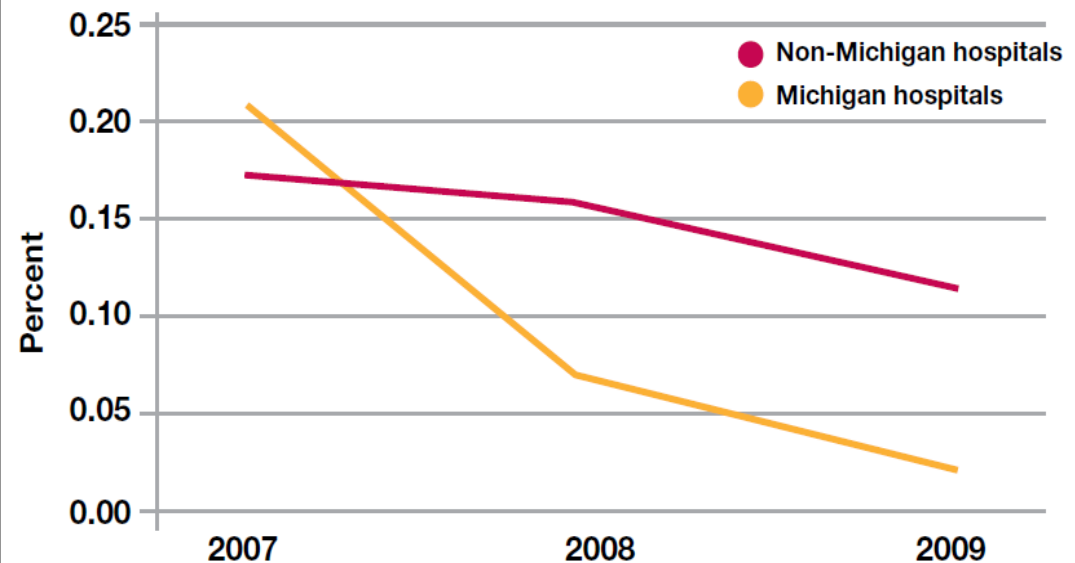
Risk-adjusted morbidity with general and vascular surgery: Hospitals in Michigan versus hospitals outside of Michigan, 2005-09



Source: Michigan Surgical Quality Collaborative and National Surgical Quality Improvement Program registries, 2005-09.

Notes: Morbidity rates declined faster in Michigan hospitals ($p < 0.001$) and, by 2009, were lower than in other hospitals participating in the National Surgical Quality Improvement Program ($p < 0.001$).

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



Source: Michigan Surgical Quality Collaborative and National Surgical Quality Improvement Program registries, 2007-09.

Notes: Thirty-day mortality rates declined faster in Michigan hospitals than in other hospitals participating in the National Surgical Quality Improvement Program ($p = 0.045$).

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



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:

CQI Name	Timeframe	Statewide Savings	BCBSM Savings
Michigan Surgical Quality Collaborative (general surgery)	2008-2011	\$174.7 million	\$71.0 million
Michigan Society of Thoracic and Cardiovascular Surgeons (cardiac surgery)	2009-2011	\$50.9 million	\$3.9 million
Michigan Cardiovascular Consortium – Percutaneous Coronary Intervention (angioplasty)	2008-2011	\$145.5 million	\$18.8 million
Michigan Cardiovascular Consortium – Vascular Interventions Collaborative (vascular surgery)	2009-2011	\$10.9 million	\$744 thousand
Michigan Bariatric Surgery Collaborative (bariatric surgery)	2008-2011	\$21.0 million	\$6.9 million



Funding Support for Hospitals Participating in CQIs

Participation and Performance

Participation Payment	Pay-for-Performance Incentive
<ul style="list-style-type: none"> • Annual Full-Time Equivalent (FTE) payment to support costs of a nurse data abstractor –Intended to cover a portion of costs for BCBSM, BCN, government and uninsured cases (projected to be approximately 80% of total cases) • Payment tied to annual case volume (e.g one FTE per X number of cases) • Support for registry costs, if applicable 	<ul style="list-style-type: none"> •Hospitals have an incentive to participate via the BCBSM Hospital Pay-for-Performance (P4P) Program •Payment tied to score received on the CQI Performance Index based on previous year’s performance •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 •A hospital can earn up to 40% of their P4P payment as a result of their performance on the CQIs

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

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

CQI Program Costs and Participation Stats

Approximate CQI Related Costs (2012)

	Coordinating Center	FTE Site Payments	Facility P4P CQI Payments
Per Individual CQI	\$500,000 - \$3 million	\$2,000 - \$200,000	\$700,000 (Average Per Hospital)
CQI Program Overall	\$13 Million	\$19 Million	\$ 52 Million

CQI Program Stats

Number of Hospitals that participate in the CQI program	75 (88%)
Percentage of hospitals that participate in 100% of CQIs that their site is eligible for (excludes new CQIs requiring substantial recruitment)	91%

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

QUALITY PROFILES

By David A. Share, Darrell A. Campbell, Nancy Birkmeyer, Richard L. Prager, Hitinder S. Gurm, Mauro Moscucci, Marianne Udow-Phillips, and John D. Birkmeyer

How A Regional Collaborative Of Hospitals And Physicians In Michigan Cut Costs And Improved The Quality Of Care

ABSTRACT There is evidence that collaborations between hospitals and physicians in particular regions of the country have led to improvements in the quality of care. Even so, there have not been many of these collaborations. We review one, the Michigan regional collaborative improvement program, which was paid for by a large private insurer, has yielded improvements for a range of clinical conditions, and has reduced costs in several important areas. In general and vascular surgery alone, complications from surgery dropped almost 2.5 percent among participating Michigan hospitals—a change that translates into 2,500 fewer Michigan patients with surgical complications each year. Estimated annual savings from this one collaborative are approximately \$20 million, far exceeding the cost of administering the program. Regional collaborative improvement programs should become increasingly attractive to hospitals and physicians, as well as to national policy makers, as they seek to improve health care quality and reduce costs.

The need to improve quality of care in US hospitals is widely recognized. Potentially available address events are common among hospitalized patients, and while written hospital performance outcomes suggest that there is ample room for improvement.^{1,2} The business case for improving hospital quality is also apparent. In surgery, for example, the true cost associated with treating complications exceeds \$10,000 per patient, the large majority of which is passed on to patients and payers.³ Additional payments for unplanned readmissions, and care following discharge for patients with complications are cost for approximately 20 percent of the total costs associated with many inpatient procedures, according to national Medicare data.⁴

Background On Hospital Quality Improvement
Despite increasing attention from payers, policy makers, and professional organizations, large-scale efforts to improve hospital quality have had little effect on patient outcomes. Public reporting of performance data may motivate hospitals to improve.⁵ However, there is some evidence that programs such as the Center for Medicare and Medicaid Services' Hospital Compare website or the Leapfrog Group's selective referral initiatives of the same model in collecting large numbers of patients to hospitals that have demonstrated superior results.^{6,7} Simply put, it hasn't been demonstrated that patients will actually stop going to hospitals that achieve poor results and start going to hospitals that achieve better ones. Even if practical barriers to changing these referral patterns could be addressed—such as efficient transfer of patient medical

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BCBSM Value Partnerships Receives Strong National Exposure Thru Recent Publications

2014

MSQC	Diseases of the Colon and Rectum	(Jan 2014)
MSQC	Journal of the American Geriatric Society	(Jan 2014)
MSQC	Journal of the American College of Surgeons	(Feb 2014)
MSQC	Annals of Surgery	(Feb 2014)

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

2013

MAQI2	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)
BMC2-PCI	Journal of the American College of Cardiology	(May 2013)
BMC2 PCI	American Journal of Cardiology	(Jun 2013)
BMC2 PCI	American Heart Journal	(Jun 2013)
BMC2 PCI	American Heart Journal	(Aug 2013)
BMC2 PCI	American Heart Journal	(Aug 2013)
BMC2 PCI	Journal of American College of Cardiology	(Aug 2013)
BMC2 PCI	American Journal of Cardiology	(Aug 2013)
MSQC	ISRN Surgery	(Aug 2013)
MSQC	Journal of Surgical Research	(Sep 2013)
MBSC	New England Journal of Medicine	(Oct 2013)
MBSC	Journal of the American College of Surgeons	(Oct 2013)
BMC2 PCI	Annals of Internal Medicine	(Nov 2013)
MSQC	Journal of the American College of Surgeons	(Nov 2013)
BMC2 PCI	Circulation: Cardiovascular Interventions	(Dec 2013)
MSQC	Journal of the American College of Surgeons	(Dec 2013)
MSQC	Journal of Vascular Surgery	(Dec 2013)
BMC2 PCI	Journal of American College of Cardiology	(Dec 2013)
BMC2 PCI	Journal of American College of Cardiology	(Dec 2013)

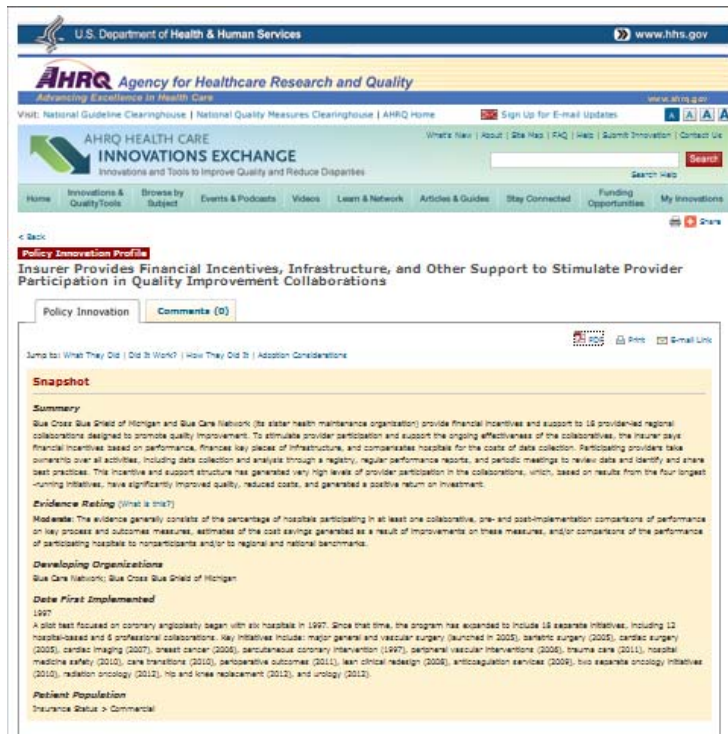
2012

BMC2 PCI	Journal of the American College of Cardiology	(Jan 2012)
ACIC	Journal of the American College of Cardiology	(Feb 2012)
ACIC	American Heart Journal	(Mar 2012)
MSTCVS, MSQC, HMS, MBSC, MTQIP, MAQI2	Journal of Thrombosis and Thrombolysis	(Apr 2012)
MOQC	Health Affairs	(Apr 2012)
ACIC	American Heart Journal	(May 2012)
BMC2 PCI	American Heart Journal	(May 2012)
MiBOQI	Journal of Clinical Oncology	(Jun 2012)
MSQC	Archives of Surgery	(Jul 2012)
MUSIC	AUA News	(Nov 2012)
BMC2 VIC	Circulation: Cardiovascular Interventions	(Dec 2012)

2011

BMC2 PCI	American Heart Journal	(Jan 2011)
BMC2 PCI	American Heart Journal	(Jan 2011)
BMC2 VIC	Archives of Surgery	(Apr 2011)
MBSC	Obesity Surgery	(Apr 2011)
MSTCVS, MBSC, BMC2 PCI, MSQC	Health Affairs	(Apr 2011)
MTQIP	Journal of Trauma	(Mar 2011)
BMC2 VIC	Journal of the American College of Cardiology	(Jun 2011)
BMC2 PCI	Journal of the American College of Cardiology	(Sep 2011)
MiBOQI	Surgery	(Oct 2011)

Recognition from AHRQ as National Best Practice



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 (premiere 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”



National Reviews and Grants: CQIs

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.”

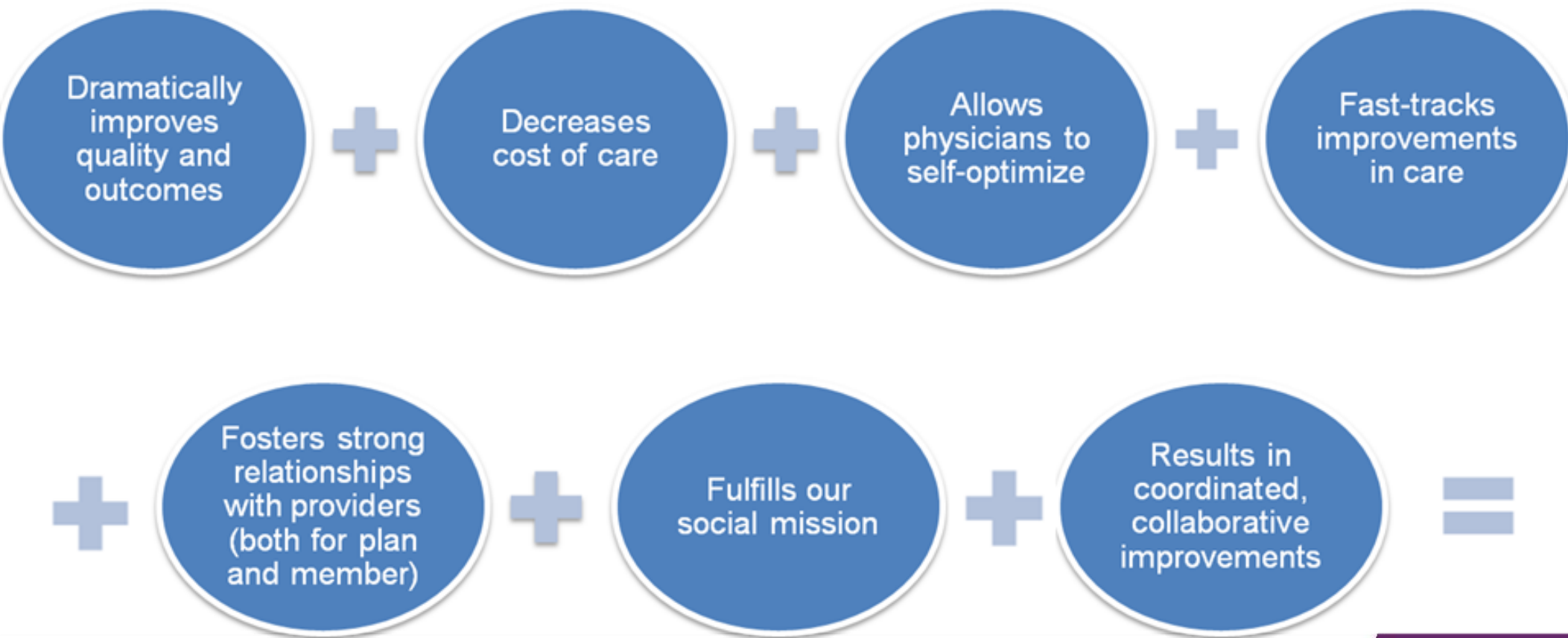


Why are CQIs so Successful?

- 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?



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



Questions?

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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

