VOICES on value

2016
Value Partnerships Annual Report
What’s inside

This report shows how Blue Cross Blue Shield of Michigan, in partnership with hospitals, doctors and other health care professionals, is driving health care transformation by meeting the needs of members, customers and health care providers. They share their stories and provide their perspectives in the pages that follow.

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Value Partnerships helps meet needs of all our stakeholders

For more than a decade, Blue Cross Blue Shield of Michigan has been working with our physician and hospital partners to improve patient care and provide value for our members and customers through Value Partnerships.

This collaborative effort with our hospital and physician partners reached even higher levels of national prominence in 2016. Several Blue plans across the country sought our expertise in replicating these programs in their communities. In addition, the Centers for Medicare & Medicaid Services recognized our Patient-Centered Medical Home model as meeting the national criteria to earn merit-based payment.

Together, we continue to transform health care in Michigan, establishing our state as a national leader in building a high-performing, value-based, cost-effective health care system.

Our Value Partnerships program benefits all our stakeholders — including health care providers, members and customers — by delivering improvements in health care quality, patient safety and outcomes.

What do doctors and hospitals want?
They want innovative health care programs that help them improve their patients’ health — and they want to be recognized and rewarded for these efforts.

What do our members want?
They want good health and a good relationship with their doctors. They want to avoid unnecessary medical services and hospital stays. And they want affordable insurance premiums, copays and deductibles.

What do our group customers want?
They want an insurer that provides innovative and affordable health care solutions that help them safeguard the health and well-being of their employees.

At Blue Cross, we’re responding to all these needs by supporting a wide range of physician-led efforts that are helping manage health care costs and improve the health of Michigan residents.
Health care value: Continuing to build on our successes

Customers have told us what they want from their health plan partner — affordability, data analytics and national delivery models that focus on improving the member experience.

For members, the power of Blue Cross is that we provide a network of high-quality physicians who are committed to their care. For our physician and hospital partners, they recognize that the Value Partnerships team supports them in their efforts to transform health care delivery.

The ultimate goal? To improve quality, cost and the patient experience.
We’re taking Value Partnerships to the next level

2016 was a year of transformation for Blue Cross Blue Shield of Michigan’s Value Partnerships program.

Value Partnerships initiatives garnered increased recognition nationally, and we’ve been able to carry our message of coordinated, patient-focused, value-based care to points across the country. Most importantly, our approach to improving value and working in concert with our provider partners is benefiting our members, customers and the entire Michigan community.

We’re on the front lines of national efforts to transform health care value. And our collective efforts are making a big difference in the health care landscape in Michigan and beyond.

We’re excited about what the coming year will bring as we continue our work to transform health care and increase health care value for all Michigan residents.
2016 highlights: Year at a glance

**Population management:** Blue Cross is helping physician practices and hospitals build the infrastructure technology and integrated care processes they need to better manage the care of their shared population of patients across the health care continuum.

**Value-based reimbursement:** We lead the nation's health care plans in moving away from a fee-for-service system toward a value-based model. This new model rewards providers for improved processes and health outcomes. It's transforming the way we pay doctors and hospitals.

**Outcomes-based reimbursement**
Our population management and value-based reimbursement programs work together to help members receive care that's based on health outcomes, not on how many services they receive. Care is coordinated among physicians, hospitals and other health care providers. Everyone is held accountable.

**Value-based reimbursement for hospitals by the numbers**

- **58** of all hospitals in Michigan have signed a value-based contract with Blue Cross as part of our value-based reimbursement program. Through these reimbursement arrangements, hospitals share in the cost savings resulting from quality improvements for a shared population of patients.

- Estimated savings in the first three years of the program totaled **$135 million**, resulting from better patient health care outcomes and fewer complications. Blue Cross shared more than half of those savings with contracted hospitals.

- **85 percent** of Blue Cross payments flow through value-based arrangements, compared with the national average of 38 percent (the national average of Health Care Transformation Task Force member plans).
“Value-based payment reform is rapidly advancing across the nation. It’s gratifying to see our work here in Michigan powering this wave of change. Achieving and sharing with providers the money we save through our reimbursement models rewards value and creates better systems of care.”

David Share, M.D.,
senior vice president
Value Partnerships

**PCMH designation program:** For the eighth consecutive year, Blue Cross’ Patient-Centered Medical Home designation program leads the nation in advancing the PCMH model of care. In this model, doctors lead a care team that helps to manage the care of their patients. The program includes 1,638 primary care practices, with 4,534 physicians who are located in 80 of Michigan’s 83 counties. For more on PCMH, see Page 13.

**Blue Distinction® Total Care:** In this groundbreaking program developed by the national Blue Cross and Blue Shield Association, Michigan residents with coverage from an out-of-state Blue plan are linked to PCMH practices in Michigan. In addition, Blue Cross Blue Shield of Michigan members who reside outside of Michigan are linked to doctors in their state who meet quality and cost performance targets.

**Value-based health plan:** Blue Cross® Personal Choice PPO offers our members lower out-of-pocket costs if they choose a primary care doctor who participates in a highly efficient Organized System of Care. Additionally, the plan provides access to the entire PPO network. For more on OSCs, see Page 18.

**How can someone find a PCMH or Blue Distinction Total Care provider?**
Through the Find a Doctor search feature on our website at bcbsm.com.
PGIP: Rewarding practitioners for improving patient care

The Physician Group Incentive Program, the cornerstone of Value Partnerships, rewards practitioners for effectively managing patient populations.

In 2016, there were 22 initiatives in PGIP designed to improve patient care and health care delivery. We’re highlighting three of the newest initiatives:

- Health Information Exchange
- Patient Experience of Care
- Resource Stewardship Initiative

“PGIP is a great forum for encouraging physician organizations to get together to try to figure out how to do things better. How can we give great quality care and also be aware of the cost of care?”

Gregg Stefanek, D.O.
Gratiot Family Care, a PCMH-designated practice, Alma

PGIP by the numbers

Nearly 20,000 active physicians in the state participate in PGIP, a collaborative effort that has improved health care quality and coordination of care.

More than 40 statewide physician organizations, representing 20,000 physicians across Michigan, work together to share information and collaborate on initiatives.

PGIP physicians are in 81 Michigan counties.

The efforts of participating physician organizations, physicians and specialists positively affect Michigan residents across the state. This includes nearly 2 million Blue Cross PPO commercial members.
Health Information Exchange Initiative: Sharing information to create better care transitions

The Health Information Exchange, or HIE, Initiative supports physician organizations that participate in a statewide notification service. Administered through the Michigan Health Information Network, or MiHIN, the service provides real-time, all-payer admission, discharge, transfer and emergency room notifications to POs about the patients of their member physicians.

Notifying primary care doctors about a hospital event helps the doctors follow up with their patients more quickly after they’re discharged. This helps to reduce complications, improve health outcomes and reduce unnecessary hospital readmissions.

New for 2016: A pilot group of physician organizations began receiving information about the medications patients receive at the time of hospital discharge. This supports the process of medication reconciliation when patients return to their primary care doctor. Medication reconciliation data will soon become part of the statewide initiative.

HIE by the numbers
As of December 2016:

- 30 physician organizations submit patient lists into the MiHIN service, which contains information on more than 7 million Michigan patients.
- 85 percent of PCMH-designated practices are participating in the HIE Initiative.
- 100 hospitals participate in MiHIN’s statewide notification services, representing approximately 92 percent of the total volume of Blue Cross admissions statewide.

Health information technology creates less fragmented care process

The American health care delivery system is highly fragmented, with many professionals in different care settings sharing responsibility for the same patients but not sharing information about these patients with one another. This is slowly changing as the health information exchange infrastructure expands.

Widespread sharing of health information requires a means of:

- Accurately identifying patients
- Obtaining accurate information about providers, including how they receive electronic information
- Identifying all providers who have a current care relationship with each patient

With these elements in place, we can improve the way we care for patients by:

- Communicating medication changes to all providers caring for a patient
- Ensuring timely follow-up visits after an emergency room admission or hospital visit
- Coordinating a patient’s plan of care across the health care continuum

These changes won’t happen overnight, but health care information is now flowing between health care providers across the state. And we’re making excellent progress in creating a less fragmented health care system.

A message from Thomas Simmer, M.D., senior vice president and chief medical officer
Resource Stewardship Initiative: Addressing health care overuse

Health care overuse, waste and unnecessary care continue to be a huge problem in the U.S.

Addressing this overuse and providing responsible stewardship of the resources available to doctors are the goals of PGIP’s Resource Stewardship Initiative, according to Gregg Stefanek, D.O., pictured at left, who serves on the advisory committee. Physician organizations are rewarded for their performance and improvement on a set of measures that focus on potentially unnecessary or overused care.

“There are a limited amount of resources, and we have to be judicious in the use of them,” said Stefanek, a family practitioner at Gratiot Family Practice in Alma. “Everyone in health care has a responsibility to consider the cost of care they provide, but it’s really about providing appropriate and effective care.”

Stefanek points to three examples of the type of inappropriate or unnecessary care that the RSI is targeting:

• A patient with a four-day history of an uncomplicated headache doesn’t need an MRI.
• A patient with a three-day history of uncomplicated back pain doesn’t need back X-rays.
• A patient with symptoms of upper respiratory infection or bronchitis that lasts for a week or less doesn’t need an antibiotic.

Many treatments and tests can actually cause patient harm. Antibiotics, for example, can cause diarrhea, a rash or the elimination of good bacteria in the stomach.

“Most every test and treatment has an associated risk,” he said, adding that it’s important for doctors to have a discussion with patients to help them decide which tests should be performed.

“The Resource Stewardship Initiative is focused on physicians doing the right thing for the patient and getting patients involved in the decision-making process,” Stefanek said.

Did you know?

A 2015 Bloomberg News study indicated that out of 55 countries, the U.S. ranks third for health care spending, but 50th for efficiency. Statistics such as these underscore the importance of our Value Partnerships program, which focuses on improving quality and efficiency.
Information sharing prevents duplication of services

This is an excerpt from a blog on MI Blues Perspectives.

Last year, I was having problems with my back. I went to see an orthopedic surgeon.

I explained the pain I was feeling, and my doctor opened up my electronic medical record to review my health history. He pulled up a CT scan that was in my file from a time I went to the emergency room for a completely different reason.

The CT scan let him see my spine and make a diagnosis, without referring me to get the same imaging done a second time. I avoided unnecessary (and potentially harmful) radiation, saved money and my doctor was able to immediately turn his attention to what was most important: helping me resolve my back problems.

Historically, each doctor would see a different piece of your unique health care puzzle depending on your need. Now, tools like electronic medical records and e-prescribing put the pieces together so doctors have an entire picture of your health, allowing them to make more informed decisions and health care recommendations.

If my orthopedic surgeon hadn’t been able to access my health file, he would have had to order the same test that I had already done in the emergency room. These types of unnecessary or duplicative tests can clog up the health care system, making it more cumbersome for the people who truly need it. They also drive up health care costs.

This blog was written by Alina Pabin, pictured right, a Blue Cross employee and member. To check out other Blue Cross blogs, visit mibluesperspectives.com and ahealthiermichigan.org.
Borgess Medical Group drops its rate of uncontrolled diabetic patients by 10 percentage points

Ascension Health issued a challenge to primary care doctors across its system: “Improve quality performance within 90 days.”

Borgess Medical Group chose diabetes management. Their mission? Lower hemoglobin A1c rates to less than 9 for 1,800 patients with uncontrolled diabetes in 90 days. Their rate of uncontrolled diabetes patients was hovering at 29.6 percent.

By breaking down the problem and thinking strategically, the Borgess team found that it didn’t have 1,800 patients with uncontrolled diabetes. Instead, it had 1,800 patients who hadn’t had their blood sugar checked in more than a year (one of the stipulations of the measure).

A quality improvement team chose different methods to contact patients.

- A campaign was launched to reach out to all patients with diabetes in need of an A1c test, using order proposals, portal communication and letters.
- Clinical pharmacists called the patients to set up appointment times.

The result? The improvement team, which set out to drop its rate of uncontrolled diabetic patients by 6 percentage points between May and June, ended up dropping it by 10 points.

“We were able to go to our Borgess providers and care coordinators to thank them for actually having a very low rate (9.4 percent) of ‘uncontrolled’ diabetic patients. The real problem was not those patients who they were working with, but those who they were not,” said Cindy Gaines, administrative president of the Borgess Medical Group.
What is a PCMH?

A care team led by a primary care physician who:

- Works closely with each patient to focus on his or her individual health needs
- Coordinates patient care, tests and prescriptions across all health care settings
- Offers around-the-clock access to someone in the practice who can make clinical decisions
- Manages patients’ chronic conditions, such as asthma or diabetes

PCMH designation program gains national recognition

In October, the Centers for Medicare & Medicaid Services recognized Blue Cross Blue Shield of Michigan’s Patient-Centered Medical Home program as meeting the PCMH criteria for its new Quality Payment Program.

This means that physicians who are designated as PCMH practices through Blue Cross will receive full credit toward one of the required components to earn incentive payments for their Medicare patients.

“This is a huge achievement for our PCMH model, and we have to thank the more than 20 medical associations and community groups that advocated on our behalf,” said David Share, M.D., senior vice president of Value Partnerships.

“These groups encouraged CMS to consider the Blue Cross PCMH model as a qualifying regional program.”

PCMH by the numbers

As of September 2016, Blue Cross designated 1,638 physician practices — representing 4,534 primary care physicians — as PCMH, an increase of more than 4 percent over the previous year.

Our PCMH-designated practices are in 80 of Michigan’s 83 counties.

More than 1.2 million Blue Cross members receive care from one of our PCMH-designated practices.

PCMH practices, compared to non-PCMH practices, had:

- 15% lower rate of adult ER visits
- 21.4% lower rate of adult ambulatory care sensitive inpatient stays
- 18.1% lower rate of adult primary care sensitive ER visits
- 22.7% lower rate of pediatric primary care sensitive ER visits
- 17.2% lower rate of overall pediatric ER visits
Teen takes control of his health with help from his PCMH

From a relatively simple ankle injury to a teen’s diagnosis of prediabetes, the value of a dedicated multidisciplinary care team in a Warren pediatric office was clearly evident.

In the spring of 2016, Macomb Pediatric Associates was informed that their patient, Michael Azar, then 17, had been discharged from an emergency room with an ankle injury. Macomb Pediatric Associates scheduled a follow-up visit to check on Michael’s ankle, but also took a more comprehensive approach — blood work revealed high hemoglobin A1c and insulin levels, indicating he had prediabetes.

Because Macomb Pediatric Associates, a member of physician organization Medical Network One, is a patient-centered medical home, Michael was assigned a team of health care professionals to help him manage and improve his health.

In addition to his primary care physician, Antoun Oska, M.D., Michael’s care team included a nurse care manager and registered dietitian care manager, who had face-to-face visits and follow-up phone calls with both Michael and his father. Dr. Oska followed Michael’s progress closely, coordinating care with the care managers and monitoring Michael’s labs.

The team provided Michael with tools and information to help him self-manage his lifestyle to include healthier food and beverage choices and daily physical activity.

Because Dr. Oska speaks Arabic, he was also able to communicate with Michael’s parents in their primary language, which was particularly helpful for Michael’s mother, who speaks and understands minimal English. Dr. Oska’s reinforcement of the care team’s message about the importance of proper nutrition and exercise helped lead to healthier meals at home that benefitted Michael’s entire family.

Since working with his care team, Michael’s weight is down and his energy is up. He has taken more active control of his health; he exercises and makes healthier food and lifestyle choices. The lab results are measurable, too. Michael now has a lower hemoglobin A1c (down about 5 points) and his “good” cholesterol levels improved by six points.

“They have done a good job to keep me informed,” Michael said of his care team. “They answer my questions.”
PCMH helps group customers rein in health care costs

Group customers who purchase health insurance for their employees continue to struggle with the rising cost of health care. Key drivers of health care costs include chronic conditions, such as diabetes, heart disease and hypertension. These conditions can be managed by addressing modifiable risk factors, including diet, obesity, inactivity, smoking, alcohol intake and high cholesterol.

Patient-centered medical homes are uniquely positioned to affect health care costs as they relate to costly chronic conditions. With its team-based approach, a PCMH practice focuses on early detection, prevention and risk management. Helping patients make lifestyle changes to manage chronic conditions requires regular interactions with members of a health care team — and PCMH practices stand ready to provide that level of support.

But that’s not all. PCMH practices provide care coordination across the entire health care spectrum, ranging from behavioral health professionals to physician specialists. This leads to better health outcomes for patients and controls health care costs.

2 ways PCMH is benefiting doctors

PCMH benefits doctors in many ways. Here are two of them:

- PCMH-designated doctors who meet certain clinical quality and cost benchmarking criteria — and who participate in the Provider Delivered Care Management program — can receive as much as 140 percent of the Blue Cross standard fee schedule. (For more on PDCM, see Page 16.)

- When CMS recognized Blue Cross Blue Shield of Michigan’s PCMH program, it paved the way for PCMH practices to receive merit-based incentives under Medicare’s Quality Payment Program.

Did you know?

Blue Cross’ PCMH program is the largest of its kind in the country.
Provider Delivered Care Management: Better coordination for chronic conditions

Our Provider Delivered Care Management program helps ensure that patients with chronic conditions receive effective and personalized care through their medical home, leading to better outcomes and lower costs.

The care team is led by a trained care manager. Additional team members may include:
- Nutritionist
- Certified diabetes educator
- Social worker
- Pharmacist

Participating practices provide patient evaluations, follow-up visits, group education and telephone assessment. Practices receive additional reimbursement for providing these care management services.

At right we offer a look at how one practice is using care management to help a patient.

Phil Kroll’s nurse care manager, Angie Siegmon, at right, talks with him about his conditions while Dr. Katherine Marston looks on.
Anchor Bay Clinic helps patient manage 8 conditions

It takes a village. And for Phil Kroll, that village is Anchor Bay Clinic, a patient-centered medical home in southeast Michigan and a member of the Medical Network One physician organization.

At age 75, Phil has eight major conditions, including coronary artery disease, chronic obstructive pulmonary disease, Type 2 diabetes, lung cancer and back problems. His care team at Anchor Bay helps him successfully manage these conditions. The multidisciplinary team includes a nurse care manager, behavioral health specialist, pharmacist and dietitian, as well as his primary care physician, Katherine M. Marston, D.O.

“I come in here when I don’t feel good. I come down here to find out what’s going on,” Phil said. “They take care of my problems.”

Angie Siegmon, R.N., is Phil’s nurse care manager. She communicates with the doctors and Phil about his conditions.

“Angie helps us to communicate with patients and checks in on them to make sure they are following and understanding everything that we may have talked about during their visit,” Dr. Marston said.

Phil added: “Angie has made a big difference for me personally.”

His blood pressure is under control, as well as his diabetes.

“Angie calls me often, sometimes even once a week to make sure everything is OK (or find out) if I need anything,” Phil said. “And I appreciate that.”

He worked with the care team dietitian to change his diet. When the dietitian first saw Phil on Jan. 12, 2016, his A1c was 6.7. A recent reading was 6.0.

Tia Ollie, an embedded pharmacist at Anchor Bay Clinic and director of pharmacy innovation at Medical Network One, has also made a big difference in the care of Phil and other patients in the practice.

“Tia is amazing,” Dr. Marston said. “She goes through all of the medications with the patients in detail. She reiterates what we changed, makes sure they understand the changes so that there’s no confusion. It’s really important to educate patients on appropriate use of medication and that helps the patients dramatically.”

By working together, the care team saved Phil from unnecessary trips to the emergency room. They don’t hesitate to send him to a specialist when they think it might benefit him.

Phil said he’s also convinced that when he was referred to John Kazmierski, D.O., a cardiologist, his life was saved.

“They take good care of me,” he said.

Phil has had such a positive experience at the practice that his daughter is now a patient at Anchor Bay Clinic.

Pharmacist provides support to improve patient care

Tia Ollie, Pharm.D., is a board-certified pharmacotherapy specialist who’s an embedded pharmacist at Anchor Bay Clinic in Chesterfield Township. It’s a role she took on after joining the physician organization Medical Network One in late 2015 as director of pharmacy innovation.

Tia is a member of the first group of pharmacists participating in the Michigan Pharmacists Transforming Care and Quality initiative at Michigan Health. She brings her pharmacy skills into primary care practices, such as Anchor Bay. Her responsibilities include working as part of a multidisciplinary team, including the primary care physician, to ensure patients are properly taking their medication, answer patient questions and reconcile their medication.

Tia works with patients individually. She reviews medication plans, collaborates with physicians to make necessary medication changes and helps patients understand how to safely take their medications.

With a population-based approach, Tia targets specific high-impact measures (diabetes, blood pressure and medication adherence) as well. She’s a liaison between patients, their doctors and the pharmacy.

The specialized knowledge and experience of clinical pharmacists such as Tia allows them to identify barriers to medication adherence and provide customized solutions. Their involvement in primary care teams significantly improves medication adherence and chronic illness care.

Blue Cross provides financial support to the MPTCQ Coordinating Center, as well as to physician practices participating in the initiative.
OSCs: Coordinating care across all health care settings

Organized Systems of Care, similar to Accountable Care Organizations, are communities of doctors and hospitals within our PPO network that collaborate to provide coordinated, high-quality patient care. OSCs form the basis of one of our newest products, Blue Cross® Personal Choice PPO.

Blue Cross® Personal Choice PPO launched in October 2016. Within just two months, more than 1,000 members had enrolled in this groundbreaking product. Members can choose to receive care within an OSC for lower out-of-pocket costs while maintaining access to the full Blue Cross PPO network.

Members who select a primary care doctor who is affiliated with a Level 1 OSC — and who use other health care providers associated with that OSC — receive high-quality, coordinated care at the lowest out-of-pocket cost. Members who have selected a primary care doctor in a Level 1 OSC — but who seek services from other doctors and hospitals outside of that OSC — require a referral from their primary care doctor to stay at the Level 1 cost share.

An agent’s perspective on Blue Cross® Personal Choice PPO

Jeff Hauser, senior director with Action Benefits, one of two managing agents for Blue Cross, offers his thoughts about Personal Choice PPO.

I think a key selling point is that Personal Choice PPO creates financial incentives for members to engage in managing the cost of their health care services through innovative plan design. It introduces consumer-driven market incentives, like price transparency and performance-based competition, that bend the cost curve without sacrificing access to the broadest PPO network in Michigan.
CQIs: Improving outcomes, reducing complications in hospital and office settings

For nearly 20 years, Blue Cross has been helping physicians and hospitals collaborate to improve patient outcomes in some of the most common and costly areas of medical and surgical care. We call these value-based, quality improvement efforts Collaborative Quality Initiatives.

In this year’s report, we’re highlighting three of them:

- Michigan Arthroplasty Registry, or MARCQI
- Michigan Spine Surgery Improvement Collaborative, or MSSIC
- Michigan Urological Surgery Improvement Collaborative, or MUSIC

Current Collaborative Quality Initiatives focus on the following areas:

Anesthesiology
Bariatric surgery
Blood clot prevention
Cardiothoracic surgery
Cardiovascular
Care transitions
Emergency medicine
General surgery
Hospital medicine safety
Knee and hip replacement
Oncology
Pharmacy
Prostate cancer
Radiation oncology
Spine surgery
Trauma
Value collaborative

We’re keeping our customers’ needs front and center

The health care industry looks a lot different today than it did a decade ago, and it will continue to change at a rapid pace. Our customers’ needs are changing, as well.

Today, our customers are asking that we remain competitive, help them manage their costs and ensure that their employees are receiving high-quality services. In Health Plan Business, we’re always looking for new and innovative ways to serve our customers.

That’s why we’re so pleased that our colleagues in Value Partnerships are working to achieve these same goals. Through programs such as our Collaborative Quality Initiatives, Patient-Centered Medical Home and value-based reimbursement, they’re helping to stem rising health care costs and improve the quality of health care for all our members.

A message from Jeff Connolly, senior vice president, Group Business, and president, West Michigan and Upper Peninsula
Michigan Arthroplasty Registry: Providing enhanced quality of life for patients with joint pain

There have been tremendous obstacles to creating a total joint arthroplasty registry in the past due to the lack of resources, an absence of standardization, an appropriate medical-legal environment and lack of collaborative efforts with information tools. I was originally skeptical about the implications of MARCQI being directly funded by the health care industry; however, allowing orthopedic physicians to take ownership of the project has led to unprecedented buy-in for the cause. This, in turn, has led to transparent and protected data that physicians and hospitals have fully accepted and which can now drive change and improve results.

It’s one thing to think you are doing well but another to have fairly accurate and objective data to corroborate these findings. This program gives us the metrics to use evidence-based care models and implement quality initiatives to improve the patient experience and outcome while improving the value of care provided.

Total joint arthroplasty is one of the most powerful things that we provide in the field of medicine, and it can provide a truly incredible improvement in the quality of life for these patients. We take patients who are often debilitated by severe joint pain and remove this disability to allow them to get back to enjoying a productive life. MARCQI has become a powerful instrument to allow us to better understand and evolve our practice.

It’s been an honor to be part of MARCQI as this has grown into one of the most valuable tools for total joint arthroplasty that I’ve seen. It’s created an evolutionary leap forward in driving system-based changes in quality of care. I’m truly grateful to MARCQI for providing these resources to allow us to be part of this advancement in medicine that’s improving the entire field of orthopedics.

Dr. Kory Johnson is the MARCQI clinical champion at Metro Health Hospital in Wyoming, Michigan.
Michigan Spine Surgery Improvement Collaborative: Sharing information about spinal surgery practices

As health care providers and surgeons, we strive each day to achieve the best outcomes for our patients.

We all have individual practice patterns based on knowledge acquired from medical literature, as well as from our own clinical experience and use of time-tested techniques to optimize surgical outcomes. As part of MSSIC, spine surgeons have an additional, unique opportunity: to openly exchange information about our spine practices.

MSSIC accrues data on tens of thousands of patients statewide, so we can explore various patient care management techniques and either validate them or modify them to achieve a best-practice approach that leads to improved results.

Since the information gathering is supported by a high degree of data analysis expertise, there’s a tremendous opportunity to identify factors that may lead to the best possible care for our spine patients. These best practices can only be gleaned by studying a large number of patients and their clinical outcomes.

We also have an opportunity to tackle difficult problems that have always been present in surgical practices — complications such as venous thrombotic events, which require large patient pools to discern meaningful differences resulting from preventive strategies.

Other more common morbidities, such as infection, urinary retention and conditions resulting in hospital readmissions, can be analyzed. Potentially, even minor variations in practices may hold the key to meaningful reduction in these types of events. In addition to exploring ways to reduce complication rates, MSSIC provides the foundation necessary to demonstrate and quantify meaningful positive outcomes from specific spine surgeries.

About MSSIC

The Michigan Spine Surgery Improvement Collaborative brings orthopedic surgeons and neurosurgeons together to study ways to improve spine surgery outcomes in Michigan. By collecting and sharing data — and discussing their observations — physicians in participating hospitals are developing best practices to reduce surgical complications, reduce the cost of this care, improve the ability of patients to function after spine surgery and reduce the need for subsequent surgeries.
Michigan Urological Surgery Improvement Collaborative: Finding better ways to treat and manage prostate cancer

After his doctor said the word “cancer,” Bill Crooks, pictured at left, didn’t hear much else as he tried to absorb the news.

“Hearing the diagnosis … it feels like life is over,” the Grand Rapids Township man said.

Diagnosed with prostate cancer in 1993, at age 60, he opted for surgery to “get it out” of his body. The operation was successful, and Bill has been cancer-free for more than 20 years. But he had to endure the surgery’s side effects of erectile dysfunction and incontinence.

So what if men such as Bill, who was diagnosed with a lower-risk form of prostate cancer, never had to be treated surgically?

Advancements in prostate cancer treatment have made it possible for some men to opt for active surveillance of the cancer, which allows them to avoid negative consequences that can dramatically decrease their quality of life.

“Looking back, I wish what’s available now was available to me then,” said Bill, speaking of the Michigan Urological Surgery Improvement Collaborative.

Giving cancer patients a voice

To ensure the patients’ voices are heard, MUSIC includes four men with prostate cancer as active participants in the collaborative. Bill is a member of the group.

Bill said having a voice with the group has allowed him to impart a deeper understanding to the doctors involved about what it’s like to be a cancer patient. He wants the doctors involved in other men’s care to know that they are real, whole people who trust in the decisions made by the medical professionals caring for them.

“I’ve spent 20 years being a mentor to men who have been diagnosed and are in the process of making a decision or living with the decisions that they have made and the treatments they have had,” Bill said. “This gave me another venue to speak directly to the physicians, and I think it is amazing how they value those of us who are patient advocates. They truly value what we have to say.”

Bill views his role as helping to validate what doctors likely already know or suspect about the patient and family experience, rather than helping to guide any clinical decisions.

“I think it’s putting in front of the physicians that we rely heavily on them and their learned decisions,” he said. “I think treating those close to us with compassion and respect is also very important.”
Real results

Since the collaborative was formed in 2012, MUSIC has achieved a number of successes, including:

- A statewide decrease in the use of both bone scans and CT scans for men with low-risk prostate cancer. This significantly reduces the amount of radiation men with low-risk cancers are exposed to.

- A nearly 50 percent reduction in prostate biopsy-related hospitalizations has been achieved by implementing a process change to address antibiotic-resistant bacteria.

- Implementation of an electronic infrastructure for measuring and, ultimately, improving functional outcomes after radical prostatectomy. By having patients fill out an electronic questionnaire before and at several points after surgery, MUSIC has been able to assess in detail men’s functional performance pre- and post-op. This has helped the group consider strategies to decrease erectile dysfunction and incontinence, the two main side effects of the surgery.
Spreading the Value Partnerships message

Sharing best practices with other Blue plans
Blue plans from across the country have expressed interest in learning more about our Value Partnerships program and how it can improve health care safety, quality and efficiency. Over the past year alone, Value Partnerships leadership met with senior executives from the following Blue plans to discuss various initiatives within Value Partnerships:

- Anthem Blue Cross and Blue Shield (Ohio)
- Blue Cross Blue Shield of California
- Blue Cross Blue Shield of South Carolina
- Blue Cross Blue Shield of Tennessee
- Excellus BlueCross BlueShield (New York)
- Hawaii Medical Service Association
- Independence Blue Cross (Pennsylvania)

Speaking about health care transformation in Hawaii
When the Hawaii Medical Service Association was putting together a panel of national experts to discuss health care transformation, it reached out to Blue Cross Blue Shield of Michigan.

David Share, M.D., senior vice president of Value Partnerships, represented Blue Cross at the multiday summit in September 2016. He shared best practices and lessons learned over the past 10 years in developing the Physician Group Incentive Program and implementing value-based reimbursement arrangements.

“I have great admiration for the ambitious, multi-stakeholder effort which the Hawaii Medical Services Association, our sister Blue plan in Hawaii, is undertaking to transform the health care system across all of the Hawaiian Islands,” Share said. “Their vision and inclusive approach are far-reaching and progressive. We have much to learn from each other.”
"I was honored to be invited to speak to a national audience about Blue Cross and our work to make health care affordable while providing the best quality care. Through innovations like offering lower cost, higher-value provider networks, Blue Cross is positioned as a leader in health care value. It was a great opportunity to showcase our health care innovation, share our successes and talk about the lessons we learned."

Kevin Klobucar,
executive vice president,
Health Care Value