



The **Value** of **Partnerships**

An innovative approach



In its 2001 report, *Crossing the Quality Chasm*, the Institute of Medicine issued the following challenge to the health care industry: “Even among health care professionals motivated to provide the best care possible, the [current] structure of payment incentives may not facilitate the actions needed to systematically improve the quality of care, and may even prevent such actions.... The goal of any payment method should be to reward high-quality care and to permit the development of more effective ways of delivering care to improve the value obtained for the resources expended.”¹



A need for change

As noted by the Institute of Medicine, traditional payment methodologies, such as fee-for-service, capitation and salaried structures, were not designed to reward quality or performance, but rewarded providers for the number of patients being treated and the volume of services delivered per patient. The need for change became apparent when payment methods were recognized as a barrier to improving the quality of care. Even before the Institute of Medicine began its quality study in 2001, BCBSM was already finding innovative ways to encourage provider collaboration and achieve substantive change in the delivery of services.

A recent analysis by San Diego-based consulting firm, Premier, concluded, “If all hospital inpatients nationwide in 2006 received most or all (76 percent to 100 percent) of a set of widely accepted care processes in four key clinical areas — pneumonia, cardiac bypass, acute myocardial infarction, and hip and knee replacement — there would have been nearly 5,700 fewer deaths, 8,100 fewer complications, 10,000 fewer readmissions, 750,000 fewer hospital days, and a savings of \$1.35 billion across the U.S. health care system.”

Source: M. Hagland, “*Catching the P4P Wave*,” November 2006, Healthcare-Informatics.com



valuepartnerships

An innovative approach

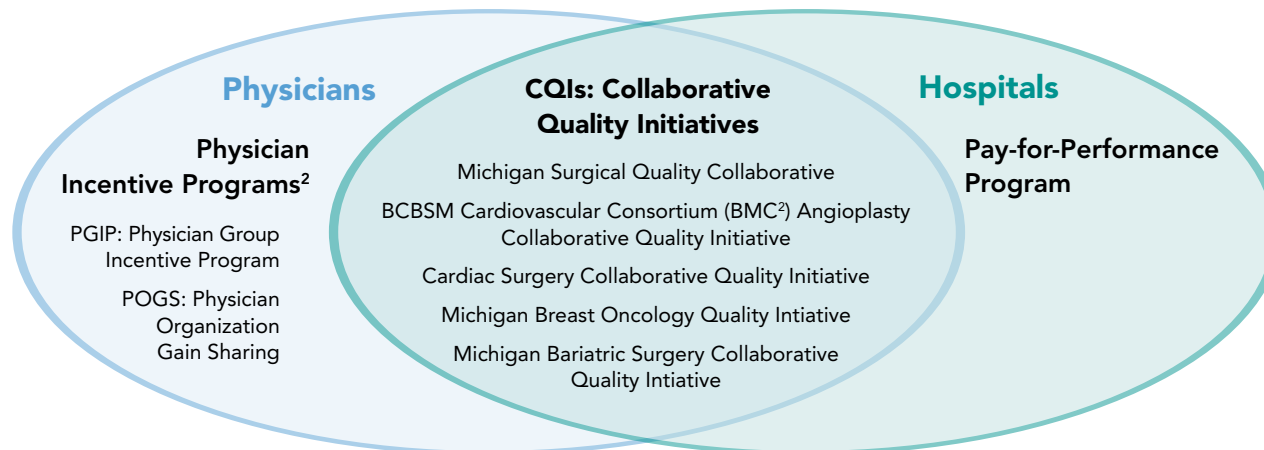
Discarding traditional approaches to rewarding providers, Blue Cross Blue Shield of Michigan has launched its **“Value Partnerships”** program — a ground-breaking, innovative approach to improving health care quality and efficiency. Through “partnering for value,” this program creates incentives for providers to partner with each other and enables BCBSM to give doctors and hospitals the support needed to transform health care in Michigan.

Value Partnerships encompasses several initiatives: five collaborative quality initiatives focused on surgical care, physician group partnerships and a hospital pay-for-performance initiative. Unlike early pay-for-performance programs, which rewarded individual physician performance,

Value Partnerships incentives are focused on physician groups, hospitals and collaborative quality improvement.

The advantage to a collaborative arrangement, like **Value Partnerships**, is that the provider, rather than the insurer, takes the lead in evaluating and improving the quality and efficiency of care. Improvements are determined using sound clinical and scientific information to guide these efforts. BCBSM’s **Value Partnerships** supports health care providers in their efforts to create systems of care that facilitate the provision of evidence-based care to patients. When doctors know what care is proven to work, they are motivated to do everything possible to ensure all patients who can benefit from evidence-based treatment actually receive it.

Value Partnership Programs



²The PGIP and POGS programs will be combined into a single physician partnership incentive program in 2007.

“Working hand in hand with providers to identify the most effective processes and treatments is the key to the success we know *Value Partnerships* will achieve. Our commitment to evidence-based medicine ultimately will make everyone successful — the doctor, the patient, the insurer and the provider of health benefits. The bottom line results will be improved quality of care for patients and significant dollars saved for businesses and individual health care purchasers.”

Daniel J. Loepp,
President and CEO, BCBSM

Initial approaches to incentives

In recent years, payers developed *pay-for-performance* and *centers of excellence* programs to reduce unnecessary costs by encouraging and rewarding high-quality providers. Pay-for-performance programs aim to improve quality by either rewarding the best performers or by rewarding good performance in all settings with financial bonuses. Centers of excellence were created to steer members to hospitals that are likely to provide best results with respect to specific conditions or procedures.

Pay-for-Performance

Pay-for-performance programs are proliferating throughout the country, including the recent launch of Medicare’s P4P program, which rewards providers for reporting on hospital quality measures. The traditional industry approach identifies and rewards individual high performers. Pay-for-performance programs are aimed at encouraging improvements in quality in all settings by rewarding superior quality with direct financial bonuses. Often, results of these programs are reported and compared publicly, increasing consumer awareness of provider performance against a set of quality and cost standards. This approach is often thought to be an effective motivational tool for providers as the focus is on individual provider performance rather than that of the group. Results are also used to support many consumer-directed health care plans.

Centers of Excellence

Centers of excellence are regional networks of high-quality hospitals that meet rigorous quality criteria and demonstrate extensive expertise in performing a particular procedure, set of procedures or treating a particular disease condition. COE participants are also chosen because they exhibit more successful outcomes than other hospitals, including lower rates of complications, readmission and mortality. Provider participants are encouraged to share information among themselves and this process is facilitated through an annual compliance reporting process. Shared information is used to revise and refine quality standards and determine best practices to improve outcomes, patient satisfaction and reduce overall health costs. Patient selection of a COE versus a non-COE provider is generally voluntary in open access plans.

BCBSM was the first

BCBSM was an innovator in incentive programs to improve health care quality, launching its first hospital incentive program in 1989, followed by its first COE effort in 1996. The revised BCBSM *Hospital Pay-for-Performance Program*, developed in 2000, updated our original hospital incentive program to more directly reward short-term acute care Michigan hospitals for their efforts to improve efficiency and quality. A front-runner in the industry, the BCBSM P4P program was developed cooperatively with hospitals, physicians and other quality experts and has drawn national attention and awards from prestigious institutions such as the Harvard Medical School (in conjunction with the Blue Cross and Blue Shield Association), the National Business Coalition on Health and the Robert Wood Johnson Foundation's Rewarding Results program.

Through this program, Michigan short-term acute-care hospitals have the opportunity to earn additional amounts on their inpatient and outpatient payments by demonstrating high quality, cost-effective performance and participating in BCBSM's Collaborative Quality Initiatives as well as the Michigan Hospital Association Keystone Hospital-Associated Infection program. Hospitals must also meet specific prequalifying conditions, such as implementing and maintaining a culture of safety, to be eligible for the program.

Overall, hospital performance has improved each year the P4P program has been in place. As hospitals meet program goals, new goals are set to raise the bar on quality. Michigan hospitals that participate in our P4P program have a noticeably better performance record on specific quality indicators than those that don't participate, and they also outperform U.S. hospitals as a whole. (See *BCBSM Hospital Pay-for-Performance Program insert for further details.*)

Another first for BCBSM

Established in 1996, a network BCBSM Cardiac Centers of Excellence program engages Michigan hospitals committed to quality of cardiac care with fewer medical complications and longer life expectancy.



To qualify for cardiac COE designation, hospitals must:

- Demonstrate experience and expertise in offering a full range of cardiac services
- Perform a minimum volume of select procedures annually
- Monitor performance and be committed to continuous quality improvement
- Exhibit successful outcomes (including lower rates of complications, re-admissions and deaths associated with cardiac procedures)
- Employ cardiac care staff who meet credentialing criteria

Currently 13 Michigan hospitals and their cardiac care staffs have earned the right to be included in BCBSM's COE network.

Blues members expect us to ensure a quality product, and we have built quality monitoring into our COE program requirements. BCBSM has an annual COE reporting process that enables us to monitor compliance with regularly enhanced program standards. We also encourage collaboration among program hospitals in sharing process information and implementing ways to improve how care is provided. Since the inception of the program, our COEs have delivered high quality and positive financial results.

National reach

Across the country, Blue Cross and Blue Shield members also have access to similar high-quality specialty arrangements. Together, BCBS plans and the Blue Cross and Blue Shield Association have developed a nationwide program, Blue Distinction Centers for Specialty Care, designating specialty centers of excellence for the treatment of specific conditions. Blue Distinction Centers offer members a nationwide and comprehensive approach to specialty centers in the areas of transplants, bariatric surgery and cardiac care. Hospitals designated as BCBSM Cardiac COEs are also recognized by the Blue Cross and Blue Shield Association as Blue Distinction Centers for cardiac services. (See *Blue Distinction Centers for Specialty Care* insert for more detail on specific components.)

A partnership and beyond

In 1997 the success of our Cardiac COEs spawned a partnership among BCBSM, hospitals and physicians to improve the quality of angioplasty care in the state. This partnership also formed the foundation for our first BCBSM Collaborative Quality Initiative. At the outset, BCBSM wanted to create a comprehensive, all-inclusive database for percutaneous coronary interventions (commonly referred to as cardiac angioplasties) that the entire community could use. About 600,000 PCIs are performed in Michigan each year, but practices vary widely.

With the development of the BCBSM Michigan Cardiovascular Consortium (BMC²) Angioplasty CQI project, health service researchers from the University of Michigan and cardiologists from 19 hospitals across the state convened to develop a data registry that included the details from every PCI case performed at participating hospitals. BMC² has since become a permanent component of our Cardiac COE program, allowing hospitals to collect cardiac patient outcomes using a statewide registry and easily share evidence-based guidelines with providers performing PCIs. BMC² is unique in that it provides a neutral ground for collaboration among otherwise competing cardiac hospitals.



“The successful collaboration between Blue Cross Blue Shield of Michigan and the top cardiovascular centers in the state illustrates what can happen when providers and insurers work together in a true partnership to study and improve cardiovascular care. In this case, thousands of Michigianians are receiving more effective and safer coronary care as a result of this effort.”

Kim Eagle, M.D., clinical director
of the University of Michigan
Cardiovascular Center

A partnership and beyond (continued)

Five years after the inception of the program, BMC² participating hospitals have observed dramatic decreases in emergency bypass surgeries, heart attacks, kidney failure requiring dialysis and mortality among angioplasty patients. Encompassing 80 percent of all angioplasty services in Michigan, the project has enhanced the safety and care of angioplasty patients statewide, saving lives, reducing serious complications and saving approximately \$2.5 million for BCBSM members and \$8 million for all Michigan patients annually through the avoidance of health care costs associated with those complications.

The success of BMC² has been featured in numerous publications. Most recently, the *New England Journal of Medicine* stated, "Although such efforts are now in the early stages of development in other states, in Michigan programs funded by Blue Cross Blue Cross Blue Shield of Michigan and Blue Care Network may become prototypes for pay-for-participation programs in surgery³." As we see it, the program is clearly a win-win proposition: Consumers benefit from the improved quality of medical care based on real, comprehensive data; providers benefit from keeping informed of what practices produce the best results; and we all benefit from keeping health care costs down.



Collaborative Quality Initiatives

Building on BMC²'s proven success in improving outcomes of care, BCBSM and our hospital provider partners launched the ground-breaking joint development of four additional CQIs. Our CQIs represent an innovative approach to improving health care where insurers and other payers provide financial and administrative support for hospitals and physician groups to collaborate with one another in evaluating and improving the quality of surgical and medical procedures. Nearly half of all Michigan acute care hospitals participate in at least one or more of our CQI efforts, and participation has expanded considerably with the integration of CQIs into our hospital P4P program.

BCBSM's CQIs have been called a "model" for the country by many industry experts and medical professionals. In fact, our CQI approach received one of only seven winning Blues Association 2006 "Best of Blue" awards for collaborative efforts in "excellence and innovation."

BCBSM's five CQIs are aimed at assessing and improving the quality of care for common major procedures received by an estimated 125,000 Michigan patients who undergo these procedures annually: 1) angioplasty; 2) cardiac and thoracic surgery; 3) general and vascular surgery; 4) bariatric surgery; and 5) breast cancer treatment.

³Birkmeyer, Nancy and John Birkmeyer. "Strategies for Improving Surgical Quality — Should Payers Reward Excellence or Effort?" *The New England Journal of Medicine* v. 354, no. 8 (2006): 864-870. b

Collaborative Quality Initiatives (continued)

To initiate a CQI, BCBSM identifies which procedures present significant opportunities to improve patient care, thereby increasing the potential for better health outcomes.

Each BCBSM CQI is based on the same guiding principles:

- Identifying Michigan hospitals interested in collaborating to improve surgical quality
- Establishing a sustainable, cost-efficient system for tracking and examining surgical processes and their link to outcomes at each participating hospital
- Collaborating with clinical champions at each participant hospital in identifying and implementing “best practices”
- Fast-tracking quality improvement initiatives targeted at specific, high-leverage procedures
- Linking quality improvement efforts to rigorous health services research, with the ultimate goal of improving surgical care across an entire region
- Demonstrating that systems of care are effectively working to optimize surgical quality and outcomes

The CQI model is unique in that it places data collection, analysis and quality improvement interventions in the hands of providers. Engaging physician participants creates an atmosphere of empowerment and goodwill to identify improvement opportunities by those who can make change happen. A coordinating center for each program (usually a teaching hospital with research focus) facilitates data analysis and sharing among participant hospitals. Data sharing among hospitals is critical to program success and essential to identifying which processes are most efficient and where they

may need to improve. Although hospitals are competing for the same patients and revenue, provider ownership of the data motivates buy-in and fosters trust among participants, which increases the likelihood of active use of the data for self-assessment and for guiding quality improvement interventions.

BCBSM’s CQI model is the first of its kind and is well-suited for national adoption as it will create systemic improvements, beginning a long-term quality improvement process. The objectives of our CQIs are to identify best practices, improve processes of care and reduce complications from surgical and medical procedures, which often lead to unplanned health care services and costs. The *New England Journal of Medicine* recently provided further encouragement for such an approach. Because surgical complications are very expensive and can cost more than \$10,000 per case on average, the Journal further states that “there is reason to hope that pay-for-participation programs [such as [Value Partnerships](#)] will reduce payers’ costs as effectively as they will improve patients’ outcomes.”⁴

BCBSM also has plans underway to launch new Collaborative Quality Initiatives for Peripheral Vascular Intervention and Cardiac Imaging services in 2007. (See *BCBSM CQI program insert for further detail.*)



Partnering with physicians

In addition to our CQIs, which are primarily hospital-based, BCBSM's *Value Partnerships* umbrella also covers our innovative partnerships with physicians. The Physician Group Incentive and the Physician Organization Gain Sharing programs functioned separately prior to 2007, and represented BCBSM's initial award-winning collaborative approach to physician partnerships. Our PGI program, implemented in 2004, was recognized by the Blue Cross and Blue Shield Association as a 2006 "Best of Blue" Award recipient for its collaborative approach to "achieving excellence and innovation." Beginning in 2007, the PGI and POGS programs have been combined into one physician initiative with a single performance assessment and reward process. The newly combined program incorporates aspects from each initial program such that the resulting initiative remains uniquely innovative in the industry.

What makes our physician partnerships so unique is that they were developed with considerable physician input — after all, who knows better how to optimize health care value than those that are delivering the care! The overall objective of these partnerships with physician organizations is to reward physicians for improving care for chronic conditions, which is expected, among other benefits, to reduce health system costs in the long-term. Although chronic conditions exist in only about 20 percent of the overall population, they constitute almost 75 percent of total health care expenditures. The collective partnerships impact over 1.4 million Michigan patients receiving care from participating primary care and selected specialty physicians. (See *Value Partnerships with Physicians insert for map of physician group participants by county.*)

These physician partnership programs focus on improving the identification and care of patients with chronic diseases, increasing the linkage of BCBSM patients to BCBSM clinical programs and increasing appropriate generic drug prescribing. Physician groups are rewarded for contributing to overall system savings through improved generic prescribing and reducing per member per month cost in highly-utilized drug categories. To date, physician groups representing a broad geographic distribution throughout the state are actively participating and results have been very positive. To illustrate, since 2005, physicians have invested in group-based "all payer" disease registries and e-prescribing capabilities, saved BCBSM customers millions of dollars through cost-effective generic prescribing and increased the referral of patients to BCBSM care management programs.



"The physician quality initiatives were designed with input from physicians — strong collaboration that has resulted in a shared sense of ownership and responsibility for their ultimate success."

Thomas Simmer, M.D.,
Senior Vice President for
Health Care Value and
Provider Affiliation and Chief
Medical Officer, BCBSM

Partnering with physicians (continued)

Other physician partnership program features introduce the concept of gain-sharing and challenge physicians to collaboratively focus on system process improvements that maintain quality while decreasing overall cost. Physician groups are also encouraged to suggest new opportunities for future quality improvement and cost savings initiatives to BCBSM to illustrate that they are fully engaged in the program.

In fact, some participants have taken the lead to form their own sub-groups, run by and for the physician groups themselves, independent of BCBSM leadership. These groups focus on challenges such as engaging patients in self-management, implementing planned care visits, and identifying and acting on savings opportunities; without compromising the quality of care. Initial physician feedback suggests that physicians are excited about the opportunity to share in new system process improvements and in the savings which will ultimately result. With the introduction of the gain-sharing features in 2006, we now have over 5,000 physicians in the state partnering with us to improve and deliver efficient and high quality care, not only for our members, but for the entire health care system. (See *Value Partnerships with Physicians* insert for further detail.)

Partnering for value

The ultimate goal of *Value Partnerships* is to work with providers to forge a common vision of a preferred health system and to energize them to transform the system to meet that vision. The role of a health plan should be to facilitate, encourage, support and reward improvement. Driving quality care improvement through provider-directed change will benefit not only our customers but all participants in the health care system. We are not in the business of delivering care — our members do not want us acting in, or interfering with, the role of the provider. Rather, the value of such a relationship comes from each of us doing our part to improve the quality of care — that's what *Value Partnerships* is all about.



Blue Distinction CentersSM for Specialty Care

Blue Distinction Centers for Specialty Care is the Blue Cross and Blue Shield nationwide program that provides quality Centers of Excellence for transplant services, cardiac care and bariatric surgery. Blue Distinction Centers do not disrupt or replace local Blue programs; rather, the national program is available to employers interested in consistent, high-quality care nationwide for their employees. Members and providers are encouraged to contact their local Blue plan designated care coordinator who can explain coverage and determine how benefits apply. The following chart indicates primary care and other services available within each Blue Distinction Centers for Specialty Care. (A map indicating participating Blue Distinction Centers by state can be found on the back of this card.)

Features	Transplants	Cardiac Care	Bariatric Surgery
<i>Primary Focus</i>	<ul style="list-style-type: none"> • Heart • Lung (deceased and living donor) • Combination heart bilateral lung • Liver (deceased and living donor) • Simultaneous pancreas kidney • Pancreas • Combination liver kidney • Bone marrow and stem cell (autologous & allogeneic) 	<ul style="list-style-type: none"> • Inpatient cardiac care • Cardiac rehabilitation • Cardiac catheterization (including percutaneous coronary interventions) • Cardiac surgery (including coronary artery bypass graft surgery) 	<ul style="list-style-type: none"> • Inpatient care • Post-operative care • Follow-up care • Patient education
<i>Other Services</i>	<ul style="list-style-type: none"> • Global pricing • Financial savings analysis • Global claims administration support • Referral management • patient satisfaction survey reports • Transplant-related continuing education programs for Blue plans 		

As indicated in the chart below, the benefits of Blue Distinction Centers for Specialty Care far exceed those of the competition.

Features	Blue Distinction	Aetna	CIGNA	United
<i>Available in at least 25 states</i>	XX	X	X	X
<i>Credible outcomes-focused metrics</i>	XX	X	XX	
<i>Designed in collaboration with provider groups</i>	XX		X	X
<i>Transparent thresholds for qualifying centers</i>	XX			X

<input type="checkbox"/>	No program	<input type="checkbox"/> X	Some Programs	<input type="checkbox"/> XX	All Programs
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Blue Distinction Centers for Specialty Care throughout the U.S.

as of January 2007

Single Location Multiple Locations



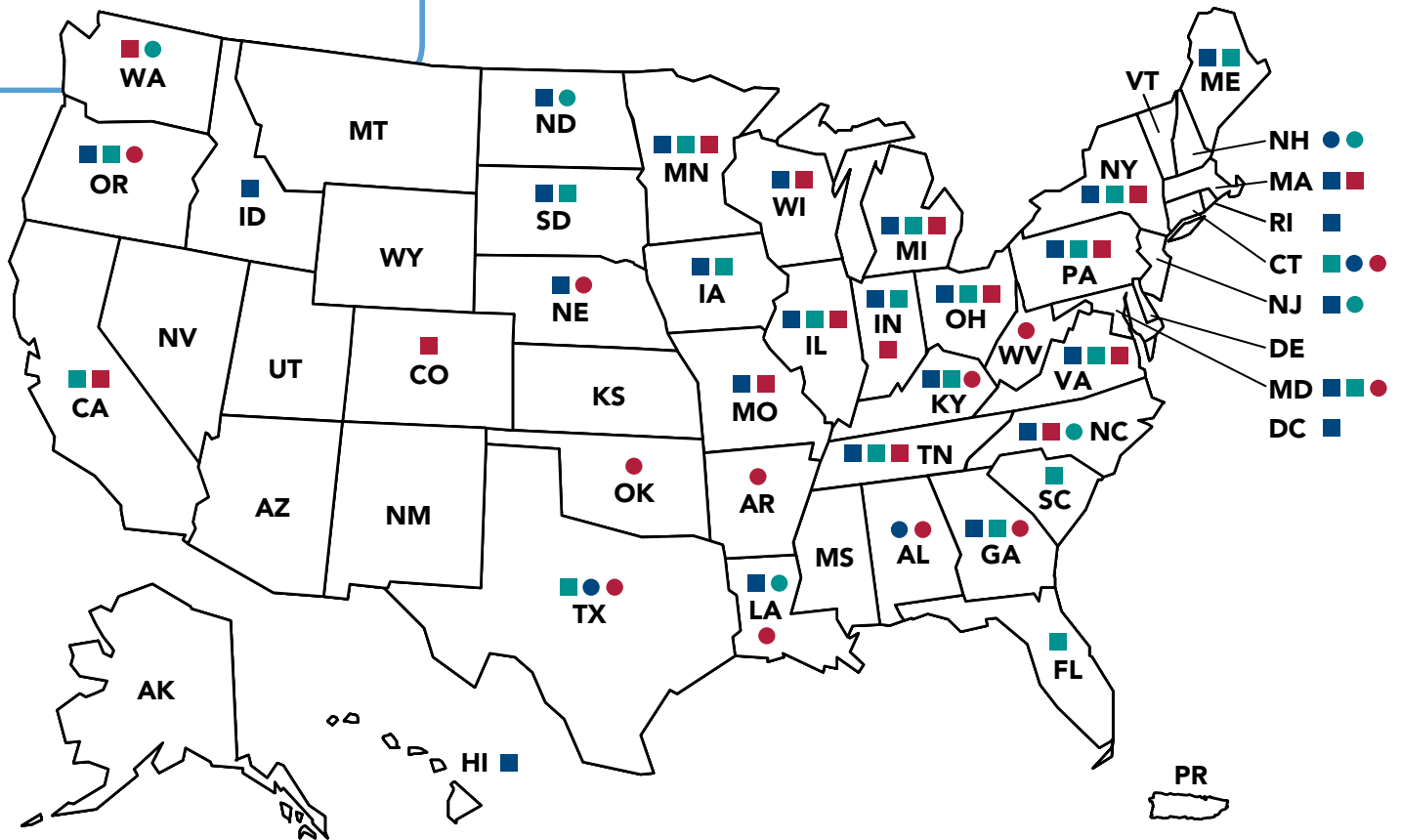
Cardiac



Bariatric



Transplants

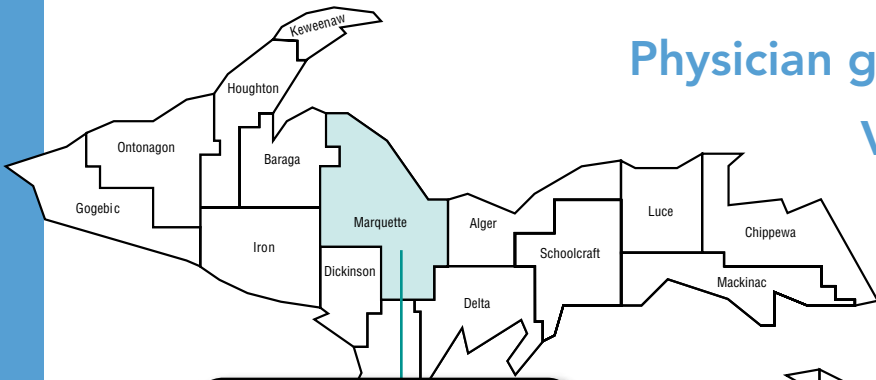


Blue Cross Blue Shield of Michigan Value Partnerships with Physicians

Our Physician Group Incentive and Physician Organization Gain Sharing programs are unique partnerships developed with physicians to improve the way health care is delivered. The focus of these programs is to create collaborative relationships between providers and BCBSM, as well as between individual providers to optimize health care value. Both programs encourage physician groups to share best practices with colleagues to transform health care and ensure physicians are providing the highest possible value to patients. Over 1.4 million BCBSM members are impacted by both programs. Beginning in 2007, the PGIP and POGS programs will be combined into a single physician partnership incentive program, and contributing features of both are listed below.

Features	Physician Group Incentive Program	Physician Organization Gain Sharing Program
<i>Program Description</i>	<p>Launched in 2004</p> <ol style="list-style-type: none"> 1) Improving chronic illness care 2) Improving patient participation in care management and shared decision-making programs 3) Improving prescribing patterns (increasing generic prescribing) for BCBSM members 	<p>Launched in 2006</p> <ol style="list-style-type: none"> 1) Achieve measurable savings in pharmacy costs, laboratory costs diagnostic imaging and in-network referrals 2) Strengthen the performance improvement infrastructure available to clinicians 3) Share savings achieved from improved practices with physicians
<i>Program Components</i>	<p>Rewards physician groups for improving the care of patients with chronic illness; linking patient to care management and shared decision-making programs; and, implementing cost-effective prescribing practices. BCBSM expects the program to create fundamental changes that will improve efficiency and positively impact the quality of care Michigan residents receive.</p>	<ul style="list-style-type: none"> • To improve the efficiency and quality of care, initial focus is on generic drug prescribing, effective prescribing in a few selected drug categories and improving treatment of patients with chronic conditions. • POGS will also include a focus on improved efficiency in the use of ancillary services such as laboratory and diagnostic imaging services, and oncology and cardiology services. • Payment includes: 1) incentive pool group payment for efforts to improve the efficiency of health care service delivery; and 2) sharing in overall program savings through higher fees and or direct payment to physician organizations.
<i>Physician Partners</i>	<p>16 physician groups with 2,900 primary care physicians (and some specialists) in 48 Michigan counties</p>	<p>31 physician groups (15 active in both PGIP and POGS programs and an additional 15 groups in POGS) totaling nearly 5,500 physicians statewide</p>
<i>Targeted Population (in Michigan)</i>	<p>Nearly 702,000 BCBSM members are impacted by PGIP. The program focuses on members with chronic conditions such as diabetes mellitus, coronary heart disease, congestive heart failure and persistent asthma and/or patients with one or more of these chronic illnesses with depression as a comorbid condition.</p>	<p>Nearly 734,000 BCBSM members are impacted by POGS. The program focuses on members with chronic conditions such as diabetes mellitus, coronary heart disease, congestive heart failure and persistent asthma and/or patients with one or more of these chronic illnesses with depression as a comorbid condition.</p>
<i>Interventions</i>	<ul style="list-style-type: none"> • Encourage physician groups to establish the necessary infrastructure to improve patient care • Provide feedback on group progress, identifying any gaps in performance • Publish physician group successes in physician newsletters to spread best practices to all Michigan physicians • Provide shared decision-making educational programs to each physician group • Provide claims data and reports to improve prescribing practices 	<ul style="list-style-type: none"> • Encourage physician groups to establish the necessary infrastructure to improve patient care • Provide feedback on group progress, identifying any gaps in performance • Publish physician group successes in physician newsletters to spread best practices to all Michigan physicians • Provide claims data and reports to improve prescribing practices
<i>Outcomes</i>	<ul style="list-style-type: none"> • Chronic Illness Care: Physicians are increasingly engaged, sharing challenges, strategies adopted and successes achieved through joint BCBSM physician group committees • Care Management: The number of patients who contact BlueHealthConnection® directly or are referred by a physician (for benign uterine conditions, coronary revascularization, back pain, and persistent back and knee pain) has increased 3 percent • Prescribing: Improvements in the generic dispensing rate have produced approximately \$7 million in savings from cost-effective prescribing • Won Blues Association 2006 "Best of Blue" Award for collaboration and innovation 	<p>To date:</p> <ul style="list-style-type: none"> • The focus has been on cost savings in pharmacy, laboratory and radiology services. • Engaged physicians are forming their own POGS subgroups to address separate issues of importance with regard to the efficiency and quality of care.

Physician groups participating in the BCBSM Value Partnerships with Physicians throughout Michigan as of April 2007



Marquette County
Upper Peninsula Health Plan: 228*

Saginaw County
Primary Care Partners: 50

Muskegon County
Hackley PHO: 77

Genesee County
Genesys Integrated Group Physicians: 94
Hurley PHO: 78
McLaren Medical Management: 78

Kent County
Advantage Health Physicians: 106
Michigan Medical, PC (MMPC): 128
Regional Delivery Network of West MI: 112
West Michigan Physicians Network: 275

Oakland County
Medical Network I: 204
Oakland Physician Network Services: 129
Oakland Southfield Physicians: 202
St. John Medical Group: 203
United Physicians: 372

Ingham County
Consortium of Independent Physician Associations: 929
MSU Health Team: 105
Sparrow Family Medical Services: 32

St. Clair County
Mercy Physician Community PHO: 34
Physician Healthcare Network: 28

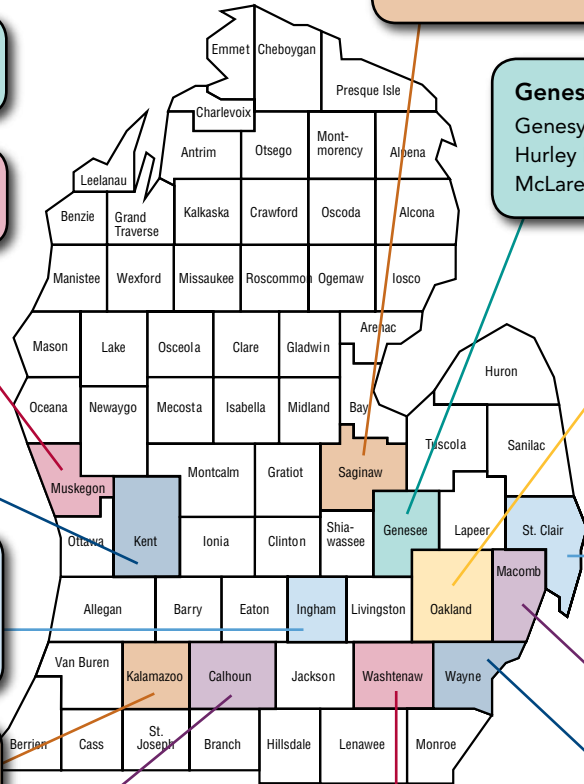
Kalamazoo County
Bronson Medical Group: 47
ProMed Healthcare: 66

Macomb County
DMC Primary Care Physicians: 152
St. John HealthPartners: 214

Calhoun County
Integrated Health Partners: 63

Washtenaw County
Huron Valley Physicians Association: 260
Integrated Health Associates: 93
U-M Health System Faculty Group Practice: 325

Wayne County
Henry Ford Medical Group: 464
St. John Health Med. Resource Group: 105
United Oakwood Providers: 217

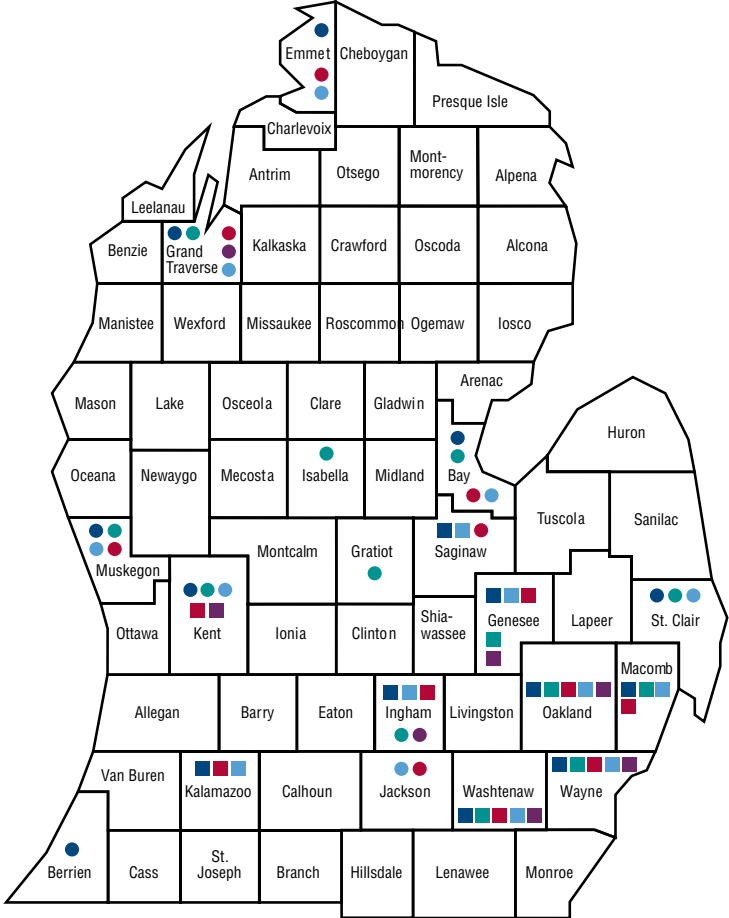
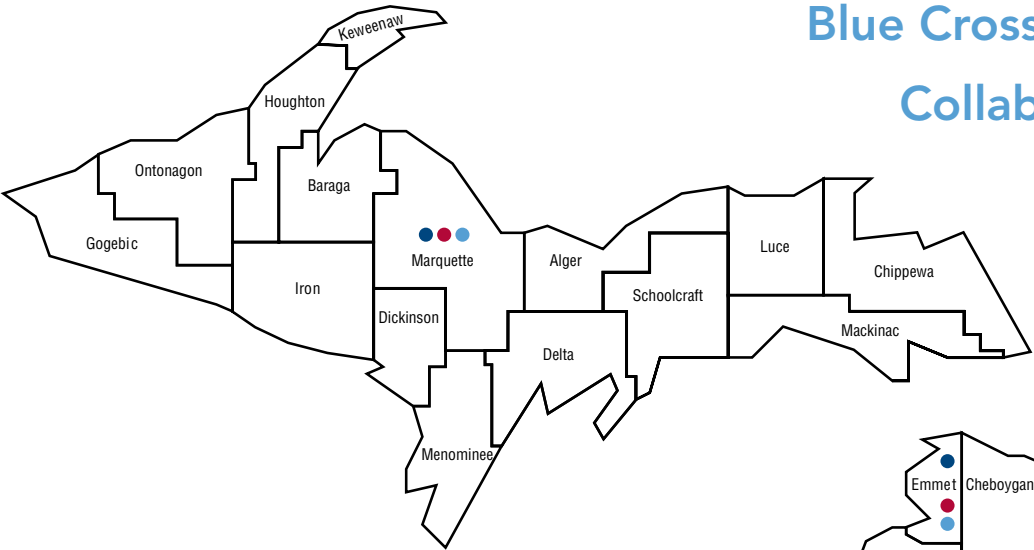


*PGIP only

Blue Cross Blue Shield of Michigan Collaborative Quality Initiatives					
<i>Program Description</i>	<p>Collaborative quality improvement programs are prospective clinical registries in which multiple institutions collect and share data to improve quality of care. Hospitals participating in a CQI program collect data on patient characteristics, processes and outcomes for the specific procedures under study and collaborate with each other to identify and implement best practices. Data are submitted to a coordinating center, which performs analyses to identify best practices and opportunities for improvement. Results are shared among participating hospitals. Currently, the University of Michigan is the data coordinating center for all BCBSM CQIs, although certain programs have additional partners that analyze and report shared outcomes. The result is improved outcomes, increased efficiencies and avoided costs from reduction in adverse outcomes. All BCBSM CQIs share the following key features:</p> <ul style="list-style-type: none"> • One or more clinical champions and dedicated personnel in place at all participant hospitals • Rigorous and efficient systems for data collection (data elements include processes and outcomes of care and patient characteristics necessary for risk adjustment) • Active participation in the statewide quality improvement consortium • Data confidentiality and trust — data should be used to guide CQI efforts, not to reward or punish the performance of participants 				
CQI Program	Cardiac Surgery Collaborative Quality Initiative	Michigan Bariatric Surgery Collaborative Quality Initiative	Michigan Surgical Quality Collaborative	BCBSM Cardiovascular Consortium (BMC²) Initiative on Angioplasty	Michigan Breast Oncology Collaborative Quality Initiative
<i>Program Components</i>	<p>Data Coordinating Center</p> <ul style="list-style-type: none"> • University of Michigan <p>Participation Criteria</p> <ul style="list-style-type: none"> • Be a member of the Society of Thoracic Surgeons • Have a Certificate of Need for open heart surgeries 	<p>Data Coordinating Center</p> <ul style="list-style-type: none"> • University of Michigan <p>Participation Criteria</p> <ul style="list-style-type: none"> • Michigan Surgical Collaboration for Outcomes Research and Evaluation, or M-SCORE <p>Participation Criteria</p> <ul style="list-style-type: none"> • Perform open or laparoscopic bariatric surgeries OR • Perform outpatient lap banding procedures 	<p>Data Coordinating Center</p> <ul style="list-style-type: none"> • University of Michigan <p>Participation Criteria</p> <ul style="list-style-type: none"> • American College of Surgeons National Surgery Quality Improvement Program <p>Participation Criteria</p> <ul style="list-style-type: none"> • Be a member of the NSQIP and ACS • Have a minimum volume of 900 general and vascular surgical cases per year 	<p>Data Coordinating Center</p> <ul style="list-style-type: none"> • University of Michigan <p>Participation Criteria</p> <ul style="list-style-type: none"> • Perform elective percutaneous coronary interventions (angioplasties) • Have surgical support for open heart surgeries 	<p>Data Coordinating Center</p> <ul style="list-style-type: none"> • University of Michigan <p>Participation Criteria</p> <ul style="list-style-type: none"> • Perform at least 150 new breast cancer cases each year • Have a breast cancer advisory committee in place, comprised of medical oncologists, surgeons, radiologists, pathologists, radiation oncologists and nurses from the community
<i>Targeted Population (in Michigan)</i>	20,000 adult patients undergoing cardiac operations each year	10,000 bariatric surgery patients each year	50,000 patients undergoing general and vascular surgery each year	30,000 patients undergoing angioplasty each year	15,000 women diagnosed with breast cancer each year
<i>Measures/Rates of Performance</i>	<ul style="list-style-type: none"> • Operative mortality • Re-operation • Stroke • Deep sternal wound infection • Renal failure • Prolonged ventilator support 	<p>Short term</p> <ul style="list-style-type: none"> • Operative mortality <p>Long term</p> <ul style="list-style-type: none"> • Patient weight-loss • Comorbidity resolution • Need for further interventions • Mortality rates 	<ul style="list-style-type: none"> • Specialty specific operative mortality and morbidity • Surgical complications • Procedure-specific performance for selected operations 	<ul style="list-style-type: none"> • In-hospital mortality • Unplanned coronary artery bypass graft surgery • Nephropathy requiring dialysis • Myocardial infarction • Stroke 	<ul style="list-style-type: none"> • Patients with metastatic disease by initial stage at diagnosis • Adjuvant radiation rates by stage • Adjuvant chemo- and hormone radiation therapy • Breast conserving surgery rate by stage
<i>Outcomes (Expected)</i>	Reduce the risk of complications and improve treatment methods before and after cardiac surgery. Greater in-depth data analysis of data will help coordinate best practices among cardiac surgeons.	Reduce the cost and risk of complications for bariatric surgery and improve outcomes. Once participant hospitals are fully engaged, the program is expected to produce significant savings from reducing adverse outcomes.	Reduce infection, illness or death associated with select surgical procedures, and provide a firm foundation for surgeons to apply best practices. Substantial savings from preventable operative complications are also expected.	Reduce the risk of complications and improve treatment methods before and after cardiac surgery. Once participants are fully engaged, the program is also expected to produce savings of nearly \$4 million annually with a return on investment ratio close to 2:1.	Improve the use of evidence-based, cost-effective therapy in the treatment of breast cancer.
<i>Other Partners (National and Regional)</i>	<ul style="list-style-type: none"> • Michigan Society of Thoracic and Cardiovascular Surgeons • M-SCORE • Society of Thoracic Surgeons 	<ul style="list-style-type: none"> • M-SCORE 	<ul style="list-style-type: none"> • American College of Surgeons • M-SCORE • NSQIP 		<ul style="list-style-type: none"> • National Comprehensive Cancer Network (Breast Cancer Outcomes Database)

Blue Cross Blue Shield of Michigan Collaborative Quality Initiative

Hospital Partners as of January 2007



Single Location	Multiple Locations	
●	■	Cardiac Surgery CQI
●	■	Bariatric Surgery CQI
●	■	MI Surgical CQI
●	■	BMC ²
●	■	Breast Oncology CQI

Blue Cross Blue Shield of Michigan Hospital Pay-for-Performance Program		
Program Description	The Hospital Pay for Performance (P4P) program gives top performing Michigan hospitals the opportunity to earn additional payments based on quality and efficiency measures. Initially, hospitals can earn up to 4 percent of their inpatient and outpatient payments based on various quality and efficiency measures. Beginning in 2008, hospitals will also have the potential to earn up to an additional 1 percent based on an annual comparison of Michigan hospital cost performance to other states in our geographic region.	
Program Components	Incentives are paid to hospitals meeting specific performance targets related to quality, resource efficiency and participation in selected collaborative quality initiatives. <i>(Refer to Measures and Rates of Performance below.)</i>	
Hospital Partners	All non-rural acute care hospitals throughout Michigan (except Veterans Administration hospitals). In 2008 a P4P for small rural hospitals will be implemented.	
Measures and Rates of Performance (measures are updated annually)	2007 Measures	Specific Components
	Prequalifying Conditions	Incentive eligibility requires that hospitals must meet prequalifying conditions, including publicly reporting their performance data and maintaining specific culture of safety requirements, medication safety and patient safety practices.
	Quality Indicators	Clinical quality indicators include, heart failure, pneumonia, surgical infection prevention, acute myocardial infarction, central line associated blood stream infection rates, and ICU care for ventilator patients. Other indicators may be added over time.
	Efficiency	Initially measured by comparing each hospital's cost per case with the statewide average. Adjustments are made to ensure that hospitals are compared on similar types of patients. Additional measures will be added over time.
	Collaborative Quality Initiatives	Hospitals are rewarded for their participation in selected Collaborative Quality Initiatives.
Outcomes	Overall Michigan hospital cost and efficiency performance has improved each year the P4P program has been in place. Keystone project efforts, in particular, demonstrated significant quality improvements (reduced mortality and infection rates) and cost reductions.	
Other Partners	The P4P Advisory Group provides input to BCBSM on the various program elements, including the development of measures, thresholds and component weights. The P4P Advisory Group includes clinical quality experts, hospital staff with direct patient care involvement, BCBSM and MHA staff, and other representatives deemed critical to the input process.	



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