MUSIC Lessons: First 4 Years

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The Michigan Urological Surgery Improvement Collaborative (MUSIC) is a statewide effort by urologists in Michigan to improve the care of patients with prostate cancer. Initiated in 2012, MUSIC was modeled after other successful quality improvement collaboratives sponsored by Blue Cross Blue Shield of Michigan (BCBSM).[1]

MUSIC currently has participation from more than 85% of the urologists in Michigan, representing 43 practices diverse in size (large urology groups to solo practitioners), structure and geography, and academic and community based. As of July 2016 the MUSIC registry included data on 30,000 men who had a prostate biopsy or a new diagnosis of prostate cancer and 6,000 men who underwent radical prostatectomy.

By any measure MUSIC has been successful.[2] We have improved imaging appropriateness, decreased hospitalizations after prostate biopsy, established a framework for measuring and reporting perioperative outcomes and long-term patient reported outcomes with urinary and sexual function, created an infrastructure for video review of radical prostatectomy by peers, initiated plans to improve shared decision making about therapy, and developed a strategy to increase appropriate use of active surveillance.[3–7] We have also learned many lessons that may be instructive to other registries or collaboratives.

The heart of MUSIC is a high quality database that urologists trust, and that adheres to the concept of "collect what you need and need what you collect." BCBSM supports trained abstractors at each practice site and a Coordinating Center housed in the Department of Urology at the University of Michigan. A clinical champion from each practice attends triannual collaborative-wide meetings, and is charged with communicating MUSIC data and projects back to the partners. There are 4 active patient advocates who represent the voice of the patient and participate in all meetings. Currently there is no specific reimbursement incentive for the physician or practice, but as payers move to value based reimbursement we are hopeful that MUSIC metrics will be part of the calculation of quality care. MUSIC is recognized as a qualified clinical data registry by the Centers for Medicare & Medicaid Services.

MUSIC is more than a registry. There is accumulating evidence that a registry by itself may be insufficient to engender a change in practice.[8] The opportunity to meet collaboratively, discuss and interpret data, propose quality interventions, plan the implementation of such interventions, and repeat the cycle of performance measurement is crucial. The regional nature of MUSIC facilitates these interactions.

MUSIC had to overcome initial distrust by practitioners of a registry supported by a payer. What access did BCBSM have to the data and would it be used in punitive fashion? The MUSIC structure provides BCBSM only aggregate, de-identified data and they have never asked for more. MUSIC also had to overcome a perception that it was just a research project of University of Michigan Urology, a perception dispelled by actions and building personal trust.

Although MUSIC has a robust web based data reporting platform, we have learned that busy clinicians rarely access it. Thus, individual data need to be pushed to them in an easily digestible format and at regular intervals, using email as well as hard copies. These reports alone do not necessarily lead to change because practitioners often believe that their patients are different. There are ingrained habits and perceptions, there is often fear of making a mistake by changing a practice, and there are nuances of each patient which create uncertainty. This is where the collaboration comes in. Importantly, physicians often express a desire for specific guidance on how to improve and change their practices.

Some topics are inherently difficult to address. Our initial projects involved imaging and prostate biopsy, topics that could be addressed with minimal personal threat. As we move into treatment decision making, surgical technique and skill, and specifics of perioperative and patient reported outcomes, we delve into far more sensitive territory.

It is necessary to continually reinforce that MUSIC is in the business of measuring to improve and not to judge. Identification of underperforming or over-performing or high or low volume surgeons and practices needs to be approached with caution, with a focus on learning from each other. No particular surgeon or practice has a monopoly on quality care and a good performance in one area does not guarantee a similar performance in another. Provocative topics such as public reporting of outcomes or surgical coaching are discussed frankly but not forced into action when the group is not accepting.

The structure of MUSIC has advantages and disadvantages. Manual data abstraction from clinical and hospital charts provides high quality data but is expensive. The sustainability of an improvement collaborative remains a concern because of these high costs, even though there are sound arguments for the value to payers of such quality improvement.[1] One would hope that improved electronic capture of data, through templated documents and natural language processing of clinic notes, as being tested with the AQUA (AUA Quality) Registry, can substantially decrease data capture costs.

The strength of MUSIC is in the interactions among the clinicians. This is how best practices are shared, new ideas are born and concepts are turned into action. As one practitioner described MUSIC, "No hidden agenda, no politics, just a dedication to be inclusive in an effort to improve patient care and outcomes." ◆

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Oxalate Diet

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informative. After tossing his wheat grinder and opting for refined vs whole grains, and after eliminating nuts and several favorite fruits and vegetables, he was not only unhappy (and now frequently constipated) but also had another stone.

A 24-hour urine collection after adopting these dietary changes revealed suboptimal urine citrate, low volume and low urinary magnesium. In our clinic we advised returning to his previous diet rich in whole grains and fruits and vegetables, more fluids, and appropriate calcium intake divided/timed with meals. Although we have not seen this patient since, we assume he is at least somewhat happier, if not at reduced risk for stones.

The recommendation for a low oxalate diet does not have sufficient evidence. Even in high risk patients, such as those who have undergone Roux-en-Y gastric bypass, dietary oxalate restriction may have little merit.[5] Strategies aimed at reducing the bioavailability of oxalate and enhancing urinary stone inhibitors are appropriate. ◆

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