Q&A

KHURSHID R. GHANI, MD ▪ DAVID C. MILLER, MD, MPH

Dr. Ghani is co-director of MUSIC and assistant professor of urology and **Dr. Miller** is director of MUSIC and professor of urology at the University of Michigan, Ann Arbor. They were interviewed by *Urology Times* Editorial Consultant **Stephen Y. Nakada, MD,** the Uehling Professor and founding chairman of urology at the University of Wisconsin, Madison.

QUALITY IMPROVEMENT

MUSIC: How statewide initiative is improving care, outcomes

Q: ***Please provide an overview of MUSIC.***

Dr. Ghani: MUSIC is what's called a "collaborative quality initiative." The state of Michigan has around 20 of these initiatives, and they are all funded by Blue Cross Blue Shield of Michigan. Blue Cross Blue Shield has a special division called the Value Partnerships program that oversees these initiatives throughout many specialties; MUSIC is focused on urologic surgery and, right now, specifically prostate cancer care.

MUSIC is a consortium of 43 practices in the state of Michigan, both academic and community practices, totaling around 250 urologists. That's approximately 90% of the urologists in the state. It was set up in 2011 by Dr. Miller and Dr. Jim Montie with funding from Blue Cross Blue Shield of Michigan. It's basically a group of urologists who are working together with the common goal to improve patient care. I've been involved in it for the last 2 years as a co-director. It's a unique group. It's a privilege to work there.

Q: ***Dr. Miller, what inspired you and Dr. Montie to do this?***

Dr. Miller: For me, there were a couple of factors. I was doing a lot of outcomes research during my residency and fellowship, and it was becoming clear to me that this was an area where it was very easy to find problems with care delivery, but there was not as much emphasis on finding solutions to those problems. This collaborative quality initiative model had emerged in Michigan, where some work was already being done in general surgery and cardiology. Clinicians in those specialties were collaborating, with support from Blue Cross Blue Shield of Michigan, and really tackling some of the big challenges in the field.

Dr. Montie, who was the chair of the urology department at the time, and I were envious that urologists weren't involved. We thought, we have common conditions that are important to patients and the opportunity to tackle some of these problems ourselves. We decided to go to Blue Cross Blue Shield of Michigan and pitch the same model in urology as a way to work on some of the big problems in the field and they said, not surprisingly, "While that's great that you're interested, so is everybody else. Show us that urologists can work together to do this."

That was the genesis of the initial Urological Surgery Quality Collaborative (USQC) that was really a "coalition of the willing" of some practices both in and outside of the state of Michigan that had urologists who had trained at the University of Michigan. We started collecting data together on imaging for early-stage prostate cancer, and we showed that we were able to reduce utilization in patients where the tests were less likely to be beneficial.

Why would anyone not participate in MUSIC?
STEPHEN Y. NAKADA, MD

I think while funding is an obstacle, there also has to be an element of trust and partnership.
KHURSHID R. GHANI, MD

Much like an NIH grant, we then had preliminary data that we were able to take back to colleagues at Blue Cross Blue Shield of Michigan and say, "Look, we worked together on this. We achieved a beneficial change in practice patterns," and that prompted them to say, "OK, let's launch in the state of Michigan."

When we started, we had no idea whether any urologists in the state would be interested. But after Blue Cross Blue Shield of Michigan approved MUSIC, they put out a request for participants, and at that point about six or seven more practices in the state came forward without us even having approached them directly. That showed, I think, that urologists were ready to participate in something like this to be proactive in terms of defining the quality of care we provide instead of being reactive as we have been on some occasions in the past.

That was the launching point, and from there we spent a lot of time building relationships. Drs. Montie, Ghani, and I have driven to almost every practice in the state of Michigan to meet with urologists in their environment to understand what their priorities are and to emphasize the point that this is about making Michigan the best place in the world for prostate cancer care. It's not about an academic emphasis or defining one center as better than the other. That's one of our fundamental principles and has been an important catalyst for our growth and sustainability.

Q: ***That sounds great. Why would anyone not participate?***

Dr. Ghani: That's a really good question, because urologists from other states come to us and say, "We can't do that in our state. How did you do it?" I think while funding is an obstacle, there also has to be an element of trust and partnership. It's a competitive market; everyone's looking for the same patient for the same work, and so there are some inherent hurdles to overcome in terms of building that trust and partnership. I think we had just a perfect storm of the right conditions. We had a stalwart and a champion like Dr. Montie, who had retired from his position as chairman. He had a very strong reputation, and people have faith in him as a leader. We had someone like Dr. Miller, who was motivated to do the day-to-day work of the collaborative, and we found an absolutely outstanding project manager (Ms. Susan Linsell). I think the environment was right for everyone to collaborate at that stage.

There are practices that have not yet joined MUSIC because of concerns about what would happen to their data and who would look at it. If it's funded by a payer like Blue Cross Blue Shield of Michigan, does it mean at some stage there are going to be some penalties or repercussions? We have to explain to the groups that the BCBSM Value Partnerships program has been going on for more than 15 years and there has been no history of that happening whatsoever in the other specialty groups that are much

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MUSIC: Improvements seen with post-Bx sepsis, imaging for PCa

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more established. It sounds like a win-win situation for everybody, but in the beginning it's not seen that way.

Dr. Miller: I think some urologists also wonder, is this just going to be another thing on our plate? We're dealing with electronic medical records and changes in reimbursement, and how do we possibly fit another initiative like this on our plate? We work through that in a very honest and transparent fashion. The proof is in the pudding in that when people come to the meetings, they see value in what we're working on and that it's relevant to their day-to-day practice.

Q: ***What are the tangible benefits to the average urologist to be involved?***

Dr. Ghani: As Dr. Miller emphasized, we don't do research, we do quality improvement. I think the first thing that MUSIC did was tackle imaging for men with low-risk prostate cancer. But what many urologists have found really helpful has been our statewide program to reduce morbidity after prostate biopsy. That's been a benefit that all the urologists, nurses, and practice managers have seen as very helpful in their practice.

We found that from a population level, there were concerns with rising sepsis after prostate biopsy and we found within the state it was around a 1.5% hospitalization rate. After developing consensus-driven protocols for antibiotic guidelines, we were able to reduce that to around .6%. That's been the strongest benefit I've seen. Urologists want guidance. But we're very conscious that it's not driven by one group or one person but instead is a consensus-driven approach.

Dr. Miller: What we try to do is first identify the challenges our colleagues are having in everyday practice. Clearly, one of the early things that was identified was biopsy-related sepsis. Imaging is another good example. First, just showing urologists their own practice patterns is very illuminating. Then they would say, "Tell us what best practices ought to be." You can use a number of different sources; there are great guidelines from the AUA and specialty orgaizations. But what's been particularly powerful is the ability to use our own data and say, "Look, in our practices in the state of Michigan, the likelihood that a test for patients meeting these characteristics is positive is almost zero." So urologists said, "Give us straightforward, pragmatic decision aids and we will implement them."

We did that, and it's impressive how quickly things change. With imaging, we went from wide variation across practices and a relatively high rate of imaging to lower overall rate and reduced variation, in many ways this change in practice patterns is the "Holy Grail" of quality improvement.

We've also been working on active surveillance for men with prostate cancer. People are very interested and concerned about quality of care in this area. We understand the nuances of low-risk prostate cancer, but what are the sequential steps that should be done to make sure we're not underestimating the grade and/or volume of cancer? We're working on standardized pathways for the consideration, confirmation, and implementation of active surveillance, as well as educational materials for patients.

Also, we try to be at the forefront of responding to changes in health policy and we've done that in a couple of ways. I credit Dr. Montie for a lot of this work. We are now a Qualified Clinical Data Registry for the Centers for Medicare & Medicaid Services, so about seven or eight MUSIC practices get credit for participation, and we handle the submission of the data from the coordinating center. Dr. Montie worked with the American Board of Urology, and now participation in MUSIC gives you credit for level 4 maintenance of certification. We're also looking very closely at MACRA and the Merit-Based Incentive Payment System to see how the data that we collect and the clinical improvement activities in MUSIC may be leveraged for those programs as well as a service to urologists.

Who are the stakeholders aside from urologists, and how do you engage them?
STEPHEN Y. NAKADA, MD

The urologists are really key stakeholders, but ultimately patients are the moral compass of what we do.
KHURSHID R. GHANI, MD

Overall, I think that many urologists in Michigan have developed collective pride in the work being done in the state.

Q: ***Who are the stakeholders aside from urologists, and how do you engage them?***

Dr. Ghani: The most important stakeholder is the patient. Everything we do is driven to improve patient care.

In addition, we are built upon a clinical registry; we are only as good as the data we collect. Without collecting the data accurately and comprehensively, we won't understand the problem, so some of the most important people in our collaborative are the data abstractors, the coordinators in the practices who actually put in high-quality prospective data on a day-to-day basis. We have to engage with them to understand why this data is being put in.

Each practice has a clinical champion—a urologist in that practice who represents MUSIC and disseminates our initiatives and core messages to the practice. Some practices can be very big so there can be one clinical champion for 20 to 30 urologists. We have to reach urologists as well as the practice managers and the nursing team.

We are fortunate that we have a strong administrative support team. We have three physician leaders, a dedicated program manager, a patient-reported outcomes coordinator, a quality coordinator, a database coordinator, and statistical analysts. It's a small staff in many ways to improve patient care on a systematic basis throughout the state.

Dr. Miller: The urologists are really key stakeholders, but ultimately patients are the moral compass of what we do. Dr. Montie had the insight to recruit patient advocates who formally participate in MUSIC. We have four patient advocates who come to every one of our meetings, sit in on our strategic conversations, and help us maintain a focus on what matters most to patients. As we talk about priorities or measures, they will often say, "Actually, that isn't what matters most to us," and it helps redirect us. They can move the discussion and work of the collaborative probably more than any single urologist. They've been an incredible resource for us.

For instance, last fall there was a lot of discussion about the ProPublica Surgeon Scorecard and Dr. Montie, Dr. Ghani, and I wrote an editorial in *U.S. News & World Report* (July 30, 2015) on the quality improvement collaborative as an alternative approach. That was our view as physicians, but we wanted to go to our patients and ask: If you had a choice between measures derived on publicly reported claims data versus the work we're doing across the state in MUSIC, what are the pros and cons of the two approaches? They were able to give us really balanced and nuanced input that helped us think about the best way to move MUSIC forward in that area.

Other key stakeholders are other clinicians. We can't do all of this work in isolation. A good example is we're trying to figure out what the best way to deploy prostate MRI. It's very much on everybody's front burner right now, but there's lots of heterogeneity in how MRIs

are performed and how they're reported, and the ability of urologists to use those as a focal point in prostate cancer care depends a lot on their radiology colleagues. So we have engaged with the Michigan Radiological Society, and Dr. Montie will be presenting at one of their next meetings to talk about how we can standardize reports for prostate MRI.

It's also really important to engage with our partners at Blue Cross Blue Shield of Michigan and constantly demonstrate the value of this work from multiple perspectives. They're not necessarily looking just for the bottom line, although that does matter. They are interested in value for their beneficiaries, but I think they also see the benefits MUSIC has in terms of engagement with urologists, primary care physicians, and other specialists.

Q: ***Is it possible to nationalize this? If so, what needs to happen?***

Dr. Ghani: I think we can do it on a national level, but it requires significant data burden and analytical push. The National Surgical Quality Improvement Program from the American College of Surgeons, has shown that you can collect data but that doesn't necessarily mean it leads to improvement. You need to have boots-on-the-ground quality improvement initiatives. I'm not sure whether it can be done on a national level because it requires satellites at the national level and then coordination in all the states, with champions on the ground and people actively pushing participation.

Dr. Miller: In many ways, I think a national data platform is entirely feasible. The AUA Quality Registry (AQUA) is a great example of that in our field. There needs to be a feedback loop after data are collected. You can see it at our meetings; people look at the data and respond to it, but then what happens between the meetings and the data review? That's where the real shoe-leather quality improvement happens where you have to go back, re-review with your patients, look at your processes, change things a little, talk to your nurses and MAs, and then look again and measure over time because it would be really easy for our imaging rates to start to rise again. How do you create a system to measure that in a sustainable fashion over time?

I think this can and should be done nationally, but it may need to be through a series of regional collaboratives because a key element of this is the social capital and the relationships among the urologists, and those occur naturally because a lot of people who practice in the state of Michigan trained at one of the programs that are involved. We share patients and interact frequently through clinical care. I think there are great spillover benefits for coordination of care and patient care that are hard to quantify as a result of MUSIC. We know each other, we trust each other, we view that as an extension of our relationships. We have a great standardized data platform that can be leveraged to drive local quality improvement activities because context matters.

The way that you drive some of these improvements would be very different in Wisconsin or Michigan than it might be in Southern California than it might be in the Pacific Northwest. Local context matters. The data could be consistent with the local quality improvement activities need to depend a little on the priorities, and then how you implement them depends on the context.

Q: ***How would a young aspiring urologist go about starting this in their region?***

Dr. Ghani: I think the ingredients for success are to have a good team that has a trusted champion. If you're a young urologist and you

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want to start this, find a mentor who is well respected and has a good reputation in your region and team with them and then identify collaborators who you know have the same desire and passion to advance patient care. No egos, no competition, no billboards. Look for the right people and then start to organically grow it.

Then it's about getting funding. We were fortunate to get funding from Blue Cross Blue Shield of Michigan, but it can also be achieved with the help of other bodies. For example, in Pennsylvania a new collaborative has been established, funded by the Partnership for Patient Care and Independence Blue Cross. There has to be an element of trust of who's doing this and why, and if you have that, then I think they've got every chance of being as successful as urologists in Michigan.

Dr. Miller: I would say start small but think big. You want to start with an idea that isn't so personal to the people you're working with that if you happen to be on one end of performance it will just lead everything to fall apart. Imaging was a good example. People were ready to understand that and it wasn't nearly as personal as surgical outcomes might be.

You also have to have a big vision for why you're doing it because people want to commit themselves to something that they think is going to really matter to their patients and their communities so you have to have a vision of how you go from that initial process to something bigger. You have to have great humility, be honest and transparent, and not deviate from those principles. The minute it starts to look like it's about you or about any one practice or institution, the relationships that exist will inevitably be threatened.

Finally, while Dr. Ghani and I often say that 80% to 90% of our focus is on pragmatic quality improvement in practice, you also have to have the willingness to use this platform to innovate in our field a little within the idea that it reflects quality improvement. For example, our work on video review of robotic prostatectomy, technical skill, and linking it with our patient-reported outcomes infrastructure is a tremendous innovation. We had 36 urologists in the state submit a video to undergo review by their peers and by a crowdsourced platform called Amazon Mechanical Turk, and we're relating that to patient-reported outcomes to see whether there are certain aspects of the procedure that correlate with better patient outcomes and how we can learn from that. It's not about measuring to judge or picking winners or losers but instead using that information to coach each other.

Also, don't be afraid to veer off from where you think you were going to go to pursue new opportunities. The reduction of biopsy infection is a classic example. That was not on the list of the first three things that we put in our proposal, but it's what we heard from the constituents and that's where we went.

Dr. Ghani: We're also starting a kidney stone initiative called ROCKS: Reducing Operative Complications from Kidney Stones. That came from urologists saying, "We want to do more than just prostate cancer now." We're also going to be doing a renal cancer initiative. UT

Speak Out

How will health care change under a Trump presidency?

"I don't know what to expect from any aspect of the President Trump camp. There is so much vagueness in what he says. He wants to repeal the ACA—what happens after that I don't know. When does the repeal happen? How long does the process take? What is it replaced with, if you repeal it?

Dr. Guleria

I don't think repealing the ACA will affect my practice too much either way. We don't have a lot of ACA patients that I know of anyway because plans are not labeled specifically ACA. I have an ACA plan for myself and my kid because it was better, cheaper than other group plans we had available.

This coming year, our practice has been looking into group plans again, so we may end up changing out of the ACA anyway. We don't have a ton of uninsured; I still have some despite the ACA, so I don't think ending the ACA will affect my practice too much.

We tend to have a pretty high population of insured patients and a lot of the ones who are typically uninsured don't qualify for the ACA because they're not legal immigrants or whatever, so they just pay cash."

Anshu Guleria, MD
Manassas, VA

"Trump campaigned saying he would repeal Obamacare. With Republicans [having] the majority in the Senate and the House, that might happen.

Dr. Gervasi

If the whole thing is repealed and we have to start over, it's going to be a much bigger thing. Go back to the old system? How do we do that?

We just had a presentation on this by Newt Gingrich at the LUGPA meeting. The ACA has worked for people who are uninsured—the lowest income people. About 75% of those people enrolled. That makes sense. But in higher income brackets, fewer people enrolled. Part of the reason is payments are just too high. The question is how do we fix that? Do we keep some of it in place, or just throw everything out? The [Trump] administration would more likely include the private sector, which goes along with his campaign platform.

We basically did OK with the old system. With the ACA, we're seeing more people who have the equivalent of Medicaid, basically Medicaid expansion patients. Those are some of the lowest paying people coming into our practice. It wasn't a big income boon for our practice.

I don't think anybody expects to hold [Trump] to exactly what he says, but it will definitely change."

Lawrence Gervasi, MD
Cleveland

"To be quite honest, the ACA really hasn't affected me. My patients are largely elderly and have Medicare or Medicare HMOs. So I really don't see Obamacare patients.

Dr. Fischman

I don't know what he's actually going to do with health care, but I would hope any new plans do away with pre-authorization requirements. I have two employees who can easily spend a half-hour on the phone if I need pre-authorization.

A few things in the ACA are good, like coverage for pre-existing conditions. But the ACA does affect people I know. A friend realized she was going to make more than she had expected this year, more than she had told them, and that meant she would lose her subsidy. So even though she wanted to work more overtime, she was afraid she would get hit with a penalty. That actually discouraged people from working more."

Nathan Fischman, MD
New Orleans