Blue Cross Blue Shield of Michigan’s Value Partnerships programs are a collection of statewide health care collaborations with physicians and hospitals that are transforming the delivery of care and improving the quality of patient care across Michigan. This innovative approach to transforming health care is:

- Enhancing clinical quality
- Decreasing complications
- Managing costs
- Eliminating errors
- Improving health outcomes

In an effort to address many of the current challenges facing our health care system, BCBSM’s quality programs offer an innovative approach to provider reimbursement, shifting from the traditional fee-for-service model to a value-based reimbursement model.

BCBSM is lowering the rate of health care cost increases while improving quality of care for BCBSM members and all Michigan residents.

One example is in the professional use trend which has been negative for 12 out of the past 13 quarters and at zero for the thirteenth of 13, ending in the 4th quarter of 2013. This is based on calculations from BCBSM’s Actuary Department.

Note: Use trend is slightly positive in first-quarter 2012 because of the extra day due to the leap year. If the impact of the extra day is removed, that trend would be negative.
Data from The Henry J. Kaiser Family Foundation, *Health Care Expenditures per Capita by State of Residence* study, indicates in a 1991 comparison to other Great Lake states, Michigan had the second highest cost in health care expenditures per resident; by 2009, Michigan had the lowest costs*. See table.

<table>
<thead>
<tr>
<th>State</th>
<th>Cost in ’91</th>
<th>State</th>
<th>Cost in ’09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ohio</td>
<td>$2,706</td>
<td>Minnesota</td>
<td>$7,409</td>
</tr>
<tr>
<td><strong>Michigan</strong></td>
<td><strong>$2,647</strong></td>
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<td>$7,233</td>
</tr>
<tr>
<td>Minnesota</td>
<td>$2,619</td>
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<td>$7,076</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>$2,544</td>
<td>Indiana</td>
<td>$6,666</td>
</tr>
<tr>
<td>Indiana</td>
<td>$2,532</td>
<td><strong>Michigan</strong></td>
<td><strong>$6,618</strong></td>
</tr>
</tbody>
</table>


As the Physician Group Incentive Program started in 2005, we believe this is an indication that our Value Partnerships programs are having a positive effect. Our practice transformation efforts through PGIP and PCMH as well as “best practices” developed through our CQIs are working in tandem to help keep Michigan health care expenses down.

The goal of our value-based reimbursement model is to advance toward full health care transformation in Michigan through our various program offerings – such as Patient Centered Medical Home, Provider Delivered Care Management, Collaborative Quality Initiatives, hospital pay-for-performance and our value-based contracts.

The Claims paid by BCBSM ASC group customers and Claims processed for BCBSM Underwritten group contracts are built on this value-based reimbursement model and thus include all value-based reimbursement owed to providers pursuant to their contracts and by virtue of their participation in quality programs.

The continued success of our quality programs depends on an active partnership with the Michigan physician and hospital community, who play a vital role in the planning, design, implementation, modification, and overall direction of the program.

Together with our statewide provider partners we are transforming the delivery of health care and providing value - a formula that is working.

\[
\text{Value} = \text{Patient Experience + Quality}\]

\[
\text{Cost}
\]
Key elements in the execution of a successful statewide quality improvement initiative include providing clinical leadership, a neutral ground for collaboration, and resources for data gathering and analysis.

BCBSM supports these efforts through various Value Partnerships programs which include the following:

I. Physician Group Incentive Program including:
   a) Clinical Quality Initiative
   b) Integrating Behavioral Health into General Medicine Care Initiative
   c) Resource Stewardship Initiative
   d) Patient Experience of Care Initiative
   e) Patient Centered Medical Home and Patient Centered Medical Home-Neighbor programs
   f) Provider Delivered Care Management program
   g) High Intensity Care Model program
   h) Organized Systems of Care program

II. Hospital Pay-for-Performance

III. Hospital Value-Based Contracting

IV. Collaborative Quality Initiatives

V. Health Care Value National Solutions

The following paper provides an overview of BCBSM’s collaboration with nearly 20,000 Michigan physicians and nearly every hospital across the state, and where future efforts will be focused. You
I. Physician Group Incentive Program

The Physician Group Incentive Program (PGIP) began in 2005 after conversations between BCBSM, the Michigan State Medical Society, and various physician organizations (POs) about how to create a health care system in Michigan that preserves and strengthens relationships between physicians and patients, and that delivers affordable, accessible, and optimal care. The objective was to design a program that would address the root causes of our high cost health care system, which include:

- Poorly aligned incentives
- Lack of population focus
- Fragmented health care delivery
- Lack of focus on process excellence
- Weak primary care foundation

BCBSM and POs agreed to partner to create natural communities of caregivers with sufficient leadership, structure, and technical expertise to leverage economies of scale and support the development of integrated information systems and shared processes of care. Initially, PGIP’s focus was on chronic disease management and strengthening Michigan’s primary care foundation, guided by the Joint Principles of the Patient-Centered Medical Home (PCMH) as defined by the American College of Physicians, American Academy of Family Physicians, American Osteopathic Association, and the American Academy of Pediatrics.

The scope of the program has subsequently expanded to include all physician specialties via the Patient Centered Medical Home-Neighbor model, with the goal of creating clinically integrated communities of caregivers who accept responsibility for ensuring judicious use of resources and for managing care at the individual and population level.

All Michigan physicians participating in PGIP, from solo practitioners to physicians practicing in large multi-specialty groups, can participate in practice transformation efforts. Physician Group Incentive Program primary care physicians (PCPs) and specialists collaborate on initiatives designed to improve and transform the health care system in the state. Each initiative offers incentives based on clearly defined performance improvement and program participation metrics.

Performance is measured at the PO level to avoid methodological limitations inherent in measuring individual physician performance, and to encourage systemic accountability and improvement. Catalyzing communities of physicians is key in sustaining small physician practices. Approximately 75 percent of PGIP primary care physicians are in solo and duo practices and would not likely have the resources and technical infrastructure to take on practice transformation by themselves. By banding together, providers are able to create shared systems of care, optimize quality and efficiency, and ensure a sustainable revenue stream into the future.

Since 2009, BCBSM has been recognizing PGIP participating PCPs that have high levels of PCMH capability implementation and strong quality, utilization and efficiency metrics, as BCBSM designated
Patient Centered Medical Homes (PCMH). Designated PCMH providers qualify for a Value-Based Reimbursement Fee Schedule (VBR Fee Schedule) that pays certain evaluation and management (E & M) and preventive codes at a higher rate depending on the quality programs in which they participate.

Similarly, specialists that participate in PGIP will, depending on their ranking, qualify for the VBR Fee Schedule, which pays certain procedure codes at a higher rate.

**Encouraging All-Patient Focus**
PGIP physicians provide care to nearly two million BCBSM commercial members. In addition, PGIP reaches beyond BCBSM’s members, affecting the care that is provided to all Michigan residents. PGIP encourages an all-patient focus rather than payer-specific system development. Developing systems of care applicable to all patients ensures that physicians don’t have to alter care processes based on whether patients have insurance, or which insurance they have.

This is an important factor in ensuring that best practice care processes are reliably provided to all patients, all of the time. This all-patient approach to practice transformation reflects BCBSM’s commitment to serving all patient populations in Michigan, and benefits patients with coverage from BCBSM and BCN, as well as commercial carriers, Medicaid health plans, Medicare, and the state’s self-pay/uninsured patients. PGIP plays a key role in reaching BCBSM's social mission of cultivating a healthier future for all Michigan residents.

**PGIP’s Established Goals**
PGIP’s established goals include the following:
- Support incremental implementation of infrastructure and performance improvement processes needed to more robustly measure, monitor, and optimize quality of care
- Reward improvement and overall performance to create meaningful incentives for all POs and their individual physicians
- Promote collaborative relationships amongst physicians and across POs that support improved care outcomes
- Achieve measurable savings in key areas of opportunity such as pharmacy, diagnostic imaging, emergency department use and inpatient admissions

**PGIP Provider Participation**
Currently, over 40 POs participate in PGIP, representing nearly 20,000 PCPs and specialists and the program continues to expand (Appendix I). Physician organizations serve as the effector arm of PGIP by providing the structure and technical expertise to support the development of shared information systems and shared processes of care amongst Michigan physicians.

As of the 2016 PGIP includes:
- 45 POs from across the state
- Nearly 20,000 physicians, including both primary care physicians and specialists
  - 5,805 primary care physicians
  - 13,799 specialist physicians
  - 6,467 practice units
Funding PGIP
In 2004, the BCBSM board of directors approved the initiation of PGIP with the understanding this incentive program would invest specifically in catalyzing physicians to improve cost and quality performance, and to create a more effective health care system. PGIP established a reward pool to actively engage physicians, via POs, in health care quality and practice transformation. In 2012 we added Organized Systems of Care as another partner to help us engage physicians and hospitals in transforming healthcare.

The PGIP reward pool is funded with a set percentage allocation that all network physicians agree to make in their network agreements from their fee schedule reimbursement. Currently, the allocation is 5 percent of most professional claims and is indicated on the physician voucher as “PGIP Allocation”. The amount in the reward pool available as incentives to the POs and OSCs is dependent on the volume of professional claims throughout the year. The allocations made to the PGIP reward pool are exclusively for PGIP and are not retained by BCBSM. BCBSM does not retain any administrative fee or other form of compensation from the PGIP reward pool.

BCBSM distributes earned incentives from the PGIP reward pool to eligible POs and OSCs bi-annually, once in January/May and again in July/November of each year.

The amount of incentives a PGIP participating PO or OSC receives from the reward pool is dependent upon performance, improvement, and achievement of goals through PGIP initiatives the PO/OSC has agreed to work on with their member physicians. POs/OSCs that receive amounts distributed from the PGIP reward pool determine how the amounts should be distributed to their member physicians and practice infrastructure. Physician Group Incentive Program POs and OSCs are the mechanism through which communities of caregivers participate in, contribute to, and help lead health system transformation.

Participating in PGIP
BCBSM Trust and Traditional participating providers interested in joining PGIP need to join a PGIP participating physician organization (Appendix I). Currently there are over 45 POs participating throughout the state. Each PO has its own criteria for membership. Practitioners should contact an organization directly to discuss its specific criteria.

Physician organizations interested in joining PGIP can obtain and complete an application. Applications are accepted during the months of July through August.

PGIP participation specifics, for either a practitioner or a PO, can be found at How to Join PGIP.

PGIP Primary Care Leadership Committee
The Physician Group Incentive Program works in partnership with the PGIP Primary Care Leadership Committee (PCLC) comprised of physician, nursing, and administrative leaders of PGIP POs, as well as individual PGIP physicians. This group provides advice and counsel on the planning, design,
implementation, and modification of PGIP and PGIP-related initiatives and also helps to define the future direction of the program. The PCLC members do not specifically represent their member POs, but rather, serve as representatives of the overall PGIP community.

PGIP Program Areas
The Physician Group Incentive Program is spearheading multiple efforts to support the evolution toward highly-functioning systems of care. Many PGIP performance initiatives engage primary care physicians and specialists who collaborate on initiatives designed to improve and transform the health care system. Some of these initiatives are performance-based initiatives which measure HEDIS performance, radiology (both high- and low-tech) use, emergency department utilization, and utilization of cardiac care services. In addition, PGIP supports the tenets of the Patient Centered Medical Home program. In the following pages we'll examine several PGIP initiatives.
a). Clinical Quality Initiative (CLQI)

The Clinical Quality Initiative replaces the Evidence Based Care Tracking (EBCT) Initiative and aims to improve the quality of health care delivered by physicians participating in PGIP by rewarding POs that support population-wide adoption and implementation of evidence-based medical guidelines into their daily practice. The CLQI uses a subset of select Health Effectiveness Data and Information Set® (HEDIS) measures (included in the Medicare Advantage Stars rating program and Health Insurance Marketplace Quality Rating System) to compare the performance and improvement of PGIP physician organizations.

For the first time, PGIP will incorporate Medicare Advantage (MA) members into the program through this Initiative and reward for performance and improvement for the entire BCBSM PPO membership which includes commercial and MA.

The 2016 goal of CLQI is to improve performance on 11 Medicare Advantage and 17 commercial clinical quality measures as listed below.

### 2016 PGIP Clinical Quality Initiative Measures

<table>
<thead>
<tr>
<th>HEDIS® Clinical Measures</th>
<th>QRS Measures for Commercial Members</th>
<th>MA Stars Measures for MA Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult BMI Assessment</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Appropriate Testing for Children with Pharyngitis</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Appropriate Treatment for Children with Upper Respiratory Infection</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Chlamydia Screening in Women</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Controlling High Blood Pressure</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Diabetes Care: Hemoglobin A1c (HbA1c) Control &lt;7.0%</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Diabetes Care: Hemoglobin A1c (HbA1c) Control 8.0%</td>
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<td></td>
</tr>
<tr>
<td>Diabetes Care: Hemoglobin A1c (HbA1c) Testing</td>
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<td></td>
</tr>
<tr>
<td>Diabetes Care: Medical Attention for Nephropathy</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Diabetes Care: Retinal Eye Exam</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Statin Use in Persons with Diabetes</td>
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<td></td>
</tr>
<tr>
<td>Proportion of Days Covered (Statins)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Proportion of Days Covered (Diabetes All Classes)</td>
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<td></td>
</tr>
<tr>
<td>Proportion of Days Covered (RAS Antagonist)</td>
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<td></td>
</tr>
<tr>
<td>Use of Imaging Studies for Low Back Pain</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

The main objective of this Initiative is to increase the number of closed-treatment gaps from a 2014 average of 59 percent to an average of 65 percent in 2016.

Through participation in this Initiative, POs receive rewards commensurate with performance and improvement on the clinical quality measures listed under goals and objectives for both BCBSM Medicare Advantage and commercial memberships. Performance and improvement scores are calculated for each PO and for each measure using a five point scale. Performance and improvement is assessed using relative measurement; each PO receives a score for each measure that is
established by comparing performance and improvement to all other PGIP physician organizations. Measure-scores are then combined to create both a composite performance and improvement score on a five point scale. There are two ways for POs to earn a higher scores, the first is to achieve high performance and second to continue to improve their performance year over year.

All PGIP physician organizations are automatically enrolled in the Clinical Quality Initiative. Evaluation of the Clinical Quality Initiative occurs annually and assesses each PO’s overall performance in specific HEDIS, STARS, and QRS measures. Evaluation will include PO participation and feedback, and is intended to provide insight into the effectiveness of the incentive model.

In program year 2014, under the EBCT Initiative, the overall commercial PGIP Composite Score based on 2014 measures increased from 34.5 percent in 2013 to 51.4 percent in 2014. The total gaps (denominator) increased by less than 1 percent from 2013 to 2014, but the gaps closed (numerator) increased 49 percent between 2013 and 2014.
b). Integrating Behavioral Health into General Medical Care Initiative
The Integrating Behavioral Health into General Medical Care Initiative, launched in 2015, is focused on the foundational steps of improving processes and communications between behavioral health specialists, primary care physicians, and other clinicians to result in improved outcomes for the patients.

This reward program uses a collaborative model where a cohort group of POs work together to implement an array of projects focused on improving behavioral health outcomes. Participating POs are rewarded for participation in collaborative activities and completion of specific quality improvement activities identified in each PO's project plan. The collaborative model is expected to run approximately 12 months in length.

Thirteen physician organizations were selected to participate in this initiative through 2016.

To ensure fully integrated medical and mental health care and to ease unnecessary spending on chronic care conditions this Initiative seeks:

- To encourage communication between primary care physicians and behavioral health specialists
- To ensure coordination of care between providers and settings

c). Patient Experience of Care Initiative
Value Partnerships supports physician organizations’ efforts related to measuring, reporting, and improving their patients’ experience of care.

The goals of MI PEC are to promote patient experience of care (PEC) measurement, reporting, and improvement through the use of a common survey tool and methodology, and, sustain the effort through a financial model supported by POs, practices and health plans. The Initiative promotes the use of a standard survey instrument - PCMH Clinician Group-Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) - to measure patient experience of care in a comparable manner across the state so that the results can be used as the basis for public reporting at the regional, PO and practice level.

In addition to the PCMH domain 4.4 and OSC capability 16.6, Value Partnerships support the Michigan Patient Experience of Care (MI PEC) workgroup and initiative and a BCBSM pilot program aimed at increasing patient experience of care.

The pilot project supports physician organizations’ and practices in their efforts to improve patient experience of care through the use of patient experience of care improvement tools and action plans development support. The pilot is a component of the BCBSM 2016 corporate goal related to customer experience.
d). Resource Stewardship Initiative

Resource stewardship is the responsible management of health care resources to ensure patients achieve optimal outcomes while avoiding tests, treatments, and procedures that have little or no added value or can be harmful. Prudent stewards consider which health care resources produce a benefit to the patient and avoid those that are of low value, potentially harmful or cost significantly more than those of similar value. This is a new initiative for the 2016 program year and all POs will be automatically enrolled.

The Resource Stewardship Initiative (RSI) encourages POs and practitioners to reduce the use of 17 specific medical services, procedures, and tests that may be overused or are of questionable value, particularly those where there is significant variation among POs.

The RSI is designed to:

- Increase PO and physician involvement in the stewardship of health care resources
- Encourage conversations at the PO level and between physicians and patients about appropriate and necessary health care
- Promote a culture of quality improvement within each PO and their associated community of caregivers
- Identify and reduce variation in the use of potentially overused/unnecessary services
- Reduce the downstream costs of health care associated with performing overused/unnecessary services
- Promote the use of evidence-based health care services
- Provide data to the POs and physicians on performance and improvement on measures of judicious use
- Assist the POs and physicians in implementing interventions to promote behavior change
- Evaluate the effects of interventions and incentives on performance

Each PO must choose between two and four RSI measures to focus on for improvement.

Physician organizations receive incentive payments commensurate with their performance relative to other POs and their improvement on the two to four RSI measures selected. In order to assess performance and make improvements, POs receive data reports with key metrics that are part of the initiative. The POs use this data to gauge performance and identify areas of opportunity.

Initiative results will be available at the end of 2016.
e). Patient Centered Medical Home Program

BCBSM’s Patient Centered Medical Home program facilitates the implementation of PCMH capabilities, and through the PCMH Designation program, and rewards those providers who have made significant progress along the PCMH continuum. Our designation program is the largest of its kind in the country.

As of the 2015 PCMH designation cycle, there are 4,349 PCMH-designated primary care physicians in over 1,550 practices. BCBSM’s PCMH-designated practices are located in 78 of Michigan’s 83 counties.

The *PCMH Interpretive Guidelines* were expanded in 2012 to incorporate the PCMH-Neighbor model, which addresses the interface of the primary care-centered PMCH model with specialty and subspecialty practices.

**PCMH Domains of Function (initiatives)**

Physician organizations and their practices participate in collaboratively-developed initiatives that support PCMH-related care processes based on 12 PCMH domains of function. These 12 initiatives are derived from the nationally-developed Joint Principles of the Patient-Centered Medical Home:

- Coordination of Care
- Extended Access
- Individual Care Management
- Linkage to Community Services
- Patient-Provider Partnership
- Patient Registry
- Patient Web Portal
- Performance Reporting
- Preventive Services
- Self-Management Support
- Specialist Referral Process
- Test Results Tracking

Physician organizations earn incentives from the PGIP reward pool based on the PCMH implementation activity of their member practices. Both PCPs and specialists are eligible to participate in each of the twelve PCMH Initiatives, provided their affiliated POs offer opportunities to do so; nearly 100 percent of PGIP-participating PCPs are actively implementing capabilities associated with the PCMH program.

The number of specialists participating in PCMH capability-building continues to grow each year. Through frequent communications to the PGIP physician organizations and the specialist community, BCBSM provides opportunities for specialists to engage in PCMH practice transformation. This concept is called Patient Centered Medical Home-Neighbor or PCMH-N.
PCMH Designation
PGIP primary care practices that have made significant progress in incorporating PCMH capabilities into routine practice, and that achieve strong quality and use results (e.g., evidence-based care, preventive services, and generic drug use) are recognized as PCMH-designated practices. The PCMH designation process was established by BCBSM in collaboration with Michigan PO leadership in 2009 and occurs annually.

PCMH-designated practices receive reimbursement that is in line with the VBR Fee Schedule. The amount of value-based reimbursement depends upon the quality programs in which the primary care physicians participate, but can be 105 percent to 130 percent of the TRUST/Traditional/BPP/EPO Maximum Fee Schedule for certain evaluation and management (E&M) and preventive procedure codes.

In 2013, an “Honor Roll” was created for practice units designated two years in a row. These practices will retain their designation as long as they maintain strong quality and use scores and continue to implement PCMH capabilities.

The performance of PCMH-designated practices compared to non-designated practices has continued to improve even as the program has expanded. Of particular note is the fact that PCMH providers designated in 2015 had 26.0 percent fewer ambulatory care sensitive inpatient discharges than their non-designated peers (note: the ambulatory care sensitive inpatient discharge metric is not used in the PCMH designation scoring process).

PCMH Designated Practices Compared to non-PCMH Practices:
2015 Designation Program (July 2014 – June 2015)

Based on claims data from 2014.

Patient Centered Medical Home practices offer their patients services that may not be offered at non-designated practices, such as 24-hour access to the care team. Patient Centered Medical Home practices coordinate specialist visits and other care, such as nutrition counseling, home care, or links to community services. They also teach patients how to manage conditions such as asthma and diabetes.
As of 2015, PCMH-designated physicians represent approximately 68 percent of all participating PGIP primary care physicians. We expect the number of designated practices will continue to increase annually as PCPs implement Patient Centered Medical Home capabilities and advance the quality of care delivered across the state of Michigan. In addition, we expect the performance of PCMH-designated practices will continue to improve as they implement the most advanced PCMH capabilities.

**PCMH – Results**

An analysis of the PCMH program has shown it has saved an estimated $269 million over its first four years, July 2008 – June 2012, because of improved quality of care and preventive care that helped patients avoid emergency room visits and hospital stays.

In addition, an article published in *Health Services Research* in July 2013 suggests favorable quality and cost results for practices that fully implement the BCBSM medical home model. The results are based on PCMH capability data for 2,432 primary care practices that were participating in PGIP between July 2009 and June 2010.

The cost and quality implications for PCMH providers at full medical home implementation are as follows:

**Adults**

- A practice that fully implemented PCMH would have on average a 3.5 percent higher adult quality composite score than a practice that implemented no PCMH capabilities
- A practice that fully implemented PCMH would have on average a 5.1 percent higher adult preventive composite score than a practice that implemented no PCMH capabilities
- A practice that fully implemented PCMH would have on average $26.37 lower PMPM costs than a practice that implemented no PCMH capabilities

*Special note: These results do not mean the program is currently saving $26.37 PMPM, because there aren’t any practices that have fully implemented our PCMH model at this time. At current levels of PCMH implementation, we estimate savings in the range of $5-$13 PMPM, but the number depends on many factors and is not specific to any group.*

**Children**

- A practice that has fully implemented PCMH would have on average a 12.2 percent higher pediatric preventive composite score than a practice that had implemented no PCMH capabilities

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The PGIP Patient Centered Medical Home program has demonstrated that small practices can thrive with the PCMH model – only a few of PGIP’s physician organizations are integrated delivery systems, and over 50 percent of all BCBSM PCMH-designated practices are comprised of only one or two physicians.

In a letter responding to an August 2011 *Health Affairs* article, which concluded that the adoption of PCMH capabilities in smaller practices throughout the country is limited, and that few small-and medium-sized physician practices are engaged in the approach, Tom Simmer, MD, BCBSM senior vice president and chief medical officer for Health Care Value, noted:

“A great deal can be learned from Michigan’s flourishing patient-centered medical home program. Collaboration and incrementalism are its cornerstones. Through partnership and ongoing support of practices at all stages of the journey to patient-centered medical care, better outcomes are realized, and physician practices—big and small—are rewarded for their efforts.”

Michigan’s PCMH Movement: Leading the Way Nationally

BCBSM and its PCMH program have been nationally recognized for the outstanding work of the Michigan physician community in breathing life into the PCMH concept. National recognition includes:

- **Blue Cross Blue Shield Association BlueWorks® Award**: Awarded in 2010 by the BCBS Association in collaboration with the Harvard Medical School Department of Health Care Policy, this premiere award recognizes Michigan’s PCMH Program for its innovation, efficacy, and the potential for replication among other Blues plans; BCBSM was the only Blues plan to receive this award.

- **URAC 2010 Best Practices in Health Care Consumer Protection and Empowerment Awards (Bronze)**: Awarded for the implementation and creation of best practices related to health care empowerment for patients.

- **Dozens of presentations**: BCBSM staff is invited to speak regularly at conferences across the country and BCBSM leadership has testified before Congress about our programs.
Specialist Engagement Expands in PGIP/PCMH

Physician Group Incentive Program POs play a key role in engaging specialists in the program. Physician organizations are tasked with educating their specialist physicians on how to engage as active members of the community of caregivers, how to achieve clinical integration, and how to share population management accountability.

There are abundant opportunities for specialties to collaborate with their PCP and specialist peers in the development and implementation of structured approaches to referrals and information sharing. In addition to several specialist-focused performance initiatives, the BCBSM *Patient Centered Medical Home Interpretive Guidelines* addresses the role of specialists and subspecialists in the PCMH-Neighbor (PCMH-N) model. PCMH-N provides the foundation to build Organized Systems of Care (OSCs).

PCMH-N is a natural extension of the PCMH program. The goals of the PCMH-N model are to:

- Ensure effective communication, coordination and integration with PCMH practices, including appropriate flow of patient care information
- Provide appropriate and timely consultations and referrals that complement and advance the aims of the PCMH practices
- Clearly define roles and responsibilities of primary care physicians and specialists in caring for the patient

PCMH-N practices engage in processes that:

- Ensure effective communication, coordination and integration with PCMH practices
- Ensure appropriate and timely consultations and referrals
- Ensure the efficient, appropriate and effective flow of information
- Effectively guides determination of responsibility in co-management situations
- Support patient-centered care, enhanced access, and high quality care
- Support the PCMH practice as the provider of whole person primary care and as having overall responsibility for ensuring the coordination/integration of care

All physicians, fully-licensed psychologists, and chiropractors are eligible to be considered for the VBR Fee Schedule. Specialists who qualify for the VBR Fee Schedule are associated with communities of caregivers which provide high value care to shared populations of patients.

In order to qualify for the VBR Fee Schedule, specialists must be a member of a PGIP physician organization for one year and must be nominated by their member PO (and possibly another PO, if that PO represents a substantial proportion of the specialist’s patients). Specialist practices are evaluated and ranked based on specialty-specific, population-level measures of cost, quality, and use. Those ranking in the top two-thirds qualify for the VBR Fee Schedule. The VBR Fee Schedule for specialists pays all RVU-based procedure codes, regardless of place of service, at a rate of 105 percent or 110 percent of the Standard Fee Schedules.
PGIP expands VBR Fee Schedule to all PGIP PCPs in recognition of strong HEDIS performance

Effective July 1, 2014, primary care physicians in the Physician Group Incentive Program are eligible for reimbursement in accordance with the VBR Fee Schedule for meeting standards on measures of clinical quality performance.

All PGIP-participating primary care physicians, regardless of their Patient-Centered Medical Home designation status, are eligible to receive the increased reimbursement. The process for determining eligibility for this is repeated annually.

The goal of the VBR Fee Schedule is to support and reward those practitioners providing high quality, evidence-based health care services, enabling our members to achieve and maintain optimal health.

The performance measures used for the value based reimbursement include adult and pediatric measures. Internal medicine physicians are scored based on the adult measures, pediatricians are scored on the pediatric measures, and family practice physicians are scored either on the adult measures or the adult and pediatric measures, depending on the composition of their patient population.

All PGIP primary care physician practices are ranked according to the appropriate measures; those practices at or above the 80th percentile will qualify for the VBR Fee Schedule.

The table below summarizes the potential value-based reimbursement available under the VBR Fee Schedule to primary care physicians for select procedure codes:

<table>
<thead>
<tr>
<th>Reimbursement as percentage of TRUST/Trad/BPP/EPO Max Fee Schedule</th>
<th>PCMH designation</th>
<th>Cost benchmark (with PCMH designation)</th>
<th>Participation in MiPCT (with PCMH designation)</th>
<th>Clinical quality performance</th>
</tr>
</thead>
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f). Provider Delivered Care Management (PDCM)

Rooted in our award-winning Patient Centered Medical Home program, Provider Delivered Care Management (PDCM) is a model whereby care management is delivered to chronically ill patients in the primary care physician’s office, provided by highly-qualified care managers. Studies suggest that care management services delivered in-person and integrated with the primary care practice are more effective than centralized phone-based interventions.

The PDCM program provides care focused on the whole patient and ensures patients with chronic conditions receive effective and personalized care, leading to better outcomes and lower costs. PDCM services may be provided to any patient who is believed to have a condition that warrants care management, including children.

The care management team provides services through the PCMH-designated practice or through the practices’ affiliated PO. In addition to a trained care manager, the clinical team may include nutritionists, certified diabetes educators, social workers, and even pharmacists. Participating practices provide care management services such as patient evaluations, follow-up visits, group education, and telephone assessment and receive reimbursement for doing so. The claims system is then used to track and report on which patients received which services, and by whom, which allows for reporting to customer groups that elect to have their employees participate.

The PDCM program is an extension of our existing BCSBM wellness and care management program called BlueHealthConnection® (BHC) which is an outreach and nurse coaching program by telephone. BHC and PDCM care managers communicate and coordinate to avoid duplication of services.

On July 1, 2015, all PCMH-designated practices are eligible to provide PDCM services.

PDCM pilot

BCBSM piloted the provider delivered care management concept from 2010-2012. It included five physician organizations, 51 physician practices, and 258 PCPs across Michigan, in Metro Detroit, Ann Arbor, Flint, Battle Creek, and Muskegon.

Results from a multi-year study of the PDCM pilot funded by the Agency for Healthcare Research and Quality and conducted by researchers from the University of Michigan, Michigan State University and BCBSM staff suggest the following:

- PDCM targeted and engaged a broader group of patients, including patients who were at earlier stage of chronic disease than HPDCM targeted members. On average, PDCM engaged members had lower claim-derived risk score and lower cost compared to HPDCM
- PDCM achieved higher engagement rates than HPDCM
- Saving estimation directionally suggests extra savings from PDCM compared with HPDCM (this finding was not statistically significant)
At the conclusion of the pilot in 2012, PDCM aligned with the Michigan Primary Care Transformation project (MiPCT), a five-year Centers for Medicare & Medicaid Services (CMS) multi-payer demonstration.

Michigan was one of eight states selected to participate in the demo, in which care management and Patient Centered Medical Homes are a key area of focus. There are approximately 1,560 providers participating in MiPCT, all of whom have been PCMH designated for five consecutive years. The MiPCT demonstration will conclude at the end of 2016.

This CMS grant has brought in hundreds of millions of additional funding to Michigan providers from the federal government for the provision of care management services — services that previously were not compensated by Medicare and Medicaid.

**PDCM Expands to Oncology Practices**

On November 1, 2013, the PDCM program was expanded to eligible PGIP oncology practices. The oncology care manager and clinical team provide their services through oncology practices that have implemented PCMH-N capabilities, to support the delivery of care management services. In addition to a trained oncology care manager, the clinical team may include nutritionists, chemotherapy educators, infusion nurses, social workers, and pharmacists.

Oncology clinical teams focus on evidence-based interventions like medication reconciliation, care transitions, in-person contact with patients whenever possible, as well as creating comprehensive care plans for patients with a cancer diagnosis.

**g). High Intensity Care Model (HICM)**

Effective October 1, 2014, the High Intensity Care Model (HICM) program was launched. The High Intensity Care Model is a program that enables Blues Medicare Advantage patients with at least six chronic health conditions to receive care management services in the physician's office and at home from a trained clinical care management team. This is a voluntary program for Blues Medicare Advantage members.

The care management team should include, but is not limited to, specially trained care managers and other clinical team members, such as registered nurses, certified-nurse practitioners, social workers, dietitians, and pharmacists — all working under the direction of a physician.

Under the High Intensity Care Model, health professionals will provide services to patients based on their chronic conditions and level of health care need. This may include goal-setting, self-management support, care transitions, remote patient monitoring, care coordination, and comprehensive care planning. Services are provided in person, in the home or practitioner's office, and also by phone.
What are the differences and similarities between Provider Delivered Care Management (PDCM) and High Intensity Care Model (HICM) services?

<table>
<thead>
<tr>
<th>Provider Delivered Care Management (PDCM)</th>
<th>High Intensity Care Model (HICM)</th>
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<tbody>
<tr>
<td>• PDCM delivers care management services to patients with moderately complex health conditions, including those with one or more chronic conditions.</td>
<td>• HICM delivers care management services to patients with highly complex conditions, generally those with six or more chronic conditions.</td>
</tr>
<tr>
<td>• PDCM delivers care management services to patients with moderately complex health conditions, including those with one or more chronic conditions.</td>
<td>• HICM is only available to BCBSM Medicare Advantage members.</td>
</tr>
<tr>
<td>• PDCM services are provided to eligible BCBSM commercial and Medicare Advantage members.</td>
<td>• In-person services at home or practitioner’s office. They may also be provided by telephone.</td>
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<tr>
<td>• PDCM in-person services are typically delivered to the member at the physician’s office.</td>
<td>• The majority of the HICM in-person services are delivered in the member’s home.</td>
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</table>

We currently have nine physician organizations participating in the program, seven in Southeast Michigan and two in West Michigan. The HICM program may be expanded to include additional physician organizations.

Coverage for this care management service is provided under Medicare Advantage benefit plans. Services are covered at 100 percent and there is no member copay, coinsurance, or deductible. Members should not be billed for these services.

h). Organized Systems of Care

The Evolution to Organized Systems of Care
From the outset, PGIP’s long-term goal has been to catalyze PCPs, specialists, hospitals and other providers to create high-functioning, comprehensive Organized Systems of Care (OSCs).

Building on the PCMH model, Organized Systems of Care are communities of caregivers with shared information systems and care processes committed to managing a patient population. Primary care physicians and their attributed patients constitute the nucleus of the OSC; specialists, sub-specialists, hospitals, and other providers who participate in the care of those patients are care partners in the OSC, and share responsibility and accountability for delivering optimal, efficient care.

OSCs are similar in concept to Accountable Care Organizations (ACOs), but place greater emphasis on responsibility to create a highly functioning system of care as well as accountability for population performance. As the ACO model emerged, BCBSM elected to continue with development of the PGIP OSC program, in keeping with our PGIP philosophy that health care is local and that providers must be collaborators in creating solutions that will optimize care in their communities. With that in mind, BCBSM provides incentives from the PGIP Reward Pool to those OSC’s demonstrating success in appropriately managing an attributed patient population. OSC’s receive reward pool funding for implementing the capabilities outlined in the three current OSC Initiatives.

As with the PCMH model, we recognize that support for incremental development of OSCs is key. In 2010, we established an OSC workgroup composed of 10 PO leaders. With this workgroup, we have developed three OSC initiatives to catalyze the implementation of OSC-level integrated patient registries, integrated performance measurement, and integrated processes of care. OSC’s receive reward pool funding for implementing the capabilities outlined in the three OSC Initiatives. In 2016 BCBSM will launch a new PPO product that will use the OSC as the foundation for its network.

Additionally, we are working to transform traditional hospital contracts to align acute care incentives with OSC objectives. Our new value-based contracting approach provides infrastructure support to implement shared information systems and care processes with their partnering physician organizations. These contracts also provide incentives for hospitals based on their partnering PCP-attributed population level cost of care performance.

Across the board, we are shifting to payment policies that redirect providers’ efforts away from traditional volume-driven care and towards innovative value-driven care. An increasing proportion of reimbursement is tied to incentivizing the development of highly effective systems of care, and rewarding provider performance in managing their patient population.
II. Hospital Pay-for-Performance Programs

BCBSM’s hospital Pay-for-Performance (P4P) programs – another key Value Partnerships program – are also helping to shape the future landscape of health care in Michigan. Launched in 1989, BCBSM’s Pay-for-Performance programs were one of the country’s first hospital incentive programs, beginning the shift towards value-driven care within the state of Michigan. The P4P program recognizes and rewards Michigan hospitals for achievements and improvements in quality, cost efficiency, and population-health management. Each year, under the P4P programs, hospitals earn an aggregate statewide incentive of 5 percent of inpatient and operating claims that is built into reimbursement. Higher performing hospitals can earn greater than 5 percent, while lower performing hospitals earn less than 5 percent. Incentives earned by all qualifying hospitals under P4P programs each year are approximately $200 million.

As BCBSM continues to travel down the path of payment innovation and value-based care delivery, the P4P program for mid and large sized hospitals recently underwent a modernization for 2014 to enhance the alignment of hospital-based incentives with advancements in PGIP and physician-based incentives. This modernization effort further establishes clinical and financial mechanisms to reward hospitals and physicians for better aligning patient care across the entire health care continuum to reduce fragmentation and create highly functioning health care systems in the form of value-based contracts.

The newly modernized P4P program continues to reward hospitals for their participation in our hospital Collaborative Quality Initiatives (CQI) programs (discussed later in this paper), but has expanded its quality focus to include population-based performance, hospital reduction of all-cause readmissions, and reward daily hospital census data reporting to support physician efforts to better manage patient care.

BCBSM also provides small and rural hospitals with the opportunity to demonstrate value to their communities and customers by meeting expectations for access, effectiveness, and quality of care through their own P4P program. As a part of this health care transformation within the state of Michigan, the rural hospital P4P program also underwent a slight modernization in 2014, positively challenging small and rural hospitals to begin to develop an awareness of population health management within their communities. The rural hospital community within the state of Michigan has proven to be a model for innovation in rural health care for many years, and the incorporation of a population-based approach into the upcoming program year will ensure these providers remain at the forefront of positive change.

As the landscape of health care continues to evolve in the state of Michigan, shifting towards a value-based system that rewards collaboration and population-based improvement, BCBSM’s Pay-for-Performance programs will continue to evolve and better align with our physician incentive programs to increase the value each delivers to Michigan hospitals and the BCBSM members they serve.
III. Value-Based Contracting for Hospitals
As previously noted, the delivery of health care is undergoing significant changes and BCBSM’s Value-Based Contract model represents our response to health care payment reform, shifting away from fee-for-service reimbursement towards rewarding increased collaboration among providers with outcome-based payments.

As of September 2015, BCBSM’s Hospital Incentive Programs team has successfully signed 69 hospitals, across 12 health systems and many independents, into Value-Based Contracting arrangements. These innovative contracts represent the joint commitment between BCBSM and Michigan hospitals to shift away from the traditional fee-for-service model towards an outcomes-based model that makes patient health the central focus.

BCBSM is focusing on population-based performance because health care transformation is accelerated when all providers responsible for a common patient population are provided with a single shared savings incentive that can only be realized through better care coordination. Focusing on improving population-based performance discourages the shifting of costs from one provider to another, and instead, rewards overall improvements in cost efficiency and care quality for the populations served by all provider partners. Although it will take some time to realize long-term cost savings from improving the overall health of the shared patient population, short-term savings are possible by better coordinating patient care across settings to reduce fragmentation and unnecessary health care resource utilization.

Providing infrastructure funding is the first phase of ensuring successful population-health management and is intended to encourage hospitals to partner with physicians and other providers to establish the tools and capabilities needed to provide high quality, cost-efficient care for a shared patient population across the care continuum. To do this, BCBSM has implemented agreements with hospitals that allocate funding specifically for this purpose. The agreements allocate a portion of each hospital’s overall reimbursement rate to implementing population health capabilities in collaboration with their physician partners. The funding is paid to the hospitals incrementally over the course of the agreement as major project milestones are completed. The infrastructure agreements are typically for a three year period, after which hospitals will be reimbursed based on their ability to implement integrated care capabilities and work with their physician partners to realize improved performance on population-based cost and quality measures.

It is important to note, however, that a hospital is not eligible for infrastructure support if it does not have an active commitment and involvement with the PGIP physician organization(s) for which it has a shared patient population. As we proceed with value-based reimbursement and infrastructure support, it is essential we continue to build on all PGIP and OSC efforts by engaging all members of the health care community to achieve the single goal of improving the health of the patient populations they serve.
IV. Collaborative Quality Initiatives (CQIs)

History of BCBSM’s CQI Program

In addition to the Physician Group Incentive Program described previously, Collaborative Quality Initiatives (CQIs) also play an important role in BCBSM’s health care transformation journey. In 1997, a group of five hospitals in Michigan – led by cardiologists at the University of Michigan and supported by the Blue Cross Blue Shield of Michigan Foundation and Blue Care Network – launched an initiative to study variation in angioplasty procedures and treatment. The initiative, known as the Blue Cross Blue Shield Cardiovascular Consortium – Percutaneous Coronary Intervention (BMC2-PCI), ultimately resulted in dramatic decreases in death rates, emergency bypass surgeries and other costly complications.

Fast forward to 2015, we now have a total of 22 CQIs that address some of the most common and costly areas of surgical and medical care in Michigan. This award-winning model is the first of its kind nationally and is highly regarded as an innovative approach to improving health care quality and value. Findings from these initiatives have been extensively published in peer-reviewed medical journals and have received national recognition and awards.

What is a CQI?

Collaborative Quality Initiatives are statewide quality improvement initiatives, developed and executed by Michigan physicians and hospital partners. Hospital CQIs are funded through reimbursement rates negotiated with hospitals. Professional CQIs are funded from the PGIP reward pool. CQIs support continuous quality improvement and development of best practices for areas of care that are highly technical, rapidly evolving and associated with scientific uncertainty.

Given that valid, evidence-based, nationally accepted performance measures are only established for a narrow scope of healthcare, BCBSM leverages collaborative, inter-institutional, clinical data registries to analyze links between processes and outcomes of care to generate new knowledge, define best practices, and guide quality improvement interventions across Michigan. Through the CQI model, providers are empowered to continuously self-assess and improve care processes and outcomes using sophisticated risk adjustment and analytic methods and pooled data from across the community to examine variations in care for the purpose of identifying which approaches are optimal.

In most cases, a CQI project relies on a comprehensive clinical registry which includes patient risk factors, processes of care and outcomes of care. A CQI registry is usually focused on a complex area of practice with clinical uncertainty, the main opportunity being to identify best practices and disseminate information about them.

Through the CQI program, BCBSM works collaboratively with 75 hospitals across Michigan, which includes all large and medium-size acute care hospitals in the state. Eighty-seven percent of eligible Michigan hospitals participate in all the CQIs for which they are eligible. Collectively, the CQIs analyze the care given to nearly 200,000 Michigan patients annually.

Each CQI program has a clinical coordinating center, which plays an integral role in its success; BCBSM works in collaboration with the CQI coordinating centers to support the hospitals participating
in each CQI. Led by a practicing Michigan-based physician leader in collaboration with a project manager, each CQI coordinating center administers the program and coalesces all of the clinical data.

CQI Coordinating Centers are responsible for the following:
- Serving as the data warehouse
- Conducting data audits
- Performing data analyses to identify best practices and opportunities for improvement
- Convening regularly scheduled meetings (typically quarterly) to share data
- Guiding quality improvement efforts
- Evaluating participants’ active engagement

Goals of the CQI Program
- To empower providers to self-assess and optimize their care by identifying opportunities to bring care into closer alignment with best practices leading to improved quality and lower costs for selected, high cost, high frequency, and highly complex procedures.
- Examine the link between care processes and outcomes in complex, highly technical areas of care to continually generate new knowledge contributing to understanding of which care processes lead to optimal outcomes.
- Measure the quality of care within and across systems of care
- Create a feedback loop to participating institutions to facilitate continuous quality improvement at their own facility
- Identify “clinical champions” at each participating hospital
- Implement fast-track quality improvement initiatives targeted at specific, high-leverage procedures
- Continue to demonstrate to consumers and purchasers of care that CQIs positively impact systems of care and help optimize the quality and outcomes of care

Why the CQI Model Works
**Three Pillars of the CQI Program**
1. Data Collection: Hospitals participating in CQIs cover the cost of collecting data from their value-based reimbursement. The reimbursement rate negotiated with a particular hospital is set to cover the majority of the hospital’s CQI data collection costs in order to enable hospitals to work in a collaborative environment with other participants of the CQI.
2. Collaborative Learning: CQI coordinating centers provide clinical leadership, coalesce statewide providers, serve as a data warehouse, conduct data audits, perform data analyses, and generate comparative performance reports.
3. Improvement Implementation: Participating hospitals work together by sharing data and disseminating best practices to improve patient care throughout the state of Michigan.
Why CQIs are so successful

- Empowers provider community to self-optimize care for their population in “real world” circumstances.
- Harness the power of continuous quality improvement – collect, analysis, share data and disseminate best practices.
- Measure to improve – not to judge.
- All patient/all payer – all patients regardless of coverage receive QI benefits.
- Collaborative, consortium-based QI catalyzes more rapid and dramatic practice transformation than independent provider improvement efforts.
- Rapid change on evidence-based medicine – what typically takes a decade or longer is often accomplished in significantly condensed periods of time.
- Locus of control remains with the providers – complete, accurate, risk adjusted, confidential, provider-owned data. BCBSM only has access to de-identified data.

Additionally, statewide CQIs continue to transform the delivery of healthcare through the analysis of procedural and outcomes data for high volume/high cost procedures resulting in the development and dissemination of best practice.

Through collaboration between providers and hospitals, rather than competition, the CQI programs have made great strides in improving the quality of care for Michigan patients by identifying best practices in some of the most common and most costly areas of surgical and medical care.

Comprehensive clinical data registries created in partnership between participating hospitals in Michigan have enabled physicians and researchers associated with each CQI to examine links between care processes and outcomes in complex, highly technical areas of care to contribute to an understanding of which care processes lead to optimal outcomes.

Through collaboration and the sharing of valuable data, BCBSM/BCN-sponsored CQIs have implemented fast-track quality improvement initiatives targeted at specific, high-leverage procedures. The pace with which newly-gained knowledge is systematically put into practice is rapidly accelerated through structured collaboration among all CQI participants. Typically, it can take up to 15 years to fully implement evidence-based medicine. However, BCBSM/BCN-sponsored collaborative quality initiatives are shortening the lag time between the implementation of new processes and resultant changes in patient care outcomes.

For example, the collaborative work carried out by the Michigan Bariatric Surgery Collaborative led to a drastic decrease in usage rates of inferior vena cava (IVC) filters – devices that the collaborative found to be causing costly complications in many bariatric surgery patients. Based on MBSC findings, the rate of IVC filter use dropped 30 percent over one quarter, as is evidenced in the graph below. The speed at which this change occurred is simply unheard of in health care, as it typically takes about 15 years to implement evidence-based medicine.
Additionally, since its inception in 2012, the Michigan Urological Surgical Improvement Collaborative (MUSIC) reduced post-biopsy infectious hospitalizations by nearly 50 percent. From 2008-2015, the Michigan Surgical Quality Collaborative (MSQC) reduced surgical site infections by more than 30 percent.

These are only a few of the many examples of the outcomes that not only equate to lower healthcare costs, but more importantly, higher quality care and better patient outcomes.

**Hospital CQIs**

Listed below are BCBSM’s hospital CQIs:

1. **Anesthesiology Performance and Improvement Reporting Exchange (ASPIRE)** – *Launched in 2015* – Aims to reduce variation in intraoperative anesthesia practices, resulting in reduced complications and better outcomes for patients.

2. **BCBSM Cardiovascular Consortium – Percutaneous Coronary Intervention (BMC2-PCI)** – *Launched in 1997* – Designed to improve the quality of care and reduce health care costs for heart patients who undergo angioplasty by reducing complications and focusing on the appropriate use of PCI.


4. **Hospital Medicine Safety (HMS)** – *Launched in 2010* – Improve the quality of care for medical patients at risk for hospital-associated Venous Thromboembolism (VTE) while reducing health care costs.
5. Michigan Anticoagulation Quality Improvement Initiative (MAQI2) – *Launched in 2009* – Aims to improve outcomes and safety for patients receiving anticoagulation therapy, improve best practices of high performing anticoagulation service (ACS) providers, disseminate strategies to providers (e.g., smaller physician offices and other hospital-based anticoagulation clinics), and reduce adverse events related to anticoagulation therapy.


9. Michigan Emergency Department Improvement Collaborative (MEDIC) – *Launching in 2016* – Establish an integrated adult and pediatric, emergency medicine-led collaborative that yields improvements in the quality and cost-efficiency of emergency care. MEDIC will leverage new and existing relationships with emergency physicians to work collaboratively to collect and analyze data, in order to identify and implement best practices across the state. The first BCBSM CQI which specifically targets and includes children.

10. Michigan Radiation Oncology Quality Consortium (MROQC) – *Launched in 2012* – Improve the quality of care for lung and breast cancer patients by determining which patients are most likely to benefit from Intensity Modulated Radiation Therapy (IMRT).


12. Michigan Spine Surgery Improvement Collaborative (MSSIC) – *Launched in 2013* – Aimed at improving the quality of care of spinal surgery through improving patient-reported outcomes following spine surgery; reducing surgical complications following spine surgery; reducing average costs of surgeries and episodes of care including surgery; and reducing the rate of repeat spine surgeries.


14. Michigan Trauma Quality Improvement Program (MTQIP) – *Launched in 2011* – Aims to improve the quality of care for trauma patients, reducing morbidity and mortality, and reducing costs of trauma care.
15. **Michigan Value Collaborative (MVC)** – *Launched in 2013* – Aims to help Michigan hospitals understand their practice patterns relative to peers so they can manage costs and improve outcomes. Participating hospitals receive comparative information about the use and costs incurred during a hospital admission as well as the related care delivered before and after the hospitalization.

**Professional CQIs**

Professional CQIs are focused primarily on ambulatory practice and differ from hospital CQIs in that they involve the collaboration of physicians representing one or more specialty groups across the state that collect, share and analyze data, identify best practices and design and implement changes that lead to improved patient care outcomes. Professional CQIs are funded by the PGIP Reward Pool.

1. **Michigan Urological Surgical Improvement Collaborative (MUSIC)** – *Launched in 2012*

   Aims to improve the quality of care provided to men with prostate cancer by improving the use and outcomes for radiographic staging studies, and patterns of care for both local therapies (e.g., radical prostatectomy, radiation therapy) and systemic androgen deprivation therapy.

**Collaborative Process Initiatives (CPIs):**

While most of the key components of a CQI and CPI are the same – for example, the inclusion of a consortium, measurement to improve, and comparative performance reporting – in a CPI the focus is entirely on a selected set of processes of care which are already known to yield good outcomes and striving to systematically implement those processes, without the additional focus on examining the relationships between processes and outcomes to generate knowledge about “what works.” CPIs are funded by the PGIP Reward Pool. BCBSM currently has four active CPIs:

1. **Lean for Clinical Redesign (Lean)** – *Launched in 2008* – Support and facilitate health care transformation through quality and process improvement initiatives utilizing Lean Thinking principles. The Lean CQI is designed to assist the Physician Group Incentive Program (PGIP) and its participating physician organizations (POs) with developing strategies for creating efficient practice transformation as well as to implement components of the Patient Centered Medical Home (PCMH) model.

2. **Michigan Oncology Clinical Treatment Pathways Program (Pathways)** – *Launched in 2010* – Brings together more than 230 medical oncologists statewide to develop clinical processes for newly diagnosed patients with breast, colon, lung, lymphoma, myeloma, ovarian, prostate, and renal cancers. The program establishes evidence-based treatment protocols, and best practices for reducing complications, increasing safety, and improving outcomes.

3. **Michigan Oncology Quality Collaborative (MOQC)** – *Launched in 2010* – Promote high-quality, effective, and cost-efficient care for cancer patients, facilitated by participation in the American Society of Clinical Oncology’s (ASCO) Quality Oncology Practice Initiative (QOPI) Health Plan Program.
4. **Michigan Pharmacists Transforming Care and Quality Consortium (MPTCQ)** – *Launched in 2015* – Expands the traditional role of pharmacists across physician organizations (POs) in Michigan to actively participate in comprehensive medical and disease management services.

**Hybrid CQI – a hospital and professional Collaborative Quality Initiative**

1. **Integrated Michigan Patient-centered Alliance on Care Transitions (IMPACT)** – Reduce hospital readmissions and improve post-discharge care coordination. I-IMPACT will engage both hospitals and partner physician organizations as participants working together as a unit, a dyad; this partnership is key. I-IMPACT will collect new data from each dyad and collaborate with the Michigan Value Collaborative (MVC) to identify the right target population as well as engage the patient’s perspective at every level of the initiative to build links for quality improvement opportunities. IMPACT is funded through a combination of negotiated hospital reimbursement and PGIP Reward Pool funds.

**CQI Results**

The collaborative, consortium-based context in which this work is done rapidly accelerates the processes of disseminating and implementing practice improvements, as is evidenced in improved outcomes for patients. The CQIs have yielded significant and measurable results and can be found by CQI in Appendix II.

**Publications**

- CQIs have been profiled in peer reviewed literature more than 150 times in the last six years. Key journals include: *Annals of Surgery, Journal of the American Collect of Surgeons, Health Affairs,* and *The New England Journal of Medicine,* among others.

- CQI influence extends far beyond Michigan and even the United States. CQIs have presented their results nationally and internationally more than 120 times in the last three years. Key presentations include: National Coalition on Health Care, American Hospital Association, American Society of Anesthesiologists, and the International Society of Arthroplasty Registries, among others. International locations have included: Switzerland, Germany, Japan, France, and Saudi Arabia.

- Several CQIs have received additional funding, from agencies such as Patient Centered Outcomes Research Institute (PCORI), National Institutes of Health (NIH), and Agency for Healthcare Research and Quality (AHRQ) to explore opportunities above and beyond the scope of their respective CQI program.
Cost Savings

Over a six year period, five programs sponsored by Blue Cross Blue Shield of Michigan to improve the quality of common medical procedures performed in Michigan hospitals have produced over $792 million in health care cost savings and have lowered complication and mortality rates for thousands of patients.

Cost savings for the five programs studied break down as follows:

<table>
<thead>
<tr>
<th>CQI Name</th>
<th>Timeframe</th>
<th>Statewide Savings</th>
<th>BCBSM Savings</th>
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</thead>
<tbody>
<tr>
<td>Michigan Surgical Quality Collaborative (general surgery)</td>
<td>2008-2013</td>
<td>$286.9 million</td>
<td>$189 million</td>
</tr>
<tr>
<td>Michigan Society of Thoracic and Cardiovascular Surgeons (cardiac surgery)</td>
<td>2009-2013</td>
<td>$109.0 million</td>
<td>$11.5 million</td>
</tr>
<tr>
<td>Michigan Cardiovascular Consortium – (angioplasty and peripheral vascular interventions)</td>
<td>2008-2013</td>
<td>$362.9 million</td>
<td>$67.4 million</td>
</tr>
<tr>
<td>Michigan Bariatric Surgery Collaborative (bariatric surgery)</td>
<td>2008-2013</td>
<td>$34.9 million</td>
<td>$15.7 million</td>
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*Statewide savings include BCBSM, BCBSM Medicare Advantage, BCN, BCN Medicare Advantage, BCC Medicaid, Medicare, Medicaid, self-payers, and all other commercial insurers.*
V. Health Care Value National Solutions

HCV National Solutions promotes BCBSM’s Value Partnerships programs along with supporting the movement from fee-for-service to fee-for-value reimbursement. From a national perspective, BCBSM’s value-based programs are aggregated together with similar Blues plans’ programs to present a national network of clinical and value-based programs available to all national customers. This is accomplished through a collaborative partnership with other Blue plans and the Blue Cross Blue Shield Association.

Blue Distinction

Through two Blue Distinction programs, we offer national solutions that identify high-performance health care providers.

1. Blue Distinction Centers:
   Facilities designated by BCBSA as Blue Distinction Centers (BDC) have demonstrated expertise in delivering patient health care safely and effectively for specific high-cost, high-variability services, which currently include bariatric surgery, cardiac care, complex and rare cancers, knee and hip replacements, maternity care (new for 2016), spine surgery, and transplants.

   The evaluation processes for these centers are based on a “total value” designation which incorporates quality and patient safety measures, cost, and network access. This national BCBSA designation is based on objective, evidence-based selection criteria established in collaboration with expert physicians and medical organizations. They review best practices, guidelines, and standards that help support the coordination and delivery of services to targeted populations with specific diagnostic and therapeutic needs. Facilities designated as BDCs have collectively demonstrated better outcomes and fewer complications for patients seeking the specialized care the center provides.

2. Blue Distinction Centers+:
   The “+” designation identifies facilities that are not only achieving the highest quality standards but are delivering it at benchmark performance on cost for the same high cost, high-variability services, except cardiac care.

   Currently, programs that have the + designation are bariatric, complex and rare cancers, knee/hip surgery, spine surgery, and transplant surgery.

Blue Distinction Centers and Blue Distinction Centers+ demonstrate better quality and improved outcomes for patients, with lower rates of complications and readmissions than their peers.
Blue Distinction Total Care

Blue Distinction Total Care integrates local value-based care programs from Blue plans across the country into a comprehensive solution for multi-state/national employers. Through Blue Distinction Total Care, BCBSM members who live in another state will have access to doctors and hospitals outside of Michigan who’ve met nationally consistent BCBSA criteria for improving health care results and lowering costs. And members who have out-of-state Blue plans but live in Michigan can be seen by Blue Distinction Total Care providers.

Blue Distinction Total Care launched in January 2015 with an unprecedented national footprint that included the majority of states.

Blue Distinction Total Care links nearly 450 local value-based care programs across 40 states into a comprehensive solution for multistate employers. Blue Cross plans are engaging nearly 110,000 physicians – 59,000 primary care and over 50,600 specialty physicians – in Blue Distinction Total Care programs to improve health care quality and increase value.

In addition, more than 13 million Blue Cross members have access to health care through Blue Distinction Total Care providers. That number is expected to grow significantly in 2016.

Blue Distinction Total Care will be rolled out to Blue Cross Blue Shield of Michigan's fully insured group members in early 2016. Blues Plans may bill employers for BDTC payments, both care coordination and provider performance payments, either through paid claims or a single line item on the claims invoice, with no administrative costs to employers for participation in these programs.

Visit bcbs.com/bdcfinder for a current list.

As of July 2015:

- 28 Michigan hospitals have Blue Distinction designation
- 90 Michigan hospitals have Blue Distinction Center+ designation

As of January 2015:

- More than 715 are being recognized nationwide as Blue Distinction Centers+
In Closing

Moving forward, BCBSM remains committed to developing innovative efforts to advance health care transformation. The continued success of our Value Partnerships programs depends on active partnership with the Michigan physician community, which plays a vital role in the planning, design, implementation, modification, and overall direction of these programs.

Because of Michigan physicians’ high level of engagement in Value Partnerships, BCBSM and the Michigan physician and hospital community have gained national recognition for the cutting edge work that is being done through these programs. Value Partnerships is a national model of innovative collaboration.

BCBSM and our partners in the PO and hospital community are routinely asked to present locally and nationally on our statewide successes in practice transformation and quality improvement. Below spotlights just a few from 2015:

- March 2015 – 10th annual P4P Summit – Transitioning from Fee-for-Service to Fee-for-Value
- April 2015 – BCBSA National Summit Conference – MSTCVS CQI and the Perfusion Registry
- May 2015 – Alternative Payment Models Conference – CQI Model and MUSIC CQI overview
- August 2015 - National Conference of State Legislatures: Innovations in Health Care Payment and Delivery – Transforming Health Care in Michigan through Value Partnerships programs

Grants & Awards

Many Value Partnerships programs – PGIP, PCMH, and PDCM – have been examined under various federal and national grant programs. This has brought national attention to Michigan and to the innovative programs being implemented by BCSBM providers, along with millions of dollars in grant money to the University of Michigan and Michigan State University.

Additionally, many Value Partnerships programs have been recognized and awarded for their contributions to improving care.

In 2015:

- Michigan Urological Surgery Improvement Collaborative was the recipient of the BCBSA Best of Blue Award
- The CQI Program was the recipient of the Dorland Case in Point Platinum Award
- The Michigan Surgical Quality Collaborative was the recipient of the Michigan Cancer Consortium Spirit of Collaboration Award

Individual CQIs as well as the program as a whole have been honored with 14 state and national awards. Honors have come from BCBS Association (in collaboration with Harvard Medical School), Michigan Cancer Consortium, National Business Coalition on Health, among others.
The commitment of the Michigan physician and hospital community to furthering health care transformation within the state has a profound impact on the success of the program, distinguishing Value Partnerships programs from other health care transformation efforts both within the state and nationally. This level of improvement would not be possible without the collaborative efforts and leadership of our physician and hospital partners.

For more information on BCBSM’s Value Partnerships program, please visit: valuepartnerships.com.

**Contact Information:**

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600 E. Lafayette Blvd.  
Detroit, MI 48226-2998  
sanderson2@bcbsm.com
## Appendix I – 2016 PGIP physician organization list

<table>
<thead>
<tr>
<th>Physician Organization Name</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Primary Contact Name</th>
<th>Primary Phone</th>
<th>Email address</th>
<th>Website</th>
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<tbody>
<tr>
<td>Advantage Health Physicians</td>
<td>245 State Street SE</td>
<td>Grand Rapids</td>
<td>MI</td>
<td>48503</td>
<td>Susan Viviano</td>
<td>616-685-1802</td>
<td><a href="mailto:vivianos@mercyhealth.com">vivianos@mercyhealth.com</a></td>
<td><a href="http://www.advantagehealth.org/">http://www.advantagehealth.org/</a></td>
</tr>
<tr>
<td>Affinia Health Network Lakeshore</td>
<td>1675 Leahy</td>
<td>Muskegon</td>
<td>MI</td>
<td>49442</td>
<td>Kelly Venne</td>
<td>231-672-4852</td>
<td><a href="mailto:vennek@mercyhealth.com">vennek@mercyhealth.com</a></td>
<td><a href="http://www.ahnpho.org/">http://www.ahnpho.org/</a></td>
</tr>
<tr>
<td>Bronson Medical Group</td>
<td>601 John Street</td>
<td>Kalamazoo</td>
<td>MI</td>
<td>49007</td>
<td>Joann Meilinger</td>
<td>269-341-6014</td>
<td><a href="mailto:meilings@bronsonhealth.org">meilings@bronsonhealth.org</a></td>
<td><a href="http://www.bronsonhealth.com/">http://www.bronsonhealth.com/</a></td>
</tr>
<tr>
<td>CIPA</td>
<td>1305 Abbot Road</td>
<td>Lansing</td>
<td>MI</td>
<td>48823</td>
<td>Linda Mackensen</td>
<td>734-302-2116</td>
<td><a href="mailto:lmackensen@medadvgrp.com">lmackensen@medadvgrp.com</a></td>
<td><a href="https://www.medadvgrp.com/cipa">https://www.medadvgrp.com/cipa</a></td>
</tr>
<tr>
<td>DMC PHO, LLC</td>
<td>28411 Northwestern Highway</td>
<td>Southfield</td>
<td>MI</td>
<td>48034</td>
<td>Thomas Walters</td>
<td>248-262-7369</td>
<td><a href="mailto:twalters@dmcpho.com">twalters@dmcpho.com</a></td>
<td><a href="http://dmcpho.com">http://dmcpho.com</a></td>
</tr>
<tr>
<td>DMC Primary Care Physicians, P.C.</td>
<td>21531 Harper Ave.</td>
<td>St. Clair Shores</td>
<td>MI</td>
<td>48080</td>
<td>Yvonne Gibson</td>
<td>586-498-8922</td>
<td><a href="mailto:ygibson23@att.net">ygibson23@att.net</a></td>
<td><a href="http://www.dmcpcp.com">http://www.dmcpcp.com</a></td>
</tr>
<tr>
<td>Genesys Integrated Group Physicians</td>
<td>3495 Center Rd.</td>
<td>Burton</td>
<td>MI</td>
<td>48519</td>
<td>Ann Donnelly</td>
<td>810-424-2209</td>
<td><a href="mailto:ann.donnelly@genesyspho.com">ann.donnelly@genesyspho.com</a></td>
<td><a href="http://www.genesys.org">www.genesys.org</a></td>
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<tr>
<td>Great Lakes OSC, LLC</td>
<td>P.O. Box 1702</td>
<td>Midland</td>
<td>MI</td>
<td>48641</td>
<td>Lori Dale</td>
<td>989-839-6636</td>
<td><a href="mailto:ldale@glosc.org">ldale@glosc.org</a></td>
<td><a href="http://www.greatermacombdpho.com">http://www.greatermacombdpho.com</a></td>
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<tr>
<td>Greater Macomb PHO</td>
<td>43421 Garfield</td>
<td>Clinton Twp.</td>
<td>MI</td>
<td>48038</td>
<td>Dirk DeLange</td>
<td>586-263-2620</td>
<td><a href="mailto:ddelang1@hfhs.org">ddelang1@hfhs.org</a></td>
<td><a href="http://henryford.com">http://henryford.com</a></td>
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<tr>
<td>Henry Ford Medical Group</td>
<td>One Ford Place</td>
<td>Detroit</td>
<td>MI</td>
<td>48202</td>
<td>Suma Varma</td>
<td>313-874-3127</td>
<td><a href="mailto:svarma2@hfhs.org">svarma2@hfhs.org</a></td>
<td><a href="http://www.hollandpho.org/">http://www.hollandpho.org/</a></td>
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<tr>
<td>Holland PHO</td>
<td>175 S. Waverly Road</td>
<td>Holland</td>
<td>MI</td>
<td>49423</td>
<td>Gina Schutter</td>
<td>616-355-3899</td>
<td><a href="mailto:gschutter@hollandhospital.org">gschutter@hollandhospital.org</a></td>
<td><a href="http://www.hollandpho.org/">http://www.hollandpho.org/</a></td>
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<tr>
<td>Huron Valley Physicians Assoc., PC</td>
<td>2002 Hogback Road</td>
<td>Ann Arbor</td>
<td>MI</td>
<td>48105</td>
<td>Shelly Deel</td>
<td>734-973-0137</td>
<td><a href="mailto:deels@hva.org">deels@hva.org</a></td>
<td><a href="http://www.hvpa.com">http://www.hvpa.com</a></td>
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<tr>
<td>IHA</td>
<td>24 Frank Lloyd Wright Drive</td>
<td>Ann Arbor</td>
<td>MI</td>
<td>48105</td>
<td>Richard Duffy</td>
<td>734-327-6382</td>
<td><a href="mailto:richard_duffy@ihacares.com">richard_duffy@ihacares.com</a></td>
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<tr>
<td>Integrated Health Partners</td>
<td>77 E. Michigan Ave.</td>
<td>Battle Creek</td>
<td>MI</td>
<td>49017</td>
<td>Ruth Clark</td>
<td>269-425-7110</td>
<td><a href="mailto:clarkr@integratedhealthpartners.net">clarkr@integratedhealthpartners.net</a></td>
<td>Integrated Health Partners' web site</td>
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<tr>
<td>Jackson Health</td>
<td>100 E. Michigan Ave.</td>
<td>Jackson</td>
<td>MI</td>
<td>49201</td>
<td>Erika Byrum</td>
<td>517-841-6940</td>
<td>erika.byrum@a</td>
<td>jpadocs.com/</td>
</tr>
<tr>
<td>Organization Name</td>
<td>Address</td>
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<td>Email Address</td>
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<td>1234 Napier Avenue</td>
<td>Benton Harbor</td>
<td>MI</td>
<td>49022</td>
<td><a href="mailto:samantha.fell@lakelandregional.org">samantha.fell@lakelandregional.org</a></td>
<td><a href="http://lakelandcare.com">http://lakelandcare.com</a></td>
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<td>Livingston Physician Organization, LLP</td>
<td>620 Byron Rd</td>
<td>Howell</td>
<td>MI</td>
<td>48843</td>
<td><a href="mailto:debra.bernstein@lakelandregional.org">debra.bernstein@lakelandregional.org</a></td>
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<td>2701 Cambridge Court Ste. 200</td>
<td>Auburn Hills</td>
<td>MI</td>
<td>48326</td>
<td><a href="mailto:leah.searcy@mclaren.org">leah.searcy@mclaren.org</a></td>
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<td>Medical Network One</td>
<td>4986 Adams Road Suite D</td>
<td>Rochester</td>
<td>MI</td>
<td>48306</td>
<td><a href="mailto:ewa.matuszewski@gmail.com">ewa.matuszewski@gmail.com</a></td>
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<td>Mercy Community Physician PHO</td>
<td>2415 24th St.</td>
<td>Port Huron</td>
<td>MI</td>
<td>48060</td>
<td><a href="mailto:tiffany.francis@stjoeshealth.org">tiffany.francis@stjoeshealth.org</a></td>
<td><a href="http://www.mercyphysiciancomunitypho.org/">http://www.mercyphysiciancomunitypho.org/</a></td>
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<td>Metro Health PHO</td>
<td>985 Gezon Pkwy. SW</td>
<td>Wyoming</td>
<td>MI</td>
<td>49509</td>
<td><a href="mailto:christina.hildreth@metrogr.org">christina.hildreth@metrogr.org</a></td>
<td>Metro Health Hospital.Metro Health PHO</td>
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<td>Michigan State University Health Team</td>
<td>D130 West Fee Hall</td>
<td>East Lansing</td>
<td>MI</td>
<td>48824</td>
<td><a href="mailto:susan.dolby@ht.msu.edu">susan.dolby@ht.msu.edu</a></td>
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<td>MidMichigan Collaborative Care Organization</td>
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<td>Midland</td>
<td>MI</td>
<td>48640</td>
<td><a href="mailto:mary.greeley@midmichigan.org">mary.greeley@midmichigan.org</a></td>
<td><a href="http://www.npoinc.org">http://www.npoinc.org</a></td>
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<td>Northern Physician Organization Inc.</td>
<td>PO Box 2160</td>
<td>Traverse City</td>
<td>MI</td>
<td>49686</td>
<td><a href="mailto:marie.hooper@metrogr.org">marie.hooper@metrogr.org</a></td>
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<td>Oakland Physician Network Services</td>
<td>2360 Orchard Lake Road Suite 105</td>
<td>Sylvan Lake</td>
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<td>48126</td>
<td><a href="mailto:mary.stahl@oakwood.org">mary.stahl@oakwood.org</a></td>
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<td>3050 Commerce Drive Suite C</td>
<td>Fort Gratiot</td>
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<td>48059</td>
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<td>Grand Rapids</td>
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<td><a href="mailto:cheriem@pwm.com">cheriem@pwm.com</a></td>
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<td>Primary Care Partners, Inc.</td>
<td>1585 Concentric Blvd.</td>
<td>Saginaw</td>
<td>MI</td>
<td>48604</td>
<td>989-583-7503</td>
<td><a href="mailto:cmorin@chs-mi.com">cmorin@chs-mi.com</a></td>
<td><a href="http://www.pmcpo.com">http://www.pmcpo.com</a></td>
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<tr>
<td>Professional Medical Corporation, PC</td>
<td>D130 West Fee Hall</td>
<td>Lansing</td>
<td>MI</td>
<td>48823</td>
<td>(517) 336-1400</td>
<td><a href="mailto:jrotter@medavgrp.com">jrotter@medavgrp.com</a></td>
<td><a href="http://www.borgess.com">http://www.borgess.com</a></td>
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<tr>
<td>ProMed Healthcare</td>
<td>5943 Stadium Drive</td>
<td>Suite 2</td>
<td>Kalamazoo</td>
<td>49009</td>
<td>269-552-2949</td>
<td><a href="mailto:cindygaines@borgess.com">cindygaines@borgess.com</a></td>
<td><a href="http://www.borgess.com">http://www.borgess.com</a></td>
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<tr>
<td>Sparrow Care Network</td>
<td>2900 Hannah Blvd.</td>
<td>East Lansing</td>
<td>MI</td>
<td>48823</td>
<td>517-364-8127</td>
<td><a href="mailto:maryann.wagner@sparrow.org">maryann.wagner@sparrow.org</a></td>
<td><a href="http://www.stmarysofmichigan.org/">http://www.stmarysofmichigan.org/</a></td>
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<td>Sparrow Physicians Health Network</td>
<td>Suite 204</td>
<td>East Lansing</td>
<td>MI</td>
<td>48823</td>
<td>517-364-8153</td>
<td><a href="mailto:bob.kardell@sparrow.org">bob.kardell@sparrow.org</a></td>
<td><a href="http://www.sparrow.org/sphn">http://www.sparrow.org/sphn</a></td>
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<tr>
<td>Spectrum Health Medical Group</td>
<td>665 Seward Avenue NW</td>
<td>Grand Rapids</td>
<td>MI</td>
<td>49504</td>
<td>616-267-0243</td>
<td><a href="mailto:jamie.jakubowski@spectrumhealth.org">jamie.jakubowski@spectrumhealth.org</a></td>
<td><a href="http://www.spectrumhealth.org/">http://www.spectrumhealth.org/</a></td>
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<tr>
<td>St. Mary's PHO, LLC</td>
<td>1015 S. Washington Ave</td>
<td>3rd Floor</td>
<td>Saginaw</td>
<td>48601</td>
<td>989-907-7509</td>
<td><a href="mailto:cheryl.gueldenzopf@stmarysofmichigan.org">cheryl.gueldenzopf@stmarysofmichigan.org</a></td>
<td><a href="http://www.stmarysofmichigan.org/">http://www.stmarysofmichigan.org/</a></td>
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<tr>
<td>Superior Health Partners</td>
<td>420 W. Magnetic Street</td>
<td>Marquette</td>
<td>MI</td>
<td>49855</td>
<td>906-225-3080</td>
<td><a href="mailto:marcie.jones@mghs.org">marcie.jones@mghs.org</a></td>
<td><a href="http://www.4mgh.org/SHP">http://www.4mgh.org/SHP</a></td>
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<tr>
<td>The Physician Alliance, LLC</td>
<td>20952 Twelve Mile Rd.</td>
<td>Suite 130</td>
<td>St. Clair Shores</td>
<td>48080</td>
<td>586-498-3572</td>
<td><a href="mailto:scott.johnson@stjohn.org">scott.johnson@stjohn.org</a></td>
<td>The Physician Alliance</td>
<td></td>
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<tr>
<td>United Physicians, Inc.</td>
<td>30600 Telegraph</td>
<td>Suite 4000</td>
<td>Bingham Farms</td>
<td>48025</td>
<td>248-593-0186</td>
<td><a href="mailto:dmercatante@updoctors.com">dmercatante@updoctors.com</a></td>
<td>updoctors.com</td>
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<tr>
<td>University of Michigan Health System</td>
<td>2500 Green Rd.</td>
<td>Suite 700</td>
<td>Ann Arbor</td>
<td>48105</td>
<td>734-647-7493</td>
<td><a href="mailto:linniec@med.umich.edu">linniec@med.umich.edu</a></td>
<td><a href="http://www.med.umich.edu/">http://www.med.umich.edu/</a></td>
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<tr>
<td>Upper Peninsula Health Group</td>
<td>228 West Washington Street</td>
<td>Marquette</td>
<td>MI</td>
<td>49855</td>
<td>906-225-7500</td>
<td><a href="mailto:dsmith@uphp.com">dsmith@uphp.com</a></td>
<td><a href="http://www.uphp.com/">http://www.uphp.com/</a></td>
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<tr>
<td>Wayne State University Physician Group</td>
<td>1420 Stephenson Highway</td>
<td>Suite 400</td>
<td>Troy</td>
<td>48083</td>
<td>248-581-5990</td>
<td><a href="mailto:pgray@med.wayne.edu">pgray@med.wayne.edu</a></td>
<td><a href="http://www.wsupgdocs.org/">http://www.wsupgdocs.org/</a></td>
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<td>616-391-3447</td>
<td><a href="mailto:vicki.woodard@wmpn.com">vicki.woodard@wmpn.com</a></td>
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<td><a href="mailto:kspeese@mhc.net">kspeese@mhc.net</a></td>
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Substantial improvements in cardiovascular outcomes have been realized in over 15 years of collaboration within the BMC2 Percutaneous Coronary Intervention (PCI):

- 10.5 percent reduction in contrast-induced nephropathy (2008-2014)
- 43.4 percent reduction in blood transfusions after angioplasty (2008-2014)
- 52 percent reduction in vascular complications (2008-2014)
- 20 percent increase in cardiac rehabilitation referral (2008-2014)
- In 2011, BMC2 PCI ventured into uncharted territory of physician review and compliance with nationally recognized appropriateness guidelines. In 2010, potentially inappropriate cases were an estimated 8.3 percent of all Michigan PCI cases; by 2013, this had dropped to 3 percent.

Improvements have also been seen in outcomes for patients with severe peripheral arterial disease who undergo vascular interventions and open vascular surgeries, as shown in Table 1. In five years of collaboration the BMC2 Vascular Interventions Collaborative (VIC) initiative has realized the following successes from 2008 through 2014:

- 33 percent reduction in vascular complications
- 46.5 percent reduction in transfusions

### 15.2 percent reduction in contrast induced nephropathy

**Table 1. Performance on Michigan Cardiovascular Collaborative VIC Metrics 2012-2014**

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<th>2014 Year-End Vascular Surgery Results</th>
<th>2012 Percent</th>
<th>2014 Percent</th>
<th>Percent Change</th>
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<td>ASA at Discharge</td>
<td>93.6 percent</td>
<td>95.2 percent</td>
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<td>Statin at Discharge</td>
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<td>86.3 percent</td>
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<td>SSI Rate (Discharge level to 30 days – Elective VS only)</td>
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<td>Skin Prep (Procedure level – Elective VS only)</td>
<td>68.6 percent</td>
<td>80.0 percent</td>
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<td>Antibiotic Redosing (Procedure level – Elective VS only)</td>
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<td>87.5 percent</td>
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<td>Post-Op MI Rate (Discharge level to 30 days – Elective VS/CEA/CAS)</td>
<td>1.8 percent</td>
<td>1.3 percent</td>
<td>27.8 percent*</td>
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<td>Transfusion, Hgb &gt;= 8 (All VS Discharges)</td>
<td>36.1 percent</td>
<td>18.0 percent</td>
<td>50.1 percent*</td>
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<td>Transfusion when asymptomatic, Hgb &gt;=8.0 (Discharge level - Elective VS only)</td>
<td>N/A</td>
<td>5.7 percent</td>
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**Michigan Bariatric Surgery Consortium (MBSC)**

With a focus on improving quality care for patients who undergo bariatric surgery, the Michigan Bariatric Surgery Consortium has:

- Decreased the pre-operative IVC filter placement rate from 7.56 percent to 0.24 percent (2007-2015)
- Increased compliance with blood clot guidelines to 84 percent (2007-2015)
- Decreased length of hospital stay beyond five days following bariatric surgery by 19 percent (2007-2011)
- Post-surgical death rates decreased by 50 percent (2007-2015)
- Readmissions declined by 38 percent (2007 – 2015)
- Overall complication rates decreased by 31 percent (2007-2015)
- Decrease in ED visit rates by 7 percent (2007-2015)

Through anonymous review of gastric bypass surgery videos by MBSC surgeons and linkage with outcomes data, a high correlation between surgical skill and positive outcomes has been suggested. Initial results have been published in the *New England Journal of Medicine* in October 2013. As a result of this important work, a grant has been received from the National Institutes of Health to develop and evaluate a video-based peer coaching program.

**Michigan Surgical Quality Consortium (MSQC)**

The goal of the Michigan Surgical Quality Consortium is to evaluate and improve the quality of general and vascular surgery while reducing health care costs. Successes include:

- Decreased surgical site infections by 30 percent (2008-2015)
- Decreased urinary tract infections by 11 percent (2014-2015)
- Decreased length of stay by 13 percent (2008-2015)
- Decreased venous thromboembolism by 15 percent (2008-2014)

Since April 2013, MSQC has been named as one of 77 federal Patient Safety Organizations (PSO) nationwide by AHRQ.

**Hospital Medicine Safety (HMS)**

The Hospital Medicine Safety consortium has been involved in the use of a validated identification process for appropriate candidates for VTE prophylaxis. This process is challenging national standards and has been recognized by the Society of Hospital Medicine as one of the top three developments in hospital medicine.

- There has been a statistically significant improvement in the rates of pharmacologic prophylaxis for high risk patients without complications.
- Participating sites showed a 35 percent improvement in patients receiving a risk assessment for potential VT
- A 36 percent increase in the amount of high risk patients who had mechanical prophylaxis ordered (based on the Padua risk assessment model to define high risk patients).
- For the PICC Use Initiative, baseline data is still being collected by most member hospitals, but improvement is beginning to be seen in the initiative goals.
1.5.4.5 Michigan Society of Thoracic and Cardiovascular Surgeons (MSTCVS) Quality Collaborative

Recognized nationally, the Michigan Society of Thoracic and Cardiovascular surgeons comprises a multidisciplinary group of medical professionals dedicated to improving the care of cardiac surgery patients in Michigan through sharing and promoting best practices based on regional and national data, clinical research and evidenced based care and guidelines.

MSTCVS results include:

- 50 percent reduction in post-operative renal failure for cardiac surgery cases (2008-Q12014) (Michigan mean of 1.6 percent vs. national average of 2.2 percent)
- 34.3 percent reduction in prolonged ventilation for cardiac surgery cases (2008-Q12014)
- 5.4 percent pre-operative use of beta-blockers for cardiac bypass surgery (national average is 7.8 percent)
- Decreased 30 day readmission rates following Isolated CABG by 31.6 percent between 2011 and 2014, as shown in Figure 9

Michigan Breast Oncology Quality Initiative (MiBOQI)

Launched in 2006, the Michigan Breast Oncology Quality Initiative is the first statewide effort to examine practice patterns in surgical, radiation and medical oncology to improve breast cancer treatment and outcomes. In 2013, the MiBOQI clinical data registry was redesigned with new data elements relative to current breast cancer treatment. As shown in Figure 10, the work of the collaborative has led to a 52 percent decrease in the use of open surgical biopsy for initial breast cancer diagnosis (2006-2014).

Michigan Anticoagulation Quality Improvement Initiative (MAQI2)

Recognizing the need for appropriate anticoagulation management to decrease - mortality rates, bleeding complications, and adverse drug events associated with anticoagulation therapy, BCBSM launched the Michigan Anticoagulation Quality Improvement Initiative (MAQI2) in 2009. The Michigan Anticoagulation Quality Improvement Initiative includes a statewide consortium centered around a comprehensive clinical registry, which is used to generate performance reports designed to improve the quality of care for patients receiving ongoing medical care for bleeding disorders under the guidance of anticoagulation services. To date MAQI2 has:

- Developed and maintain an Anticoagulation Toolkit and mobile app to help providers manage patients on warfarin more safely and effectively and to serve as a resource for patients seeking information on anticoagulation. Michigan Anticoagulation Quality Improvement Initiative consortium members continue to attend local, state, and national meetings to promote the use of the toolkit and to get feedback from community providers on ways to improve it. The toolkit and mobile app are updated regularly and can be found at www.anticoagulationtoolkit.org.

- Participating MAQI2 sites successfully modified protocols to comply with national guidelines recommending less frequent lab testing for some patients on warfarin. This has resulted in over 60,000 fewer lab tests performed at MAQI2 sites over the past two years, reducing healthcare costs and patient burden.
Participating sites have implemented a process by which adverse events are systematically reviewed to identify root causes and develop prevention strategies. Over 70 adverse events have been reviewed by multi-disciplinary committees resulting in changes to management protocols, staff training, referral processes, and patient education.

Additionally, they have started working on improvements in the following areas:

- Initiation of anticoagulation
- Maintaining therapeutic anticoagulation
- Monitoring anticoagulation at the appropriate frequency
- Managing of perioperative dosing
- Managing nontherapeutic international normalization ratios (INRs)
- Achieving and measuring safety (rates of adverse events)
- Managing bleeding
- Patient education

**Michigan Arthroplasty Registry Collaborative for Quality Improvement (MARCQI)**

The Michigan Arthroplasty Registry Collaborative for Quality Improvement has built a statewide registry of baseline data with the goal of addressing clinical variations in patient outcomes related to hip and knee joint replacement surgery to ultimately identify best practices, improve outcomes and reduce costs. To date, MARCQI has:

- 33 percent reduction in blood transfusion during first four months of implementing the quality initiative.
- Implemented an infection prevention bundle across of 54 participating hospitals.
- Reduced discharges to extended care facilities post knee or hip replacement surgery.
- Reduced variation in practice for VTE prophylaxis, transfusion, tranexamic acid (TXA) administration.

**Michigan Trauma Quality Improvement Project (MTQIP)**

The Michigan Trauma Quality Improvement Program (MTQIP) Collaborative Quality Initiative aims to address inconsistencies and variations in patient outcomes related to trauma-based care. The goals of MTQIP are to create a quality improvement infrastructure for trauma care that will improve the quality of care for trauma patients and reduce the costs of this care in the State of Michigan.

The Michigan Trauma Quality Improvement Program is focused on the following quality improvement initiatives:

- **Traumatic brain injury (TBI):** Intracranial Pressure monitoring or operation in severe TBI within 8 hours of emergency department arrival
  - Initial collaborative aggregate performance – 67 percent (2012)
  - Target aggregate performance – 80 percent
  - Current performance to date – 79 percent (2014)
- **Venous thromboembolism (VTE):** VTE rate
  - Initial collaborative aggregate performance – 2.3 percent (2008-2010)
  - Target aggregate performance – 1.5 percent
  - Current performance to date – 1.2 percent (2014)
- **Venous thromboembolism (VTE):** Pharmacologic VTE prophylaxis on/before day 3 following admission
  - Initial collaborative aggregate performance – 34 percent (2012)
  - Target aggregate performance – 50 percent
  - Current performance to date – 40 percent (2014)
• Hemorrhage control: Increase the percent of patients receiving a ratio of blood to plasma of ≤ 2.5 in the first 4 hours of a massive transfusion event
  o Initial collaborative aggregate performance – 28 percent (2011)
  o Target aggregate performance – 80 percent
  o Current performance to date – 61 percent (2014)

**Michigan Oncology Quality Consortium (MOQC)**

The goal of the Michigan Oncology Quality Consortium (MOQC) program is to promote high-quality, effective, and cost-efficient care for cancer patients, facilitated by participation in the American Society of Clinical Oncology’s (ASCO) Quality Oncology Practice Initiative (QOPI) Health Plan Program. Quality Oncology Practice Initiative is a quality improvement tool focused on process and safety measures at the oncology practice level. MOQC was launched in January 2010.

MOQC results include:

- Enrolled 54 medical oncology practices, representing 315 oncologists.
- Assisted 16 practices in attaining QOPI certification since the program began.
- Developed an Advanced Care Planning (ACP) Initiative focused on clarifying patients' understanding of their illnesses and treatment options; understanding patients' values, beliefs and goals of care, identifying patients' wishes, and identifying a substitute decision maker.
- Michigan aggregate performance in two of the six measurement categories, breast and colon/rectal cancers, meet or exceed the 90 percent threshold for aggregate performance established as the performance goal by the Coordinating Center.
- Michigan Oncology Quality Consortium in partnership with the Michigan Cancer Consortium has dramatically improved tobacco cessation referrals in Michigan with 2,093 cancer referrals made to the Quitline in the first two years. The program provides free nicotine replacement therapy (NRT) and counseling services to oncology patients.
- Developed an Oral Oncolytics Collaborative, which provides practices and patients with resources in treatment planning, symptom and toxicity monitoring, medication adherence, and financial assistance.
- Created and distributed to participants a palliative care dashboard and a root cause analysis tool to assist in addressing performance gaps.

Michigan Oncology Quality Consortium participating practices perform better than the national average on all QOPI palliative care measures except hospice and palliative referrals. MOQC, in partnership with the Michigan Cancer Consortium, has dramatically improved tobacco cessation referrals in Michigan with 2,053 cancer referrals made to the Quit Line. The program provides free nicotine replacement therapy (NRT) and counseling services to oncology patients.

**Michigan Urological Surgery Improvement Collaborative (MUSIC)**

In an effort to improve the quality of care provided to men with prostate cancer, BCBSM created the Michigan Urological Surgery Improvement Collaborative (MUSIC). Launched in January 2012, this initiative is an all-payer Michigan registry that collects data on patient demographics, cancer severity (including pathological details from needle biopsies), utilization and outcomes for radiographic staging studies, and patterns of care for both local therapies (e.g., radical prostatectomy, radiation therapy) and systemic androgen deprivation therapy. Data is analyzed to determine the performance of each participating Michigan urology practice in comparison to peers.
The MUSIC Coordinating Center performs analyses designed to identify specific care components associated with better patient outcomes. Based on these analyses, MUSIC leadership develops strategies for the dissemination of this information to participating providers in an effort to implement best practices in local communities. Ultimately the initiative aims to disseminate findings to the broader Michigan healthcare community.

There are 235 urologists, representing 42 practices currently participating in MUSIC. Results include:

- Collected data on more than 24,000 patients in 3.5 years of data collection.
- Partnered with four patient advocates, as well as the spouse of a patient. These individuals are involved in all of the consortium’s activities and offer the patient perspective, which is critical to the program’s success.
- Approved by CMS as a PQRS Qualified Clinical Data Registry (QCDR).
- Achieved a statewide decrease in the utilization of both bone scans and CT scans for men with low-risk prostate cancer through the use of comparative performance feedback, review of current guidelines, and dissemination of best practices.
- Used MUSIC data to subsequently develop and implement evidence-based appropriateness criteria for radiographic staging of all men with newly-diagnosed prostate cancer.
- Achieved a fifty percent reduction in prostate biopsy-related hospitalizations by implementing process changes for antibiotic prophylaxis focused on addressing fluoroquinolone resistance.
- Established a novel metric (MUSIC NOTES) that defines an uncomplicated early post-operative recovery, and compares these outcomes across diverse urology practices.
- Created a statewide, electronic infrastructure for measuring and improving patient-reported functional outcomes after radical prostatectomy.
- Developed an infrastructure for video-based assessment of surgical technique with the aim of linking such assessments with patient-reported outcomes data thereby allowing examination of the extent to which differences in technical proficiency can be distinguished, and whether they matter, for patients undergoing robotic prostatectomy.
- Through the assembly of a panel of MUSIC experts, developed appropriateness criteria and a standardized framework for recommending treatment for patients with low-risk prostate cancers. This tool can be combined with the assessment of patient preferences to facilitate shared decision making.

**Michigan Oncology Clinical Treatment Pathways**

In an effort to improve quality and decrease variation in oncology clinical practice among Michigan physician practices, BCBSM introduced the Michigan Oncology Clinical Treatment Pathways Program (Pathways Program) in January 2010. The Pathways Program provides recommended treatment pathways for newly diagnosed patients with breast, colon, lung, lymphoma, myeloma, ovarian, prostate and renal cancers who are receiving chemotherapy for the first time or are receiving a new line of chemotherapy due to disease progression or metastases.

PATHWAYS results include:

- Entry into the decision report tool, Caret™ provides real-time analysis of adherence with disease site treatment and supportive care pathways.
- Participants are able to generate over 50 pre-built customizable reports to review adherence rates for each disease and supportive care pathway within their own practice in addition to ranking reports and trending reports.
• An estimation of cost for each Pathways regimen is available electronically and aggregated as costs of therapy for each pathways practice. Practices are able to review site-level data of maximum, minimum, average, and median costs of medication therapies for defined lines of therapy as well as their data compared to the aggregate for all participating sites.

• In 2014, 98.3 percent of cases met the American Society of Clinical Oncology (ASCO) Choosing Wisely® item of not providing chemotherapy for patients with advanced incurable cancer with a poor performance status (ECOG 3-4).

• In 2014, 89.7 percent of cases met the ASCO Choosing Wisely® item of avoiding use of unnecessary myeloid growth factors.

• In 2014, 89.2 percent of moderately emetogenic regimens and 96.5 percent of low emetogenic regimens met the ASCO Choosing Wisely® item of not giving patients starting a chemotherapy regimen that has a low or moderate risk of causing nausea or vomiting antiemetic drugs intended for use with a regimen that has a high risk of causing nausea or vomiting.

• Since January of 2014, 37 participating practices have completed over 2000 cases resulting in an overall adherence rate of 80 percent for treatment pathways and 86 percent for supportive care pathways.
  • Disease site physician workgroups comprised of specialists have been utilized to review and provide evidence- and value-based recommendations to individual disease pathways which are reviewed by a 15-member oncologist Steering Committee for approval.
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<td>MCLAREN BAY REGIONAL; MCLAREN CENTRAL MICHIGAN; MCLAREN FLINT; MCLAREN GREATER LANSING; MCLAREN LAPEER REGIONAL; MCLAREN MACOMB; MCLAREN NORTHERN MICHIGAN; MCLAREN OAKLAND; MCLAREN PORT HURON; MCLAREN BAY REGIONAL <a href="http://www.mclarenpho.org">http://www.mclarenpho.org</a></td>
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<td>Organization</td>
<td>City</td>
<td>Phone</td>
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<td><strong>Northern Michigan Health Network</strong></td>
<td>Traverse City</td>
<td>2314218505</td>
<td>Antrim;#Benzie;#Charlevoix;#Chippewa;#Crawford;#Emmet;#Grand Traverse;#Kalkaska;#Leeelanau;#Mackinac;#Manistee;#Mason;#Otsego;#Wexford</td>
<td>KALKASKA MEMORIAL HOSPITAL;MCLAREN NORTHERN MICHIGAN;MUNSON MEDICAL CENTER;WEST SHORE MEDICAL CENTER HOSPITAL</td>
<td><a href="http://www.npoinc.org">http://www.npoinc.org</a></td>
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<td>Oakwood Accountable Care Organization, LLC</td>
<td>Dearborn</td>
<td>3132536058</td>
<td>Wayne</td>
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<td><a href="http://www.oakwoodaco.org">http://www.oakwoodaco.org</a></td>
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<td>Physician Direct Organized System of Care</td>
<td>Sylvan Lake</td>
<td>2486820088</td>
<td>Oakland</td>
<td>HURON VALLEY SINAI HOSPITAL;ST JOSEPH MERCY OAKLAND</td>
<td><a href="http://www.opns.com">http://www.opns.com</a></td>
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<td>Physician Healthcare Network, PC</td>
<td>Fort Gratiot</td>
<td>8103858082</td>
<td>Sanilac;#St.Clair</td>
<td>DECKERVILLE COMMUNITY HOSPITAL;MARLETTE REGIONAL HOSPITAL;MARQUETTE GENERAL HOSPITAL;MCLAREN PORT HURON;SAINT JOHN RIVER DISTRICT HOSPITAL;ST JOSEPH MERCY PORT HURON</td>
<td><a href="http://www.physicianhealthcare.com">http://www.physicianhealthcare.com</a></td>
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<td>Physician Hospital Organization of Battle Creek dba Integrated Health Partners</td>
<td>Battle Creek</td>
<td>2694257110</td>
<td>Calhoun;#Eaton</td>
<td>BRONSON BATTLE CREEK HOSPITAL; OAKLAWN HOSPITAL</td>
<td><a href="http://www.intergratedhealthpartners.net">http://www.intergratedhealthpartners.net</a></td>
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<td>Physicians' Organization of Western Michigan, Inc</td>
<td>Grand Rapids</td>
<td>6164587324</td>
<td>Allegan;#Barry;#Kalamazoo;#Kent;#Mason;#Ottawa</td>
<td>ALLEGAN GENERAL HOSPITAL;NORTH OTTAWA COMMUNITY HOSPITAL;PENNOCK HOSPITAL</td>
<td><a href="http://www.powm.com">www.powm.com</a></td>
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<td>Saginaw</td>
<td>9895837516</td>
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<td>Genesee;#Lapeer</td>
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<td><a href="http://www.pmcpo.com">http://www.pmcpo.com</a></td>
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<td>Regents of the University of Michigan</td>
<td>Ann Arbor</td>
<td>734 936 3568</td>
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<td>6162677012</td>
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<td>SPECTRUM HEALTH GERBER MEMORIAL; SPECTRUM HEALTH KELSEY HOSPITAL; SPECTRUM HEALTH LUDINGTON HOSPITAL; SPECTRUM HEALTH REED CITY CAMPUS; SPECTRUM HEALTH UNITED HOSPITAL; SPECTRUM HEALTH ZEELAND COMMUNITY HOSPITAL; SPECTRUM HLTH BIG RAPIDS HOSPITAL</td>
<td><a href="http://www.spectrumhealth.org">http://www.spectrumhealth.org</a></td>
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<td>ST JOSEPH HOSPITAL SYSTEM TAWAS; ST MARY'S OF MICHIGAN STANDISH HOSPITAL; ST MARYS OF MICHIGAN MEDICAL CENTER</td>
<td><a href="http://thephysicianalliance.org">http://thephysicianalliance.org</a></td>
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<td><a href="http://thephysicianalliance.org">http://thephysicianalliance.org</a></td>
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<td>United Physicians Integrated Care</td>
<td>Bingham Farms</td>
<td>2485930100</td>
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<td><a href="http://www.updoctors.com">http://www.updoctors.com</a></td>
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<td>Upper Peninsula Managed Care</td>
<td>Marquette</td>
<td>9062257500</td>
<td>Alger;#Baraga;#Chippewa;#Delta;#Dickinson;#Gogebic;#Houghton;#Iron;#Luce;#Mackinac;#Marquette;#Ontonagon;#Schoolcraft</td>
<td>ASPIRUS GRAND VIEW; ASPIRUS KEWEENAW HOSPITAL; ASPIRUS ONTONAGON HOSPITAL; BARAGA COUNTY MEMORIAL HOSPITAL; BELL MEMORIAL HOSPITAL; CHIPPEWA COUNTY WAR MEMORIAL HOSPITAL; DICKINSON COUNTY MEMORIAL HOSPITAL; HELEN NEWBERRY JOY HOSPITAL; MACKINAC STRAITS HOSPITAL AND HEALTH CENTER; MARQUETTE GENERAL HOSPITAL; MUNISING MEMORIAL HOSPITAL; NORTHSTAR HEALTH SYSTEM; OSF ST FRANCIS HOSPITAL; PORTAGE HEALTH HOSPITAL; SCHOOLCRAFT MEMORIAL HOSPITAL; VA MEDICAL CENTER - IRON MOUNTAIN</td>
<td><a href="http://www.uphealthgroup.com">http://www.uphealthgroup.com</a></td>
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<td>West Michigan Physicians Network</td>
<td>Grand Rapids</td>
<td>6163913447</td>
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<td>SPECTRUM HEALTH HOSPITAL;SPECTRUM HEALTH UNITED HOSPITAL;SPECTRUM HEALTH ZEELAND COMMUNITY HOSPITAL;SPECTRUM HLTH BIG RAPIDS HOSPITAL</td>
<td><a href="http://www.wmpn.com">http://www.wmpn.com</a></td>
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