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MICHIGAN ONCOLOGY QUALITY CONSORTIUM

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

MOQC 2026

MEDICAL ONCOLOGY BIANNUAL MEETING

Our Purpose: To further the success of interdisciplinary teams that improve the quality and value of cancer care.

While Blue Cross Blue Shield of Michigan and MOQC work collaboratively, the opinions, beliefs and viewpoints expressed by the presenters do not necessarily reflect the opinions, beliefs and viewpoints of BCBSM or any of its employees.

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Welcome

Keli DeVries, LMSW

MOQC Core Values

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TRUST & INTEGRITY

COMPASSION

GROWTH MINDSET

COLLABORATION

MOQC Strategic Objectives

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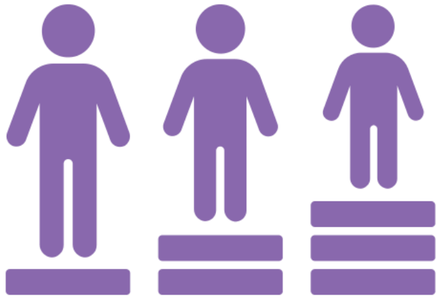

Bridging Gaps

Maximizing Value

Fostering Interprofessional Development

AGENDA

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Time	Topic	Facilitator
9:00am	**Welcome**	Keli DeVries, LMSW
9:10am	**MOQC News** • Patient and Caregiver Oncology Quality Council • Steering Committee Update	Tracey Cargill-Smith, POQC Dawn Severson, MD
9:20am	**Performance on Measures**	Lydia Benitez, PharmD, BCOP Lynn Henry, MD, PhD
10:00am	**The Voice of the Patient/Caregiver**	Erika Lojko, POQC
10:10am	**Advance Care Planning and MI-POST**	Amy Bailey, LMSW Tracy Bargeron, MSN, RN Summer Bates, FNP-BC, ACHPN
12:50pm	**Closing**	Keli DeVries, LMSW

Introductions

Please rename yourself to include your…

Full name

Organization

Pronouns

Participants on the phone…

Please rename yourself or put your name in the chat

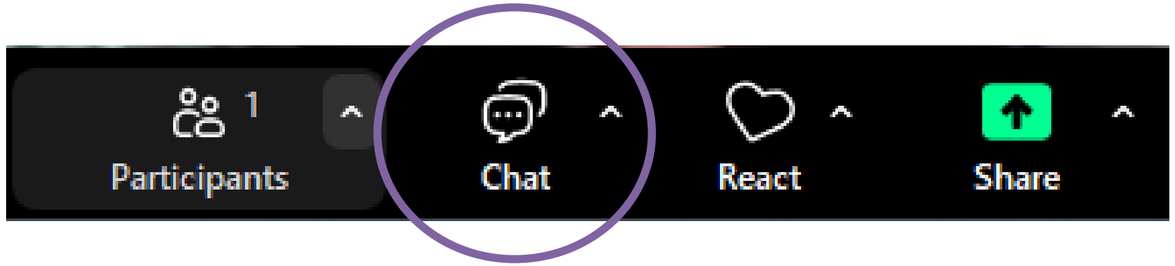
Reminder – How to Mute/Unmute

To mute your microphone

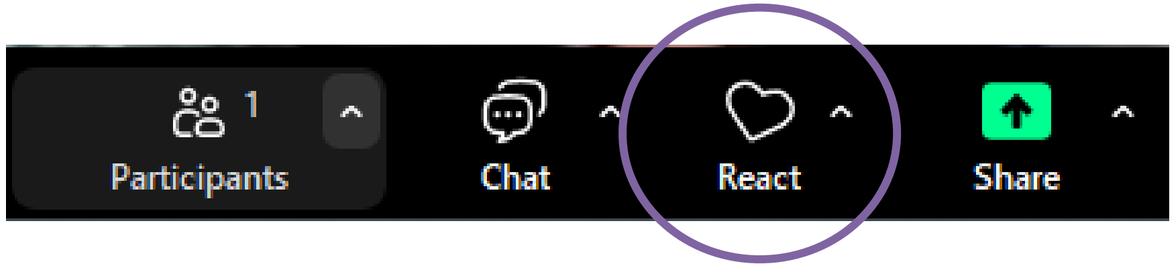
To unmute your microphone

***6 to mute/unmute**

Reminder – Chat

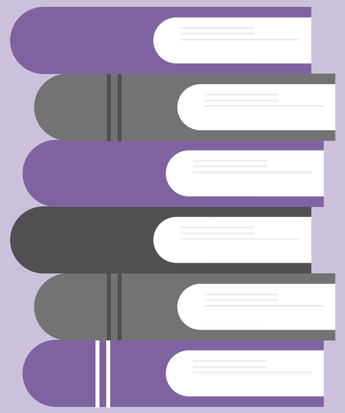


Use Chat to ask/answer questions or ask for help



Add your reactions

Confidentiality



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As a Jointly Accredited Provider of Interprofessional Continuing Education Credit, the National Center for Interprofessional Practice and Education Office of Interprofessional Continuing Professional Development (OICPD) complies with the ACCME and Joint Accreditors' Standards for Integrity and Independence in Accredited Continuing Education. The National Center has a conflict of interest policy that requires all individuals involved in the development, planning, implementation, peer review and/or evaluation of an activity to disclose any financial relationships with ineligible companies. The National Center performs a thorough review of the content of the accredited activity to ensure that any financial relationships have no influence on the content of accredited activities. All potential conflicts of interest that arise based on these financial relationships are mitigated prior to the accredited activity.

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In support of improving patient care, this activity is planned and implemented by The National Center for Interprofessional Practice and Education Office of Interprofessional Continuing Professional Development (OICPD) and the Michigan Oncology Quality Consortium. The National Center OICPD is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

Physicians: The National Center OICPD designates this activity for a maximum of **4** *AMA PRA Category 1 Credit(s)*™. Physicians should only claim credit commensurate with their participation.

Nurses: Participants will be awarded up to **4** contact hours of credit for attendance at this activity.

Nurse Practitioners: The American Academy of Nurse Practitioners Certification Program (AANPCP) accepts credit from organizations accredited by the ACCME and ANCC.

Pharmacists and Pharmacy Technicians: This activity is approved for **4** contact hours (.4 CEU)

Social Workers: As a Jointly Accredited Organization, the National Center OICPD is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. The National Center OICPD maintains responsibility for this course. Social workers completing this course receive up to **4** continuing education credits.

IPCE: This activity was planned by and for the healthcare team, and learners will receive **4** Interprofessional Continuing Education (IPCE) credits for learning and change

IPCE CREDIT™

UNIVERSITY OF MINNESOTA

MOQC Update: New Team Members

MOQC Interns

Jacob Keer

Joey McIntyre

MOQC
2025 Achievements & Highlights

Blue Cross Blue Shield of Michigan
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Statewide Non-Medical Needs Expansion
7 Domains Screened Annually
EHR → 2-1-1 Integration

Oncology Stewardship
Statewide Biomarker Benchmarking
—— Collaborations with ——
Economic Alliance for Michigan (EAM)
Testing Coverage by Payers
Pharmacy Times Continuing Education
3 CE Modules (mNSCLC)

Financial Navigation
36 MOQC Navigators Trained
MDHHS Partnership
Partnership with Patient Advocate Foundation

Palliative Care
CAPC MOQC Certificate Program — Cohort 1
14 Clinicians Trained
7 MOQC Regions Represented

Patient-Reported Outcomes (PROs)
536 Patients Surveyed
18 Practices

Family History
38% Documentation Rate
Sustained Improvement Since 2024

Interprofessional Development
Advance Care Planning + Post-Op Healing
119 Participants
18 Practices Represented

Caregiver Navigation
- **Secured Grant** to Pilot Caregiver Navigation Training
- **Partnered with Rush to Develop Program, Launching in 2026**

Dissemination
- 4 Posters at National Meetings
  - **ASCO Quality, CAPC, JADPRO**
- Presented at **MSHIELD and MVC** Collaborative-Wide Meetings
- Exhibited at Food as Medicine Summit
- **Published Olanzapine Manuscript** May 2025 in **JAMA Network Open**

Comfort Cuisine
4,312 Meals Provided
50 Patients Supported
27 Caregivers Supported
COMFORT CUISINE

Pharmacist Oncology Excellence Program in Michigan

5 YEARS OF SUCCESS

PROGRAM SCOPE

12 Pharmacists supporting **10,323** patients in collaboration with **113** physicians across **28** practices.

HIGH VOLUME PATIENT ENGAGEMENT

Pharmacists conducted over **33,000** encounters with **33,600** interventions were made to optimize care for over **10,000** patients.

PATIENT SURVEY

89 % of patients strongly agreed they felt more knowledgeable/confident about their treatment & potential side effects after speaking with a pharmacist

IMPROVED OUTCOMES

Reduction in emergency department visits, improvement in chemotherapy does intensity, increased education & medication adherence assessment

SAFETY QUALITY CARE OUTCOMES SATISFACTION

CORE PHARMACIST ACTIVITIES

PATIENT EDUCATION & SUPPORT

Delivered to **89%** of all enrolled patients

TIME SAVINGS

Saved **8** hours per week per Physician and/or Advanced Practice Pracititioner

CARE COORDINATION

Intervened to coordinate or escalate care for **38%** of patients

THERAPY OPTIMIZATION

Made at least **1** medication modification for **37%** of patients to improve outcomes

Contact Us: www.moqc.org/poem

Statewide Gynecologic Oncology Tumor Board

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- Launching spring 2026
- Monthly, virtual meetings
- Multidisciplinary teams to review and advise on gynecologic oncology cases
- Practices can submit cases to MOQC

The Language Games: The Art of Renaming Everything

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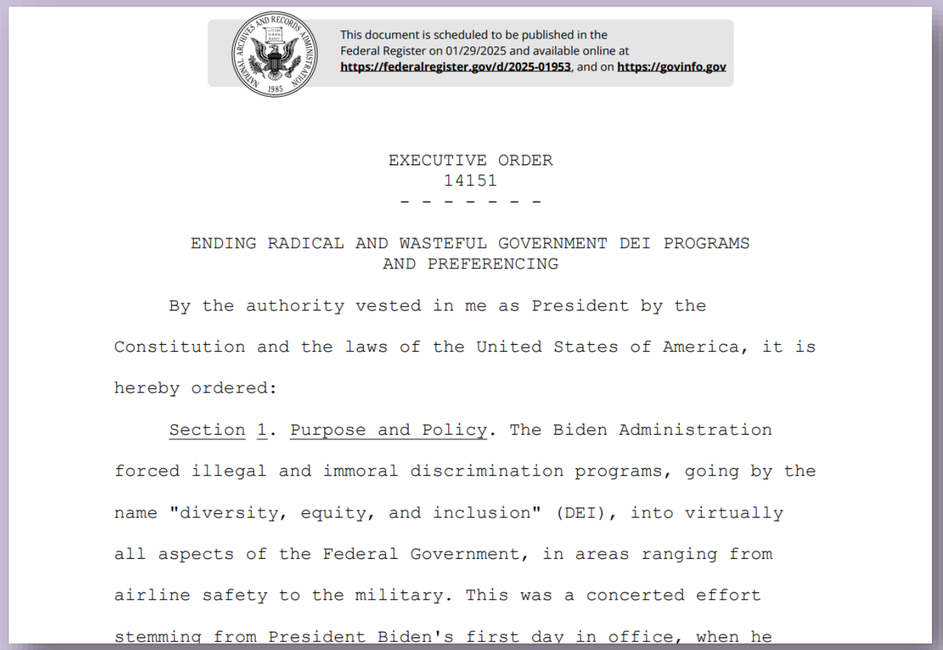
There have been several changes to committee and resource names, but their work and purposes have not changed.



This document is scheduled to be published in the Federal Register on 01/29/2025 and available online at **https://federalregister.gov/d/2025-01953**, and on **https://govinfo.gov**

EXECUTIVE ORDER
14151
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ENDING RADICAL AND WASTEFUL GOVERNMENT DEI PROGRAMS AND PREFERENCING

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered:

Section 1. Purpose and Policy. The Biden Administration forced illegal and immoral discrimination programs, going by the name "diversity, equity, and inclusion" (DEI), into virtually all aspects of the Federal Government, in areas ranging from airline safety to the military. This was a concerted effort stemming from President Biden's first day in office, when he

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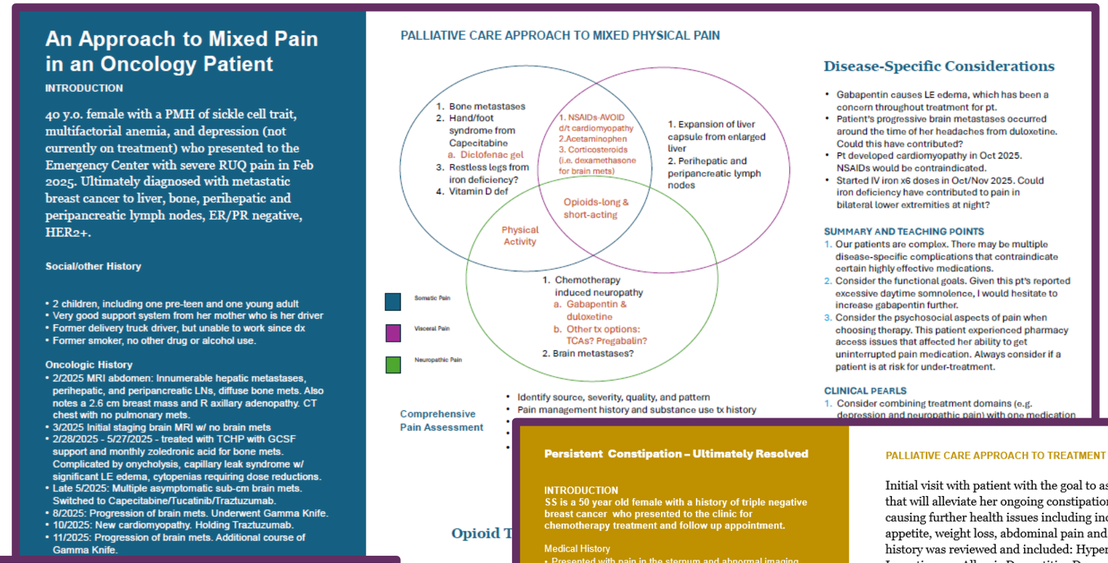
CAPC MOQC Palliative Care Certificate Program

CAPC MOQC Palliative Care Certificate Program

MICHIGAN ONOGOLOGY QUALITY CONSORTIUM

- 6-month active training
- 14 graduates:
  - 7 Nurse Practitioners
  - 6 Physician Assistants
  - 1 MD
- All MOQC regions



An Approach to Mixed Pain in an Oncology Patient

INTRODUCTION

40 y.o. female with a PMH of sickle cell trait, multifactorial anemia, and depression (not currently on treatment) who presented to the Emergency Center with severe RUQ pain in Feb 2025. Ultimately diagnosed with metastatic breast cancer to liver, bone, perihepatic and peripancreatic lymph nodes, ER/PR negative, HER2+.

Social/other History

- 2 children, including one pre-teen and one young adult
- Very good support system from her mother who is her driver
- Former delivery truck driver, but unable to work since dx
- Former smoker, no other drug or alcohol use.

Oncologic History

- 2/2025 MRI abdomen: Innumerable hepatic metastases, perihepatic, and peripancreatic LNs, diffuse bone mets. Also notes a 2.6 cm breast mass and R axillary adenopathy. CT chest with no pulmonary mets.
- 3/2025 Initial staging brain MRI w/ no brain mets
- 2/28/2025 - 5/27/2025 - treated with TCHP with GCSF support and monthly zoledronic acid for bone mets. Complicated by onycholysis, capillary leak syndrome w/ significant LE edema, cytopenias requiring dose reductions.
- Late 5/2025: Multiple asymptomatic sub-cm brain mets. Switched to Capecitabine/Tucatinib/Trastuzumab.
- 8/2025: Progression of brain mets. Underwent Gamma Knife.
- 10/2025: New cardiomyopathy. Holding Traztuzumab.
- 11/2025: Progression of brain mets. Additional course of Gamma Knife.

PALLIATIVE CARE APPROACH TO MIXED PHYSICAL PAIN

1. Bone metastases
2. Hand/foot syndrome from Capecitabine
   a. Diclofenac gel
3. Restless legs from iron deficiency?
4. Vitamin D def

1. NSAIDs AVOID d/t cardiomyopathy
2. Acetaminophen
3. Corticosteroids (i.e. dexamethasone for brain mets)

1. Expansion of liver capsule from enlarged liver
2. Perihepatic and peripancreatic lymph nodes

Opioids-long & short-acting

Physical Activity

1. Chemotherapy induced neuropathy
   a. Gabapentin & duloxetine
   b. Other tx options: TCAs? Pregabalin?
2. Brain metastases?

Somatic Pain
Visceral Pain
Neuropathic Pain

Comprehensive Pain Assessment

- Identify source, severity, quality, and pattern
- Pain management history and substance use tx history

Disease-Specific Considerations

- Gabapentin causes LE edema, which has been a concern throughout treatment for pt.
- Patient's progressive brain metastases occurred around the time of her headaches from duloxetine. Could this have contributed?
- Pt developed cardiomyopathy in Oct 2025. NSAIDs would be contraindicated.
- Started IV iron x6 doses in Oct/Nov 2025. Could iron deficiency have contributed to pain in bilateral lower extremities at night?

SUMMARY AND TEACHING POINTS

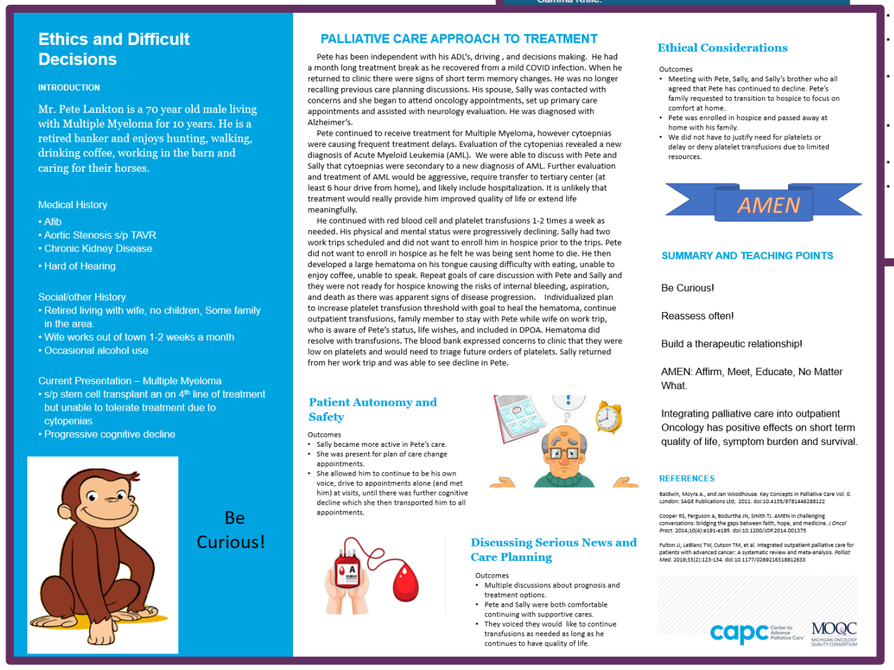
1. Our patients are complex. There may be multiple disease-specific complications that contraindicate certain highly effective medications.
2. Consider the functional goals. Given this pt's reported excessive daytime somnolence, I would hesitate to increase gabapentin further.
3. Consider the psychosocial aspects of pain when choosing therapy. This patient experienced pharmacy access issues that affected her ability to get uninterrupted pain medication. Always consider if a patient is at risk for under-treatment.

CLINICAL PEARLS

1. Consider combining treatment domains (e.g. depression and neuropathic pain) with one medication

Opioid T

- Discharged from the h
  oxycodone 5 mg Q8 ho
- Oncologist started fen
  mcg/hour Q72 h in late
  oxycodone 5-10 mg Q4
- **Hospitalized for unco**
  April 2025. Fentanyl
  25 mcg/hour. Oxycod
  hours for incident pain
- **Optimal rescue dose**
  long-acting dose. Opt
  dose 5-10 mg.
- Ultimately settled at 15
  approximately three ti
- **Consider that this pa**
  undertreatment of pa



Ethics and Difficult Decisions

INTRODUCTION

Mr. Pete Lankton is a 70 year old male living with Multiple Myeloma for 10 years. He is a retired banker and enjoys hunting, walking, drinking coffee, working in the barn and caring for their horses.

Medical History

- Afib
- Aortic Stenosis s/p TAVR
- Chronic Kidney Disease
- Hard of Hearing

Social/other History

- Retired living with wife, no children, Some family in the area.
- Wife works out of town 1-2 weeks a month
- Occasional alcohol use

Current Presentation – Multiple Myeloma

- s/p stem cell transplant an on 4th line of treatment but unable to tolerate treatment due to cytopenias
- Progressive cognitive decline

Be Curious!

PALLIATIVE CARE APPROACH TO TREATMENT

Pete has been independent with his ADL's, driving , and decisions making. He had a month long treatment break as he recovered from a mild COVID infection. When he returned to clinic there were signs of short term memory changes. He was no longer recalling previous care planning discussions. His spouse, Sally was contacted with concerns and she began to attend oncology appointments, set up primary care appointments and assisted with neurology evaluation. He was diagnosed with Alzheimer's.

Pete continued to receive treatment for Multiple Myeloma, however cytoepnias were causing frequent treatment delays. Evaluation of the cytopenias revealed a new diagnosis of Acute Myeloid Leukemia (AML). We were able to discuss with Pete and Sally that cytoepnias were secondary to a new diagnosis of AML. Further evaluation and treatment of AML would be aggressive, require transfer to tertiary center (at least 6 hour drive from home), and likely include hospitalization. It is unlikely that treatment would really provide him improved quality of life or extend life meaningfully.

He continued with red blood cell and platelet transfusions 1-2 times a week as needed. His physical and mental status were progressively declining. Sally had two work trips scheduled and did not want to enroll him in hospice prior to the trips. Pete did not want to enroll in hospice as he felt he was being sent home to die. He then developed a large hematoma on his tongue causing difficulty with eating, unable to enjoy coffee, unable to speak. Repeat goals of care discussion with Pete and Sally and they were not ready for hospice knowing the risks of internal bleeding, aspiration, and death as there was apparent signs of disease progression. Individualized plan to increase platelet transfusion threshold with goal to heal the hematoma, continue outpatient transfusions, family member to stay with Pete while wife on work trip, who is aware of Pete's status, life wishes, and included in DPOA. Hematoma did resolve with transfusions. The blood bank expressed concerns to clinic that they were low on platelets and would need to triage future orders of platelets. Sally returned from her work trip and was able to see decline in Pete.

Patient Autonomy and Safety

Outcomes

- Sally became more active in Pete's care.
- She was present for plan of care change appointments.
- She allowed him to continue to be his own voice, drive to appointments alone (and met him) at visits, until there was further cognitive decline which she then transported him to all appointments.

Discussing Serious News and Care Planning

Outcomes

- Multiple discussions about prognosis and treatment options.
- Pete and Sally were both comfortable continuing with supportive cares.
- They voiced they would like to continue transfusions as needed as long as he continues to have quality of life.

Ethical Considerations

Outcomes

- Meeting with Pete, Sally, and Sally's brother who all agreed that Pete has continued to decline. Pete's family requested to transition to hospice to focus on comfort at home.
- Pete was enrolled in hospice and passed away at home with his family.
- We did not have to justify need for platelets or delay or deny platelet transfusions due to limited resources.

AMEN

SUMMARY AND TEACHING POINTS

Be Curious!

Reassess often!

Build a therapeutic relationship!

AMEN: Affirm, Meet, Educate, No Matter What.

Integrating palliative care into outpatient Oncology has positive effects on short term quality of life, symptom burden and survival.

REFERENCES

Baldwin, Moyra A., and Jan Woodhouse. Key Concepts in Palliative Care Vol. 0. London: SAGE Publications Ltd, 2011. doi:10.4135/9781446288122

Cooper RS, Ferguson A, Bodurtha JN, Smith TJ. AMEN in challenging conversations: bridging the gaps between faith, hope, and medicine. *J Oncol Pract*. 2014;10(4):e191-e195. doi:10.1200/JOP.2014.001575

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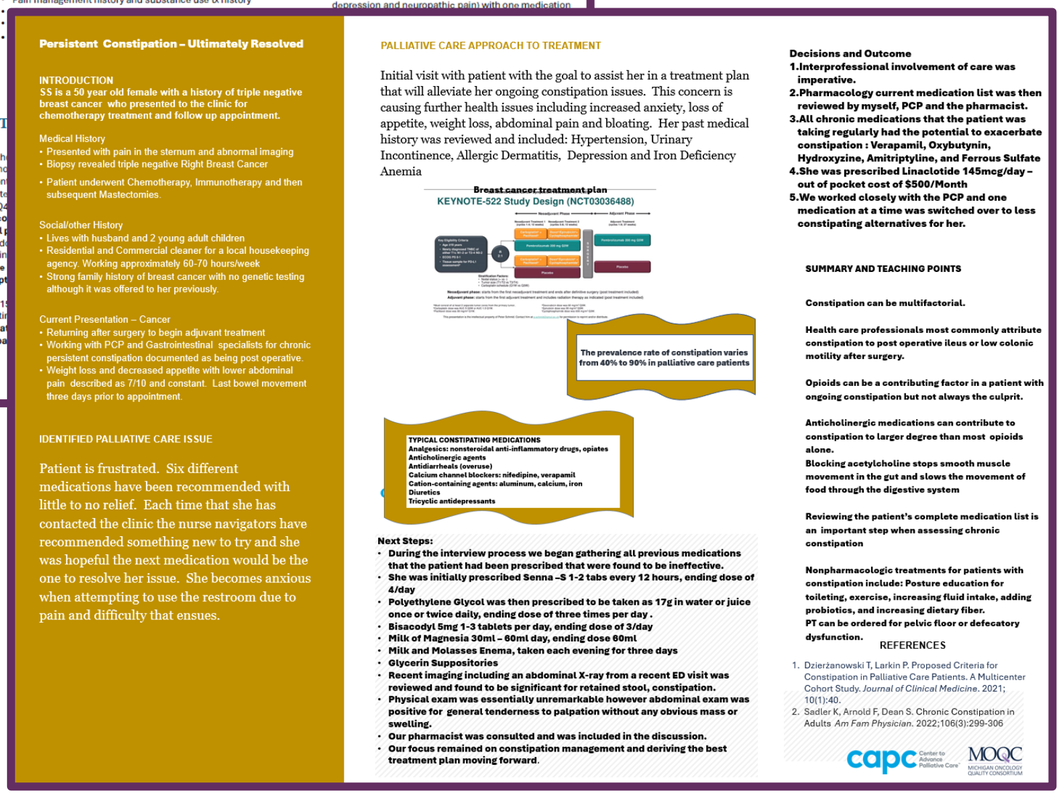

Persistent Constipation – Ultimately Resolved

INTRODUCTION

SS is a 50 year old female with a history of triple negative breast cancer who presented to the clinic for chemotherapy treatment and follow up appointment.

Medical History

- Presented with pain in the sternum and abnormal imaging
- Biopsy revealed triple negative Right Breast Cancer
- Patient underwent Chemotherapy, Immunotherapy and then subsequent Mastectomies.

Social/other History

- Lives with husband and 2 young adult children
- Residential and Commercial cleaner for a local housekeeping agency. Working approximately 60-70 hours/week
- Strong family history of breast cancer with no genetic testing although it was offered to her previously.

Current Presentation – Cancer

- Returning after surgery to begin adjuvant treatment
- Working with PCP and Gastrointestinal specialists for chronic persistent constipation documented as being post operative.
- Weight loss and decreased appetite with lower abdominal pain described as 7/10 and constant. Last bowel movement three days prior to appointment.

IDENTIFIED PALLIATIVE CARE ISSUE

Patient is frustrated. Six different medications have been recommended with little to no relief. Each time that she has contacted the clinic the nurse navigators have recommended something new to try and she was hopeful the next medication would be the one to resolve her issue. She becomes anxious when attempting to use the restroom due to pain and difficulty that ensues.

PALLIATIVE CARE APPROACH TO TREATMENT

Initial visit with patient with the goal to assist her in a treatment plan that will alleviate her ongoing constipation issues. This concern is causing further health issues including increased anxiety, loss of appetite, weight loss, abdominal pain and bloating. Her past medical history was reviewed and included: Hypertension, Urinary Incontinence, Allergic Dermatitis, Depression and Iron Deficiency Anemia

Breast cancer treatment plan
KEYNOTE-522 Study Design (NCT03036488)

The prevalence rate of constipation varies from 40% to 90% in palliative care patients

TYPICAL CONSTIPATING MEDICATIONS
Analgesics: nonsteroidal anti-inflammatory drugs, opiates
Anticholinergic agents
Antidiarrheals (overuse)
Calcium channel blockers: nifedipine, verapamil
Cation-containing agents: aluminum, calcium, iron
Diuretics
Tricyclic antidepressants

Next Steps:

- **During the interview process we began gathering all previous medications that the patient had been prescribed that were found to be ineffective.**
- **She was initially prescribed Senna –S 1-2 tabs every 12 hours, ending dose of 4/day**
- **Polyethylene Glycol was then prescribed to be taken as 17g in water or juice once or twice daily, ending dose of three times per day .**
- **Bisacodyl 5mg 1-3 tablets per day, ending dose of 3/day**
- **Milk of Magnesia 30ml – 60ml day, ending dose 60ml**
- **Milk and MoLasses Enema, taken each evening for three days**
- **Glycerin Suppositories**
- **Recent imaging including an abdominal X-ray from a recent ED visit was reviewed and found to be significant for retained stool, constipation.**
- **Physical exam was essentially unremarkable however abdominal exam was positive for general tenderness to palpation without any obvious mass or swelling.**
- **Our pharmacist was consulted and was included in the discussion.**
- **Our focus remained on constipation management and deriving the best treatment plan moving forward.**

Decisions and Outcome

1. **Interprofessional involvement of care was imperative.**
2. **Pharmacology current medication list was then reviewed by myself, PCP and the pharmacist.**
3. **All chronic medications that the patient was taking regularly had the potential to exacerbate constipation : Verapamil, Oxybutynin, Hydroxyzine, Amitriptyline, and Ferrous Sulfate**
4. **She was prescribed Linaclotide 145mcg/day – out of pocket cost of $500/Month**
5. **We worked closely with the PCP and one medication at a time was switched over to less constipating alternatives for her.**

SUMMARY AND TEACHING POINTS

Constipation can be multifactorial.

Health care professionals most commonly attribute constipation to post operative ileus or low colonic motility after surgery.

Opioids can be a contributing factor in a patient with ongoing constipation but not always the culprit.

Anticholinergic medications can contribute to constipation to larger degree than most opioids alone.
Blocking acetylcholine stops smooth muscle movement in the gut and slows the movement of food through the digestive system

Reviewing the patient's complete medication list is an important step when assessing chronic constipation

Nonpharmacologic treatments for patients with constipation include: Posture education for toiletting, exercise, increasing fluid intake, adding probiotics, and increasing dietary fiber.
PT can be ordered for pelvic floor or defecatory dysfunction.

REFERENCES

1. Dzierzanowski T, Larkin P. Proposed Criteria for Constipation in Palliative Care Patients. A Multicenter Cohort Study. *Journal of Clinical Medicine*. 2021; 10(1):40.
2. Sadler K, Arnold F, Dean S. Chronic Constipation in Adults *Am Fam Physician*. 2022;106(3):299-306

CAPC MOQC Cohort 2 Application

Apply by January 23:

- Oncology APPs from MOQC practices
- Primary care and oncology physicians and APPs from FQHC and tribal clinics
- Tuition covered by MOQC (value of $2,500 per person)

https://moqc.org/initiatives/clinical/moqc-capc-palliative-care-certificate-program/

Palliative Care Certificate Program: Cohort 2

The CAPC MOQC Palliative Care Certificate Program equips participants with practical primary palliative care skills to deliver compassionate, team-centered care, whether you are just getting started or looking to strengthen your approach.

Application open Jan 6-23, 2026 to

- Oncology APPs (NPs and PAs) from MOQC practices
- Primary care and oncology Physicians, NPs, and PAs from FQHCs and tribal clinics

Center to Advance Palliative Care capc

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PROGRAM HIGHLIGHTS:

- Access to all CAPC resources during training
- Tuition covered by MOQC ($2,500 per person)
- Highly experienced instructors
- 8-10 hours monthly time commitment
- Continuing education credits
  - 28.75 CME/33.55 Nursing Contact Hours
- Building a Michigan network of palliative care providers
- Graduation celebration

IMPORTANT 2026 DATES:

Kick off/Orientation Event (5.30-7pm EST):
March 19

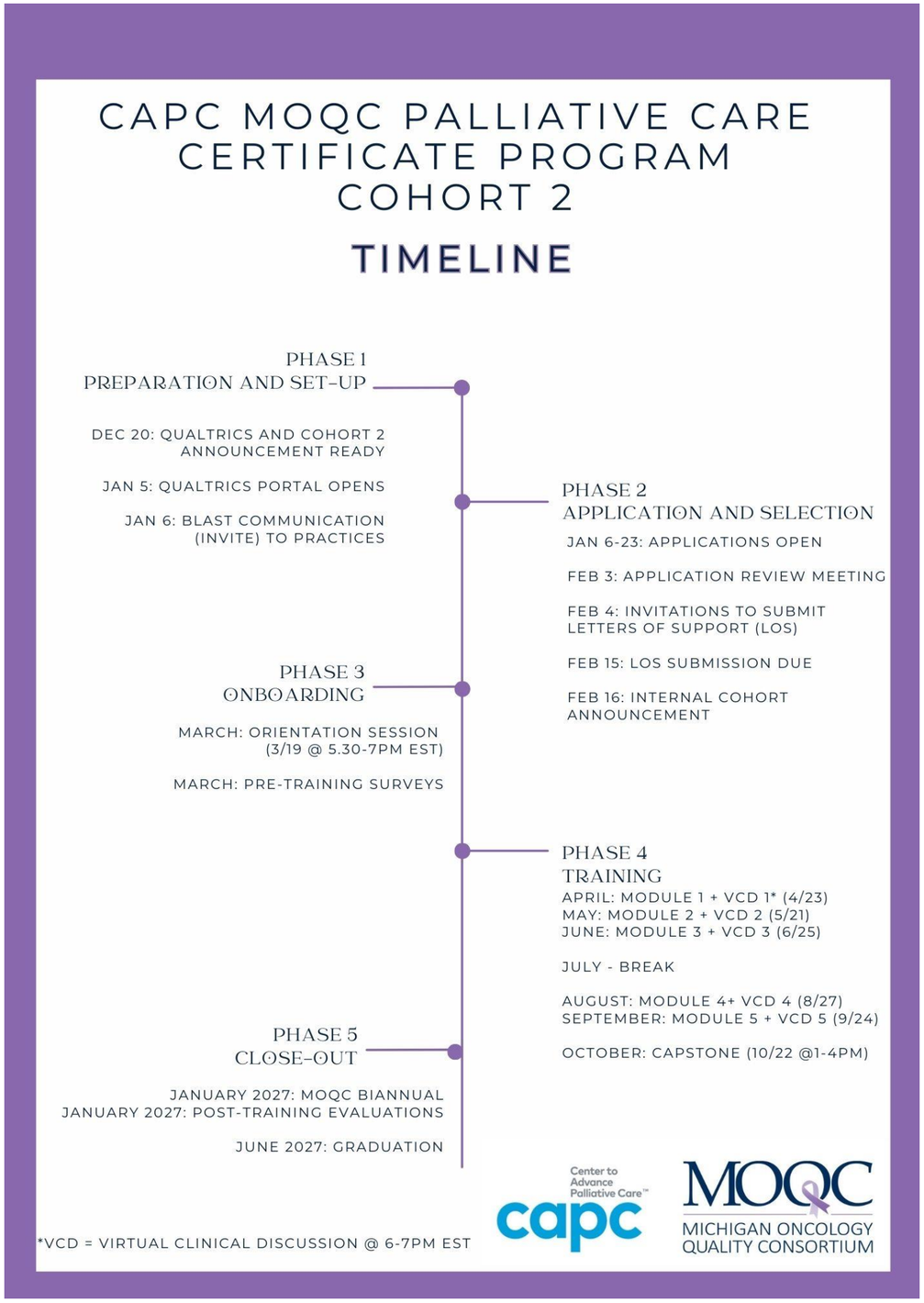
Virtual Clinical Discussions (6-7pm EST):
April 23 ● May 21 ● June 25 ● Aug 27 ● Sept 24

Capstone Presentation (1-4pm EST): Oct 22

2026 Virtual Training Schedule

April	Assessing the needs of patients and caregivers
May	Strengthening the patient-clinician relationship and understanding care goals
June	Non-pain symptom management
July	Break in training
August	Pain management
Sept	Preventing crises and planning ahead
Oct	Capstone project

Application deadline January 23, 2026
Applications available January 6 at the link or QR code
https://moqc.org/initiatives/clinical/moqc-capc-palliative-care-certificate-program/
Questions? moqc@moqc.org



Key Dates in 2026

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Application deadline: January 23

Tentative acceptance notification: February 4

Deadline to submit Letter of Support: February 15
(a template will be provided)

Kick-off/Orientation:
Thursday, March 19th @ 5.30-7PM (EST)

LIVE Virtual Clinical Discussions (Thursdays, 6-7PM EST):
April 23
May 21
June 25
July - break
August 27
September 24

Capstone Event:
Thursday, October 22 @ 1-4PM (EST)

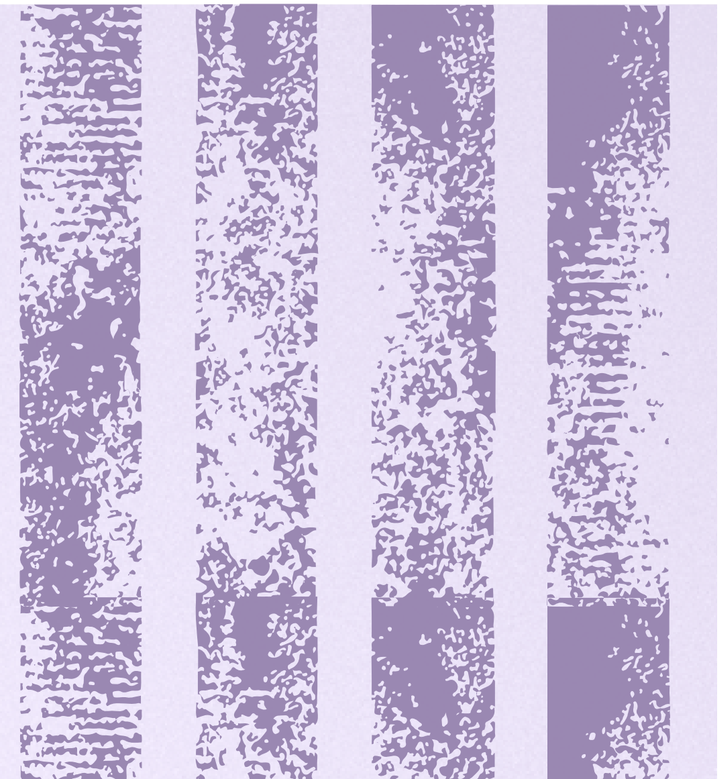
POQC
PATIENT AND CAREGIVER
Oncology Quality Council

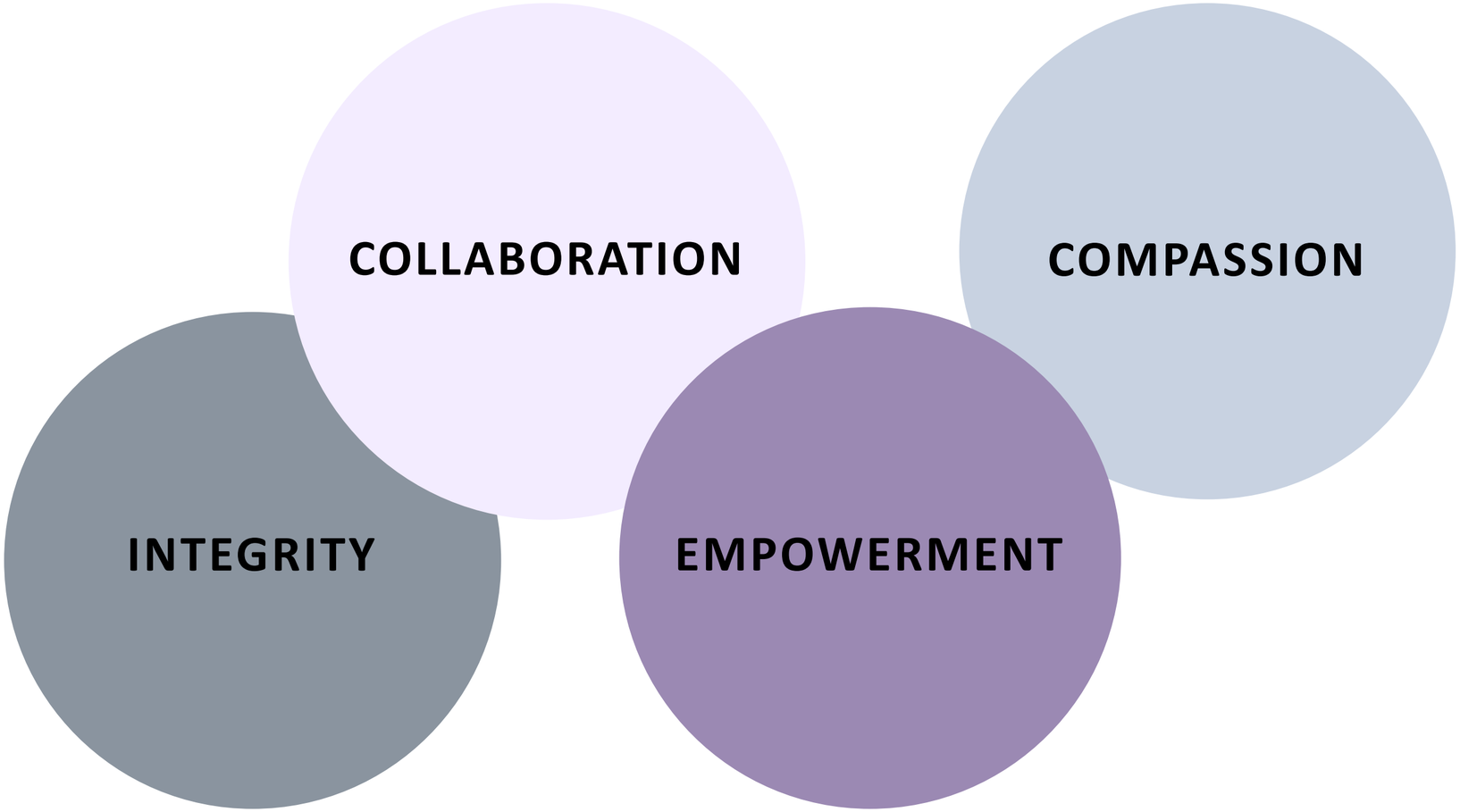
MOQC
MICHIGAN ONCOLOGY
QUALITY CONSORTIUM

POQC Updates

Tracey Cargill-Smith, POQC

Core Values





Purpose Statement

"We use our lived experiences

to improve cancer care

in Michigan."

Vision Statement

"Compassionate, quality cancer care for all"

Workgroup Spotlight

Recruitment and Retention

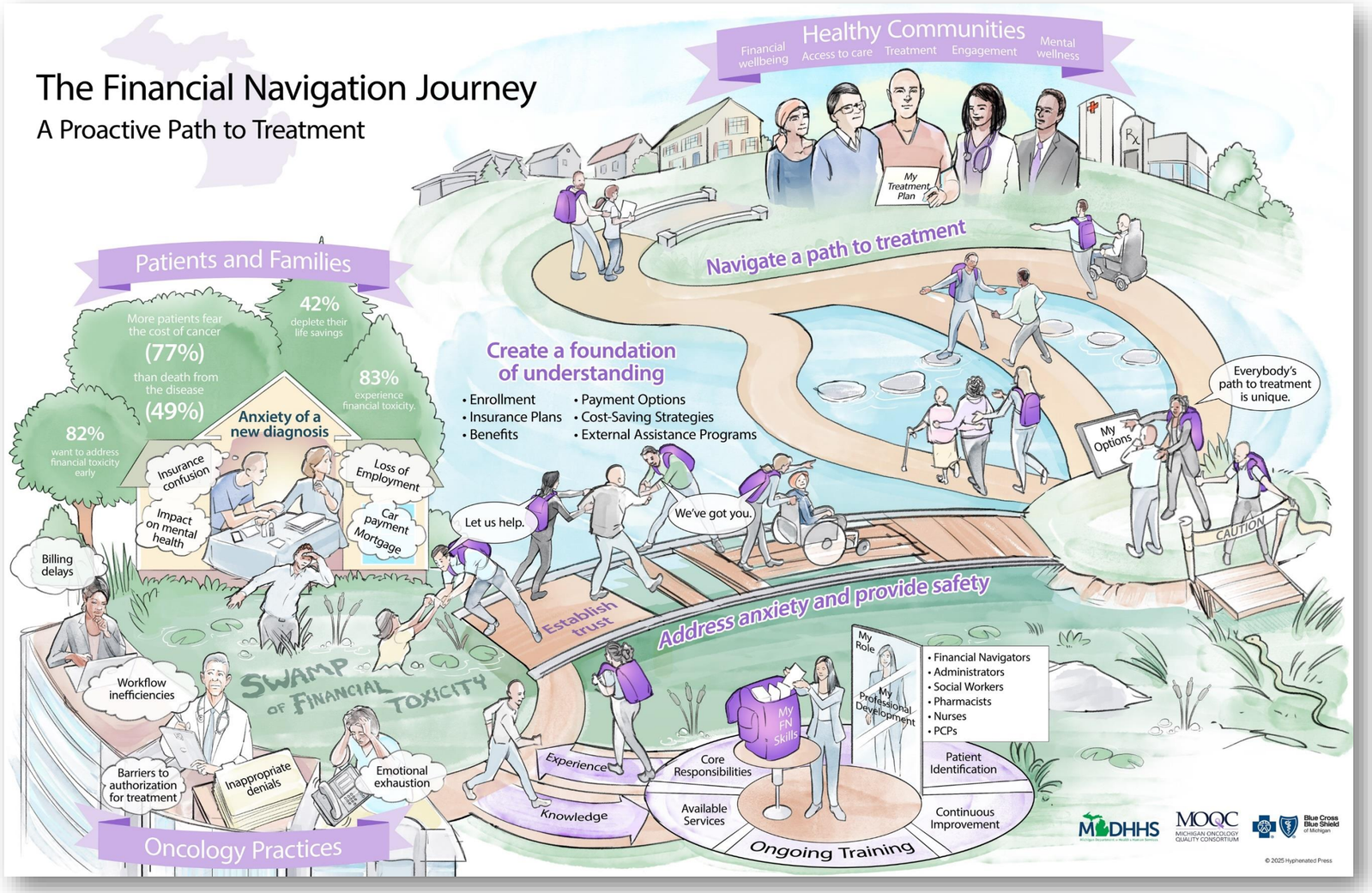
6 new members

POQC

PATIENT AND CAREGIVER
Oncology Quality Council

Workgroup Spotlight

Financial Navigation



Workgroup Spotlight

Patient and Caregiver Resources

Resources Search Engine

Cancer has a huge impact on patients and their families, friends and other caregivers. Use this search engine to help find answers, guidance, and support.

MOQC is always working to gather and share resources that are important for anyone touched by cancer.

Looking Ahead

Steering Committee Update

Dawn Severson, MD

Steering Committee Members

MOQC
MICHIGAN ONCOLOGY QUALITY CONSORTIUM

Savitha Balaraman, MD
MHP Oakland Medical Group

Kevin Brader, MD
University of Michigan Health-West

Tracey Cargill-Smith, POQC

Tammy Cedo, POQC

Tim Cox, MD
Bronson Cancer Center

Diane Drago, POQC

Donna Edberg
Great Lakes Cancer Management Specialists

Nick Erikson, MBA
Trinity Health

Joan Gargaro, POQC

Tom Gribbin, MD
The Cancer and Hematology Centers

Michael Harrison, POQC

Diana Kostoff, PharmD, BCPS, BCOP
Henry Ford Health

Kathy LaRaia
Munson Healthcare

Sherry Levandowski, MD
MyMichigan Health

Erika Lojko, POQC

Michele Loree, MSW
KCI @ McLaren Greater Lansing

Sheritha Rayford, POQC

Tayna Rudd
MHP Oakland Medical Group

Aimee Ryan
Great Lakes Cancer Management Specialists

Colleen Schwartz
MOQC Abstractor

Nisha Patel, PharmD, BCPS
Henry Ford Health

Jatin Rana, MD
KCI @ McLaren Greater Lansing

Zeyad Sako, MD
Corewell Health West

Dawn Severson, MD
Henry Ford Health Services

Beth Sieloff, MPH, RYT-200
Cancer Prevention and Control, Inter-Tribal Council of Michigan

Heather Spotts, MSW
KCI @ McLaren Greater Lansing

Mike Stellini, MD, MS
Karmanos Cancer Center

Carmen Stokes, PhD, FNP-BC, CNE
Henry Ford Health Services

Ammar Sukari, MD
Karmanos Cancer Institute

Padmaja Venuturumilli, MD
Hematology Oncology Consultants

Shannon Wills-Velez, PhD, MS, PA-C
Henry Ford Health

Leadership Update

MICHIGAN ONCOLOGY QUALITY CONSORTIUM

Lydia Benitez, PharmD, BCOP

Director, POEM and Stewardship

Lynn Henry, MD, PhD

Director, Clinical Initiatives