



Welcome!

MCT2D Collaborative Wide Meeting

June 16, 2023

Lauren Oshman, MD, MPH

MCT2D Program Director

Today's Agenda

Time	Presentation Title	Speaker
8:00am-8:30am	Welcome & Review of Quality Data	Lauren Oshman, MD MCT2D Program Director
8:30am-9:15am	Health Equity and Social Determinants of Health	Sheryl Kelly, Ph.D., LP MSHIELD Equity Advisor Matthias Kirch, MS MSHIELD Health Informatics Specialist Jordan Greene, MPH MSHIELD Engagement Specialist
9:15am-9:45am	Health Equity within MCT2D: Vision and Goals	Lauren Oshman, MD, MPH MCT2D Program Director Larrea Young, MDes Multimedia Design Project Manager MCT2D Health Equity Champion
9:45am-10:00am	Break	
10:00am-11:00am	CGM Panel and Discussion	Heidi Diez, PharmD MCT2D Co-Program Director Keith McIntyre MCT2D Patient Advisor Panelists: Kelsey Mapes, RN Alma Family Practice Saira Sundus, MD Endocrine Consultants of Mid-Michigan Bobby Dabici, PharmD Lakeland
11am-12pm	Supporting System Level Change	Amir Ghaferi, MD Froedtert & Medical College of Wisconsin

MCT2D Year in Review

Accomplishments & Data Review

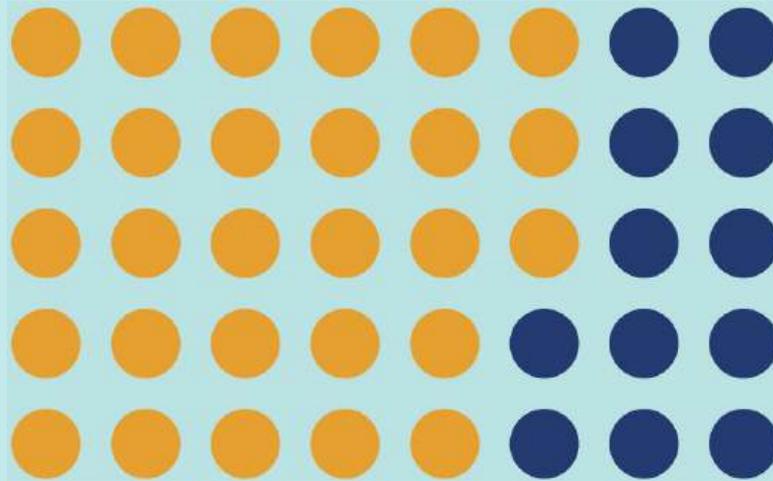


MCT2D: we're on a mission!

- **Mission**: To engage and empower clinicians and patients across Michigan to accelerate dissemination and implementation of evidence-based strategies to prevent and reverse progression of Type 2 Diabetes and its complications
- **Vision**: A world where type 2 diabetes is no longer a progressive disease.

Who We Are

Physician Organizations



28/40

of all physician
organizations in Michigan



Who We Are

Practices



310

**primary care
practices**

Added 79 practices in 2022



21

**endocrinology
practices**

Added 6 practices in 2022



15

**nephrology
practices**

Added 6 practices in 2022

MCT2D Participating Practices by Cohort

-  Cohort 1
-  Cohort 2



MCT2D Committees



Patient Advisory Board



Steering Committee
Met 2x in 2023, next meeting Fall 2023



Pharmacist Workgroups
Quarterly



Advocacy Committee
Coming Soon!

MCT2D Regional Meetings

Fall 2022

Topics: Endocrinologist presentations, comprehensive low carbohydrate diet educational session

193 total attendees across 7 regions

“Good, in depth, presentations, informative printed materials.”

Spring 2023

Topics: Tirzepatide updates, Coverage Quest, Insurance Coverage Tips & Tricks

251 attendees across 7 regions

“This is my first MCT2D meeting. The information provided seems very helpful to our providers. The length is appropriate, the agenda/presentations were well planned.”

Posters designed by members

Ditch the Sticks

Managing your blood sugar just got easier!



Here are 4 reasons to talk to your care team about getting a Continuous Glucose Monitor:

- 1 No more routine blood sugar logs and finger pokes
- 2 Know your blood sugar around the clock
- 3 Get notified when your blood sugar is too low or too high
- 4 Easier to manage your diabetes

MCT2D Michigan Collaborative for Type 2 Diabetes
Committed to preventing and reversing Type 2 Diabetes in Michigan

MANAGING YOUR TYPE 2 DIABETES

DIET
Talk to your healthcare team about lowering your carbohydrate intake to lower your blood sugar. Make sure to include high-quality protein and healthy fats!

IDENTIFY YOUR GOALS
What is your goal weight and hemoglobin A1C? A general recommendation is to lose 5-10% of your weight and have an A1C of less than 7%.

ATTEND APPOINTMENTS
If you miss an appointment, call your care team to reschedule, as regular follow-up is important. Ask your provider regularly about your health.

BLOOD GLUCOSE MONITORING
Use a glucometer or continuous glucose monitor (CGM) as recommended by your care team. Monitoring your blood sugar helps you manage your diabetes!

EXERCISE DAILY
Work your way up to at least 30 minutes of daily exercise. This could be walking, playing a sport, or exercising in a gym.

TAKE MEDICATIONS AS PRESCRIBED
Many different medications can be used to help manage your diabetes. Make sure you take your medication when it is supposed to be best for you and how to minimize side effects.

ENGAGE IN YOUR CARE
Consider joining a diabetes support group or seeing a dietitian. This can provide you with additional support to help you succeed!

STAY HYDRATED
Drink plenty of water daily. Limit your consumption of sugary drinks, high-calorie, and alcohol beverages.

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Committed to preventing and reversing Type 2 Diabetes in Michigan

YOUR role in your DIABETES MANAGEMENT

Do something today that your future self will thank you for!

Routine A1C testing (as ordered)
Goal is less than 7%.

Lowering your carbohydrate intake

Take medication as prescribed

Move your body

Stay up to date on your eye exams, routine foot and dental care

Talk to your care team for more details!

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DIABETES AND YOUR HEMOGLOBIN A1C

It's More Than Just a Number

What is an A1C?
A blood test that measures your average blood sugar over the last 3 months.

Why check my A1C?
Your provider checks A1C to see how well you are managing your blood sugar control.

What is the goal A1C?
7% or lower. Ask your provider for your specific goal A1C.

What complications occur from having a high A1C?

- Neuropathy & Tingling and Numbness in feet and hands
- Heart Disease: Heart attack, stroke
- Hearing Loss
- Kidney Disease
- Retinal Disease: Blurred vision, blindness

What can I do to improve my A1C?

- Eat Right: Lower carbohydrates and sugar in your diet. Increase healthy fats and protein.
- Get Moving: Be active several times a week.
- Medication: Take your medication as prescribed.
- Monitor Your Blood Sugar: At home as often as directed by your provider.
- Diabetes Care: Talk to your care team about any plans to change your diet or exercise regimen.

It is important to talk to your care team about any plans to change your diet or exercise regimen.

Ask your provider about getting your A1C checked today!

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YOU HAVE THE POWER TO BEAT DIABETES

YOU vs DIABETES

WORK WITH YOUR DIABETES CARE TEAM

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Brighten Your Day with 30 Minutes of Activity!



Being active makes your body more sensitive to insulin, the hormone that allows your cells to turn blood sugar into energy.

This can help you manage your diabetes. Make sure to energize your day with 30 minutes of movement.

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Committed to preventing and reversing Type 2 Diabetes in Michigan

Diabetes Management

It's a lot to juggle, but you've got this!

Ask your care team about new ways to help manage your diabetes.

DIET
EXERCISE
MEDICATION
REDUCING STRESS
MEDICAL CARE

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Committed to preventing and reversing Type 2 Diabetes in Michigan

Leave those high carb white foods in the clouds and take a bite out of the rainbow!

Did you know eating less carbohydrates can help you manage your type 2 diabetes?

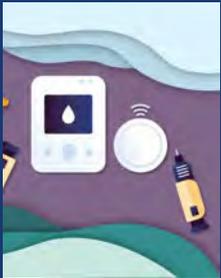


Want to learn more about a low carb lifestyle? Ask your doctor or care team!

MCT2D Michigan Collaborative for Type 2 Diabetes
Committed to preventing and reversing Type 2 Diabetes in Michigan

Designed by Jamie Nettleton, RN, BSN

Learning Community Events to Date



Management of
Chronic Kidney
Disease

273

Attendees/Viewers



Operationalizing
Low Carbohydrate
Diets

376

Attendees/Viewers



Provider Delivered
Care Management
Billing Codes

228

Attendees/Viewers



Cardiology and
Type 2 Diabetes

280

Attendees/Viewers



Implementing
MCT2D Initiatives

67

Attendees/Viewers

Upcoming Learning Community Events



Metabolic Surgery for Prevention and Treatment of Type 2 Diabetes

Monday, July 24
12-1 PM



Patient Motivation

Monday, Sept 25
12-1PM



Multidisciplinary Teams and Utilizing Diabetes Specialists

Friday, August 18
12-1 PM



Pharmacotherapy for Obesity

Friday, Nov. 17
12-1PM



Navigating CGMs

Monday, Dec 11
12-1PM

Type 2 Diabetes Policy Wins

Since June 2022:

- **United Healthcare** removed prior authorization for continuous glucose monitors for participating MCT2D practices
- **Blue Cross Complete** aligned their CGM policy with MCT2D recommendations
- **Medicare** removed their 3x insulin requirement and changed it to any insulin use
- **Michigan Medicaid** published clearer guidelines around CGM coverage for patients with T2D.
 - MCT2D drafted a letter to Michigan Medicaid and engaged practices by inviting them to submit letters as well. MCT2D shared our comments with practices who wanted to model their letter off ours



HEALTHY EATING JUMPSTART

GROCERY DELIVERY PROGRAM

THANK YOU PRACTICES AND POS



33

MCT2D practices recruited

Oct 2022-May 2023

84

Participants

In Process
**Medical
Record
Transfer**

In Process
**End of
program
surveys &
interviews**

“This program gave me a whole new way to look at diabetes. For a long time I felt sluggish and would rather sit on the couch than do laundry and now I feel I can do more and feel much better off.”

“I went to the hospital in December and they didn't even think I had diabetes because my sugars were so good.”

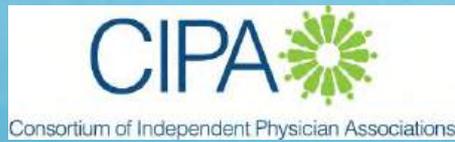




So I was really
really excited
when we were
selected for
the Jumpstart.

So I was really, really excited when we were selected for the
jumpstart.

Jamie



For helping make this program a success!

Launched since last June

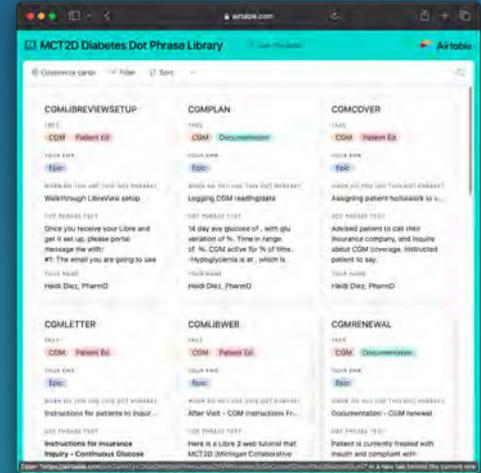


Dietitian and
Pharmacist 1on1
Consults

Coming Soon:
Cooking Demo and
Breadless
Collaboration



Best Practices
Database



Dot Phrase
Library



New tools since last June

Top 10 Coverage Tips
www.mct2d.org

Cost and coverage of diabetes medications and CGM devices is one of the biggest challenges our collaborative members face. As part of our ongoing effort to support our practices in navigating the insurance coverage process, we hosted a series of lightning discussions with cost managers, physicians, pharmacists, and other office staff who are part of MCT2D. From these discussions, we compiled a list of 10 tips that we hope will help your practice tackle many challenges related to insurance coverage.

General Coverage and Prior Auth

- 1. Favor co-pay in the inpatient**
 - **Time the check of prior authorization:** claims appeals, and patient assistance program applications by assigning a point person at your practice(s) to lead these efforts and become the "go-to" "practice" that will "lower costs on the back-end" were able to reduce overall administrative time needed across the practice and were able to support more patients with fewer setbacks.
- 2. Know the criteria and have your notes or smartphrase ready**
 - **Copy and paste is your friend.** Use SMART (http://www.smartphrase.com) or go old-school with copy and paste to ensure that all required criteria are captured in the notes. **Sharing is caring.** Talk to your colleagues about their fall phrase or smartphrases and share your own!

Patient Empowerment

- 3. Assign patient homework**
 - Give our **affordable** **Year Diabetes Care** booklet with your patients, with tips on how to talk to their insurance company to get the coverage/allowance they need. Additionally, build a **one phrase/smartphrase** that has key questions for patients to ask their insurance company so they have it available when they get home. If they need a more hands-on approach, pick one 30-45 min as a starting point and send it to the pharmacy. Advise the patient to ask the pharmacist about the cost of the copy before they pick up the prescription, and to consider if this copy will be affordable for their long term. If the copay is too expensive for them, they can decline the medication and should reach out to their insurance plan to find out the preferred and lowest cost drug in the class. They notify their doctor's office of a new prescription.
- 4. Get a head start**
 - **Lowering barriers (if you have access to them):**
 - Use medication samples to bridge the 90-day/coverage period and get patients started on the medication quickly.
 - Use CGM as our samples to demonstrate the utility of real-time data to patients, to verify the accuracy of the technology, and to gather a sample of glucometer data for patients that are not regularly testing.

MCT2D.org

Top 10 Coverage Tips

Healthy Eating JUMPSTART

HOME PLAN COOK LEARN

WELCOME TO JUMPSTART

A low carb lifestyle for Type 2 Diabetes

DOWNLOAD THE WELCOME PACKET

⚠️ Talk to the clinician who manages your diabetes before you start a low carbohydrate lifestyle. Low carb lifestyles may not be a good fit for people with certain health conditions or taking certain medications. SAFETY INFORMATION >

What is a **low carb lifestyle**?

A low carb lifestyle limits your intake of carbohydrates

PRINTABLE VERSION

Download a printable version of this page

Jumpstart Low Carb Website and Tools

Dr. Heidi Diez, PharmD

Lead Pharmacist, MCT2D
Clinical Pharmacist, Family Medicine at Domino Farms
Assistant Professor, University of Michigan College of Pharmacy

Injectable How-To Video Series

Updated tools since last June

LOW CARB CHEATSHEET

0g CARB FOODS (per serving)

- Meats: Beef, Lamb, Pork, Veal (8 oz)
- Poultry: Chicken, Turkey, Duck (8 oz)
- Fish / Seafood: Salmon, Tuna, Shrimp, Scrimp, Lobster, Crab (8 oz)
- Eggs: White or whole (2 eggs)

1-5g CARB FOODS (per serving)

- Leafy Greens: Spinach, Arugula, Kale, Cabbage, Turnip, Broccoli, Cauliflower, Eggplant, Zucchini, Asparagus, Green Beans, Bell Peppers, Cucumbers, Mushrooms, Onions, Tomatoes, Carrots, Celery, Avocado, Olives, Nuts, Seeds, Berries, Fats, Oils, Vinegars, Dressings, Mustards, Mayonnaise, Pickles, Pickled Vegetables, Herbs, Spices, Salt, Pepper, Sugar, Honey, Maple Syrup, Stevia, Coconut Oil, Coconut Flour, Coconut Butter, Coconut Milk, Coconut Cream, Coconut Yogurt, Coconut Whipped Cream, Coconut Oil, Coconut Butter, Coconut Milk, Coconut Cream, Coconut Yogurt, Coconut Whipped Cream, Coconut Oil, Coconut Butter, Coconut Milk, Coconut Cream, Coconut Yogurt, Coconut Whipped Cream.

5-10g CARB FOODS (per serving)

- Berries: Raspberries, Blueberries, Blackberries, Strawberries, Raspberries, Blueberries, Blackberries, Strawberries, Raspberries, Blueberries, Blackberries, Strawberries.
- Vegetables: Cauliflower, Broccoli, Zucchini, Eggplant, Spinach, Arugula, Kale, Cabbage, Turnip, Broccoli, Cauliflower, Eggplant, Zucchini, Asparagus, Green Beans, Bell Peppers, Cucumbers, Mushrooms, Onions, Tomatoes, Carrots, Celery, Avocado, Olives, Nuts, Seeds, Berries, Fats, Oils, Vinegars, Dressings, Mustards, Mayonnaise, Pickles, Pickled Vegetables, Herbs, Spices, Salt, Pepper, Sugar, Honey, Maple Syrup, Stevia, Coconut Oil, Coconut Flour, Coconut Butter, Coconut Milk, Coconut Cream, Coconut Yogurt, Coconut Whipped Cream.

10-20g CARB FOODS (per serving)

- Whole Wheat Bread, Pasta, Rice, Beans, Lentils, Quinoa, Sweet Potato, Fruit Juice, HF Syrup, etc.

HIGH CARB FOODS

- White Bread, Sugar, Honey, Maple Syrup, Stevia, Coconut Oil, Coconut Flour, Coconut Butter, Coconut Milk, Coconut Cream, Coconut Yogurt, Coconut Whipped Cream.

Low Carb Cheatsheet and tracker

SGLT2i & GLP-1 RA PATIENT ASSISTANCE PROGRAMS

BYDUREON BCSiE & BYETTA EXENATIDE XR (AstraZeneca)

AZ & ME PRESCRIPTION SAVINGS PROGRAM
 1-800-292-8383
 Must have no prescription coverage for needed medication.

FARXIGA DAPAFLIZOZIN (AstraZeneca)

AZ & ME PRESCRIPTION SAVINGS PROGRAM
 1-800-292-8383
 Must have no prescription coverage for needed medication.

INVOKANA CANAGLIFLOZIN (Johnson & Johnson)

JOHNSON & JOHNSON PATIENT ASSISTANCE FOUNDATION, INC.
 1-800-612-8227
 No insurance coverage (as of Jan 2023).

JARDANCE EMPAGLIFLOZIN (Boehringer Ingelheim & Eli Lilly)

10 CARB PATIENT ASSISTANCE PROGRAM
 1-800-554-8317
 Must be uninsured or underinsured.

Patient Assistance Programs and Copay Savings Cards

Affording Your Type 2 Diabetes Care

Patient Cost Assistance Toolkit

RECEIPT

TOTAL \$

THANK YOU

MCT2D

www.MCT2D.org

Affording Your T2D Care Toolkit

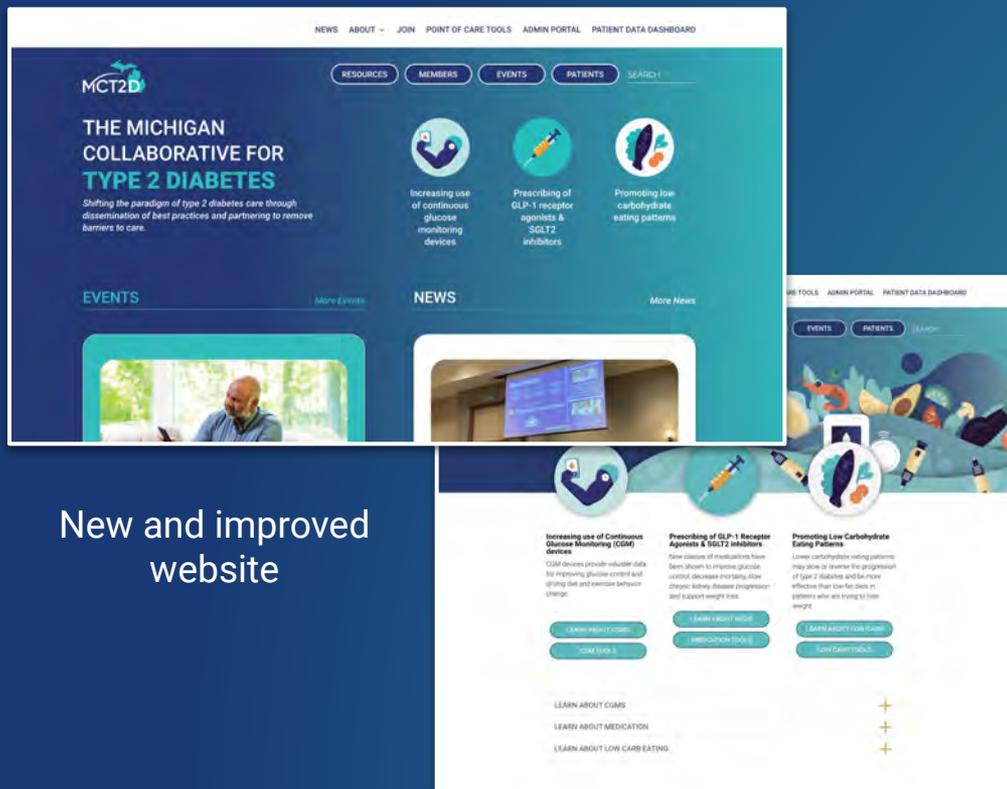
PRIVATE & PBM Coverage for GLP-1 RA & GIP

	TRULICITY Dulaglutide	OZEMPC Semaglutide	RYBELSUS Semaglutide	VICTOZA Liraglutide	MOGLIARO Tirzepatide	BYDUREON BCSiE Exenatide
AETNA	Preferred	Preferred	Preferred	Preferred	No info.	Not Covered
BCBSM	Preferred	Preferred	Preferred	Preferred	Preferred	Not Covered
EXPRESS SCRIPTS	Preferred	Preferred	Preferred	Not Covered	Preferred	Preferred
HAP	Preferred	Preferred	Preferred	Preferred	Preferred	Not Covered
PRIORITY	Preferred	Preferred	Not Covered	Preferred	Preferred	Not Covered
PRIORITY (OPTIMIZED)	Preferred	Preferred	Not Covered	Preferred	Preferred	Not Covered
UNITED	Preferred	Preferred	Preferred	Preferred	Preferred	Preferred

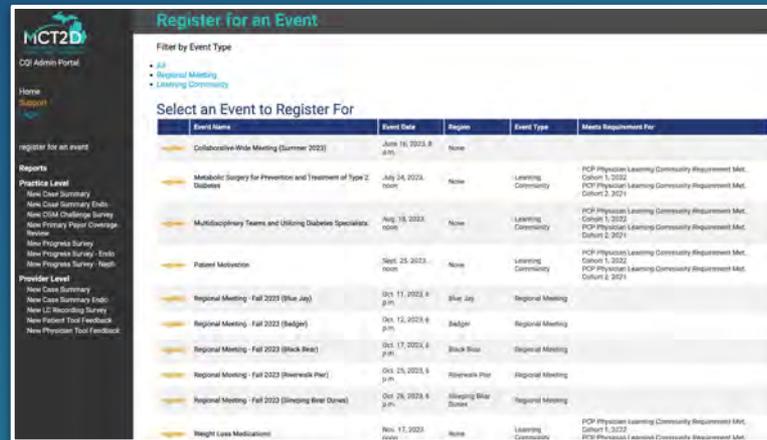
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES | mct2d.org | www.michigancollaborative.org

Coverage Guides

What's next?



New and improved website



New Admin Portal with members dashboard

- Online, interactive coverage guide
- New tools including new low carb handouts, parachute health, CGM support and more!

MCT2D Dashboards

- In 2022, launched summary statistics in the dashboard
- Have been completing user feedback sessions to enhance the look, feel, and operability of the dashboard
- In June 19th refresh and enhancement, Blue Care Network patients will be added, resulting in a 28% increase in patients represented by the dashboard
- Working on specialist attribution
 - Nephrology specialist attribution to be completed by end of September
 - Still finalizing endocrinology attribution model
- Working on a data use agreement for Medicaid claims data and making progress!

A blurred background image of a city street with buildings and cars, overlaid with the text 'COMING SOON' in large, white, bold, sans-serif capital letters.

COMING SOON

Coming soon!

- PO level reports
- Initial reports coming in July, then will follow a quarterly cycle
- Updated look and feel of the dashboard
- All payor clinical data by end of 2023 or early 2024

Looking Ahead



Upcoming 1on1
PO/MCT2D calls to learn
about your progress and
provide support



Next PCP VBR cycle will
introduce PO level
process measures
around MCT2D initiatives



Recruiting new POs and
practices in Q1 2024



THANK YOU

Thank you!

**We appreciate
you joining us
today and for
your work
improving care
for patients
with T2D!**

MCT2D Data

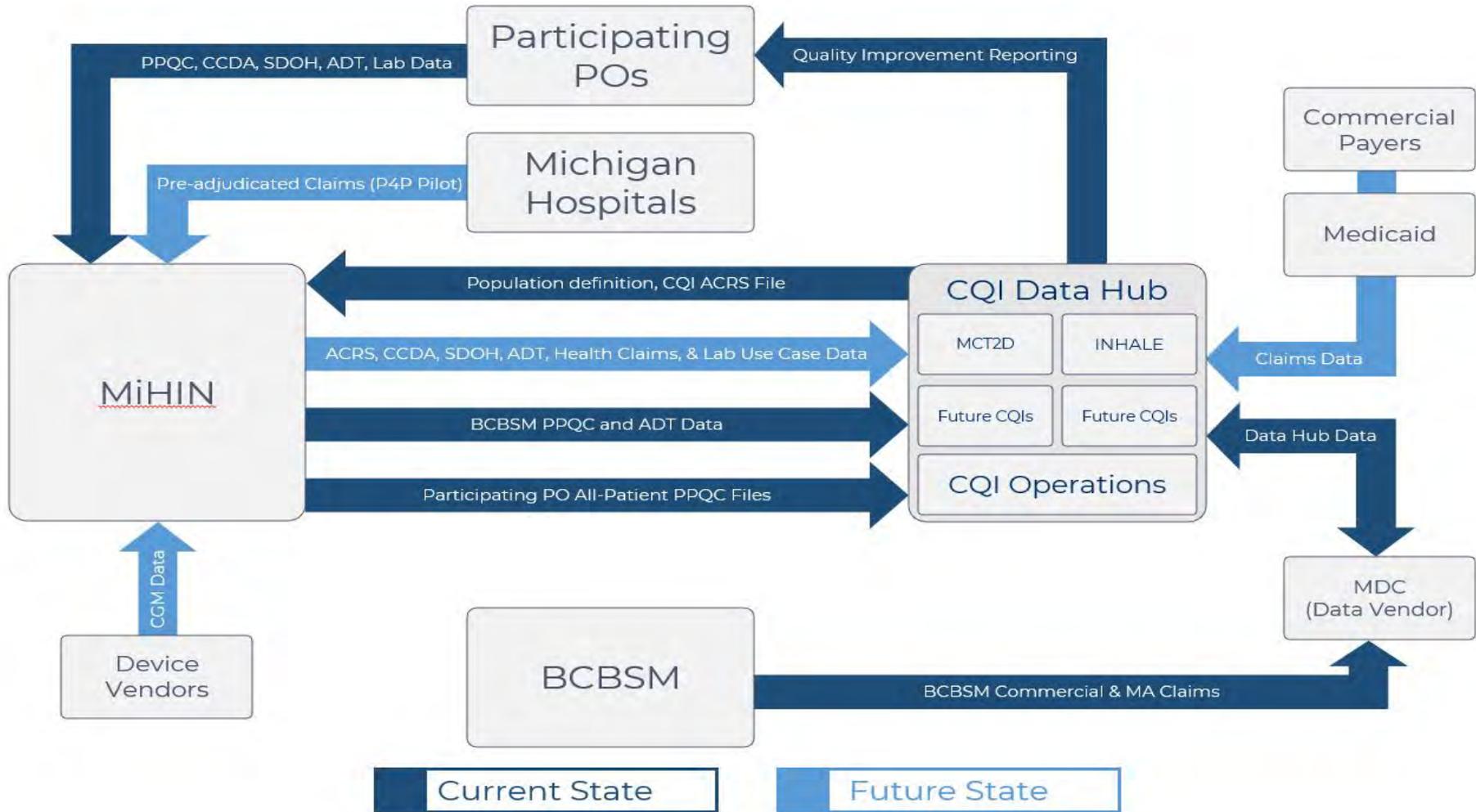
Methods

Sample

- Type 2 diabetes patients defined as having at least one of the following characteristics:
 - 1) ICD-9/ICD-10 Diagnostic Code for T2D
 - 2) A1c of 6.5% or greater
 - 3) Prescribed diabetes medication

Limitations

- Claims data only for patients with Blue Cross Blue Shield of Michigan Preferred Provider Organization (BCBSM PPO) and Medicare Advantage coverage
- Units unknown for lab values
- Medication data not available for patients with pharmacy carve outs



Methods/Assumptions

- Lab Values
 - HbA1c
 - Deleted values less than 4.0%
 - Deleted values greater than 20.0%
 - Body Mass Index (BMI)
 - Deleted values less than 15.0
 - Deleted values greater than 150
 - Weight
 - Deleted values less than 45.0
 - Values from 45-99.9 converted from kilograms to pounds
 - Values greater than 1,600 converted from ounces to pounds
 - Deleted values still greater than 600.0 after conversions

Demographics

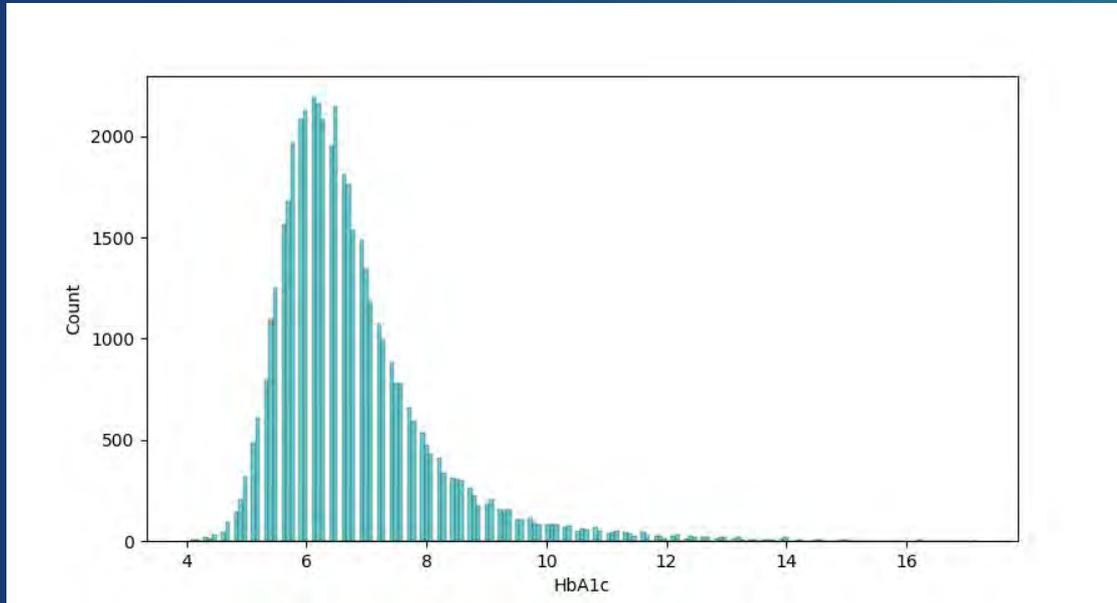
- 70,936 patients

Age	N	Percentage (%)
65 and older	35748	50.39%
Younger than 65	35188	49.61%

Gender	N	Percentage (%)
Female	35294	49.75%
Male	35642	50.25%

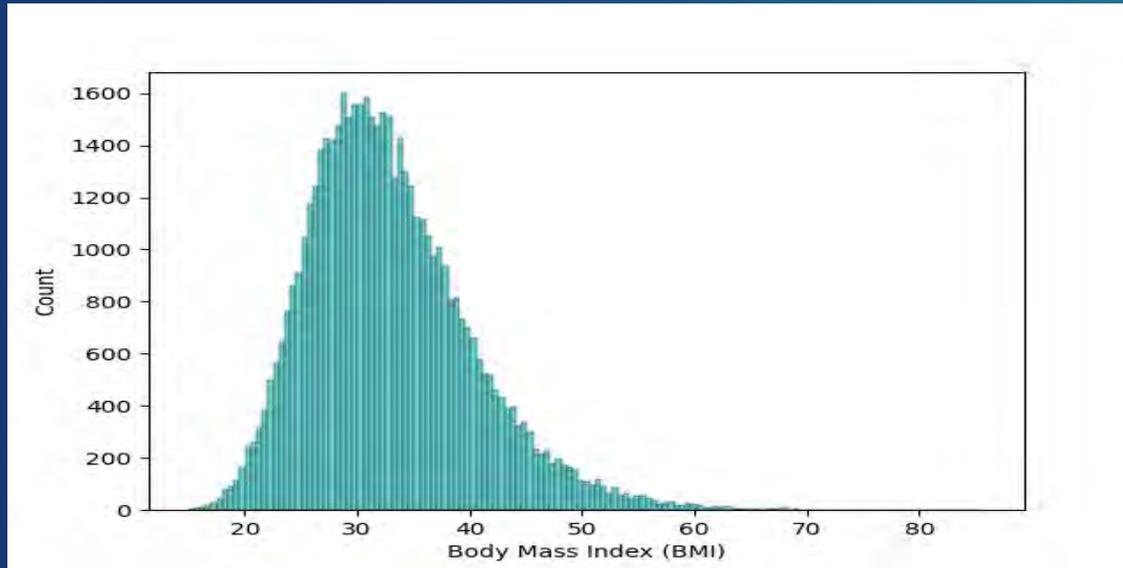
HbA1c

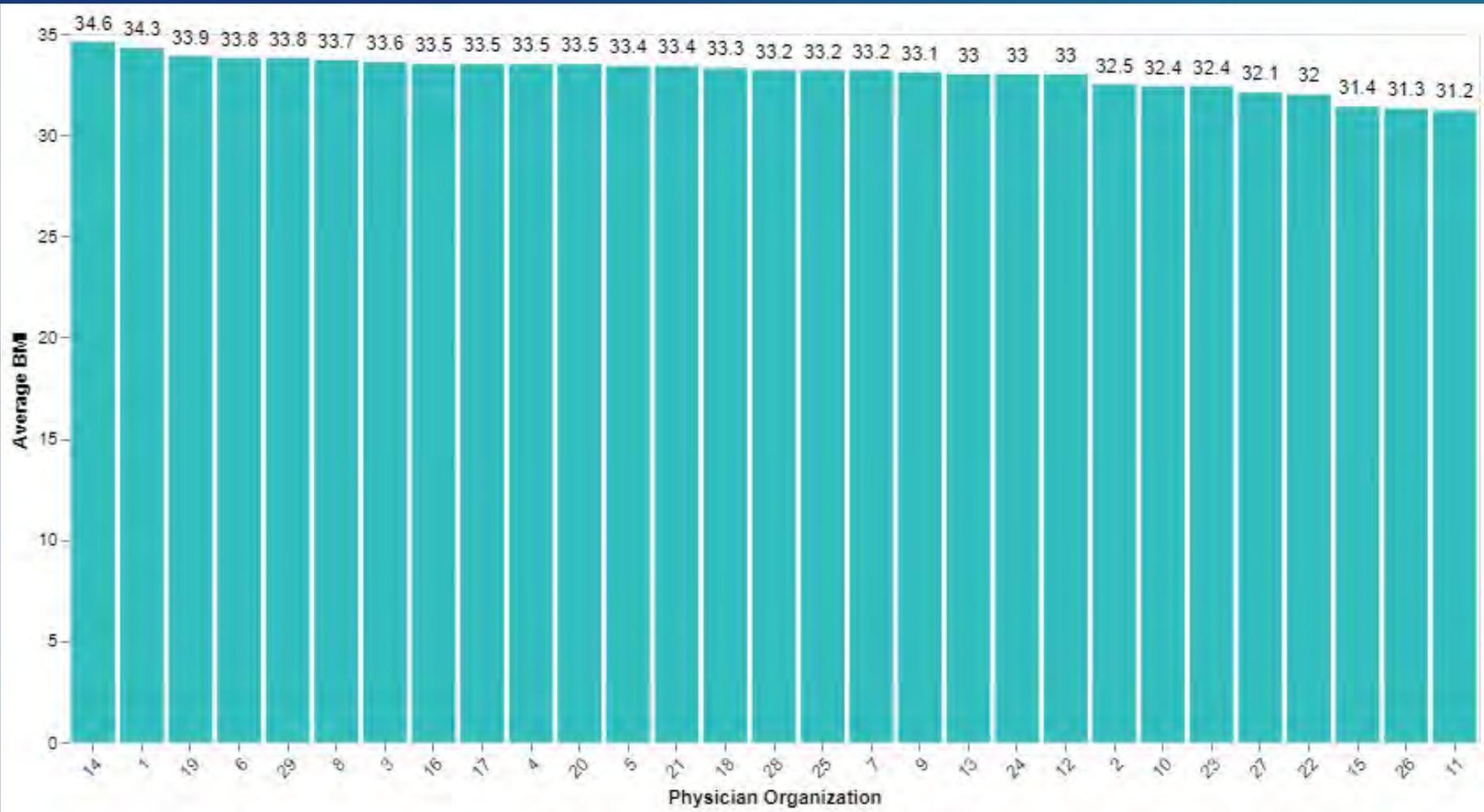
HbA1c	N	Mean	Median	Mode	Minimum	Maximum
	46621	6.75	6.50	6.10	4.0	17.2



BMI

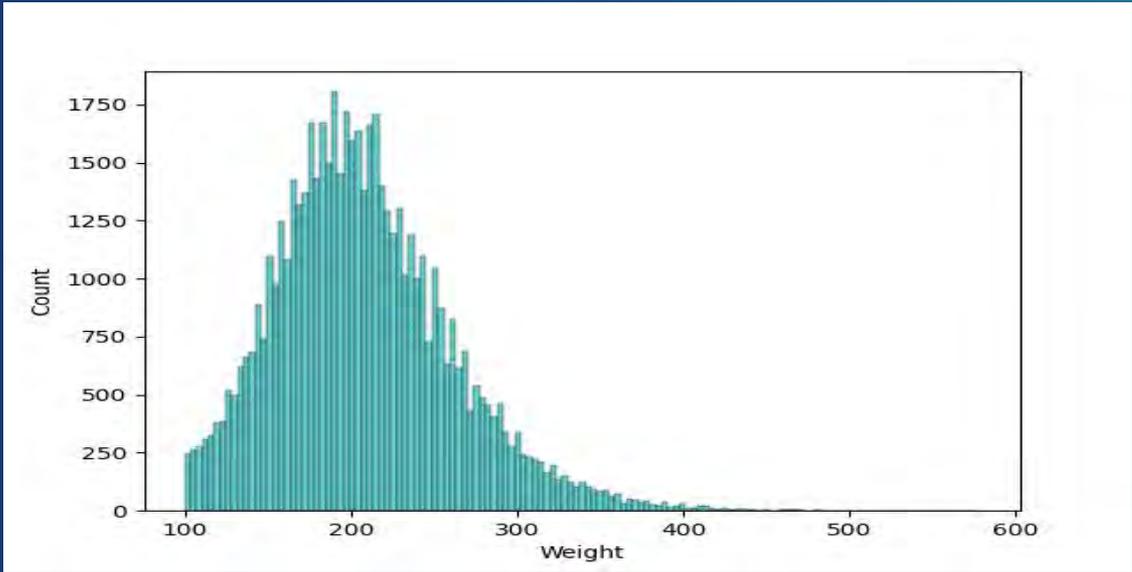
BMI	N	Mean	Median	Mode	Minimum	Maximum
	51400	32.96	31.98	31.00	15.00	85.82

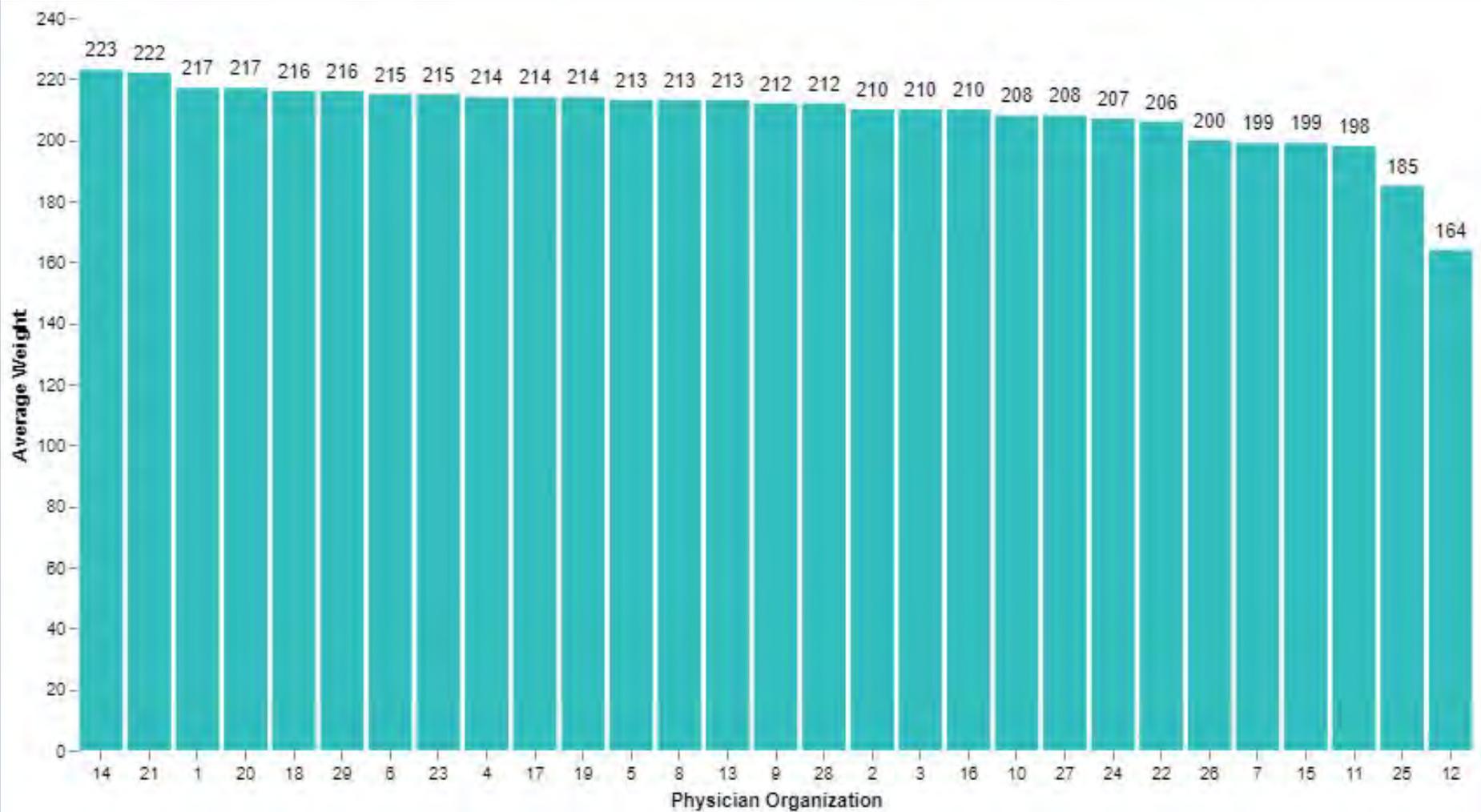




Weight

Weight	N	Mean	Median	Mode	Minimum	Maximum
	56160	208.15	202.40	200.00	100.00	578.80

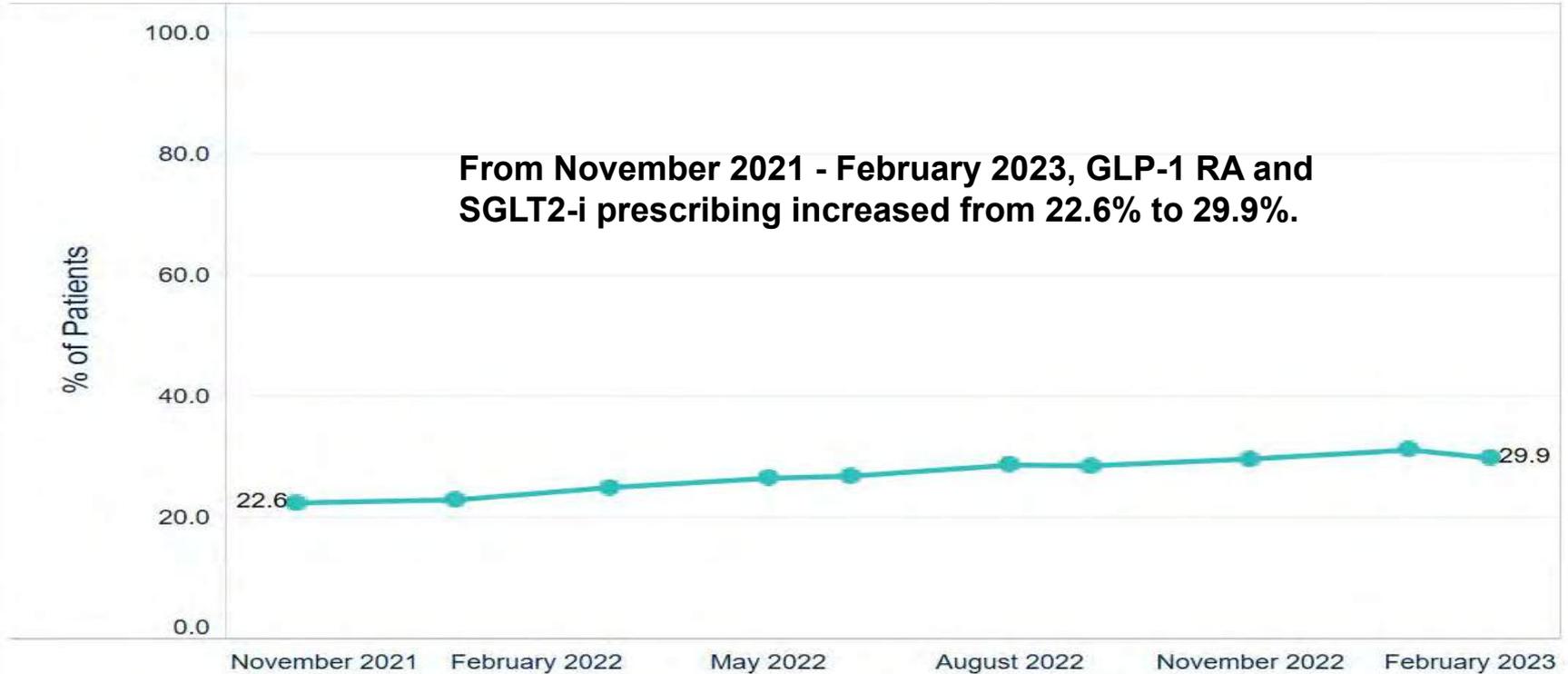




SGLT2i or GLP-1RA (Rx Fills in Last 6 Months)

Collaborative

June 1, 2021 - February 28, 2023



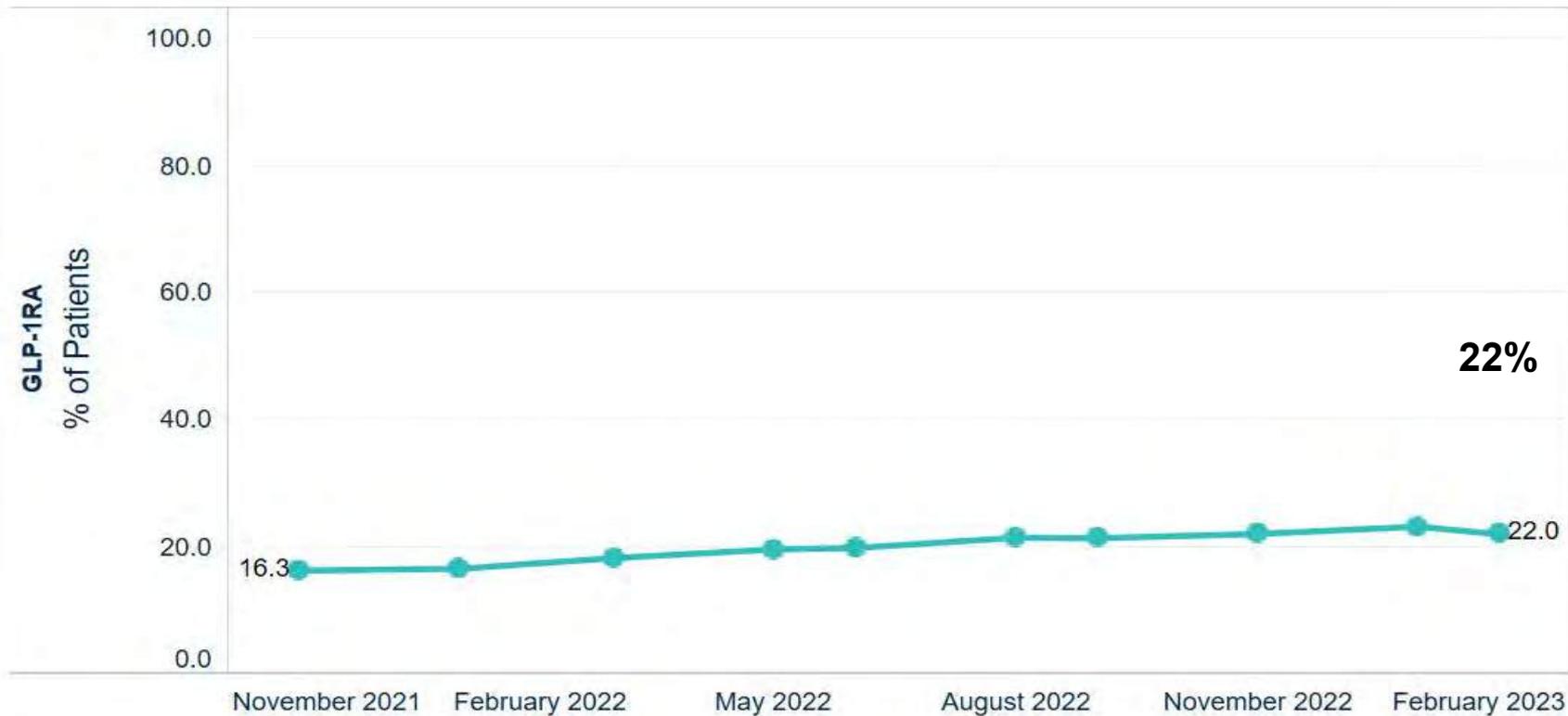
Note:

(1) 42,849 (60.46%) patients do not have Rx Coverage in the last month of the reporting period

Rx - All (Rx Fill in Last 6 Months)

Collaborative

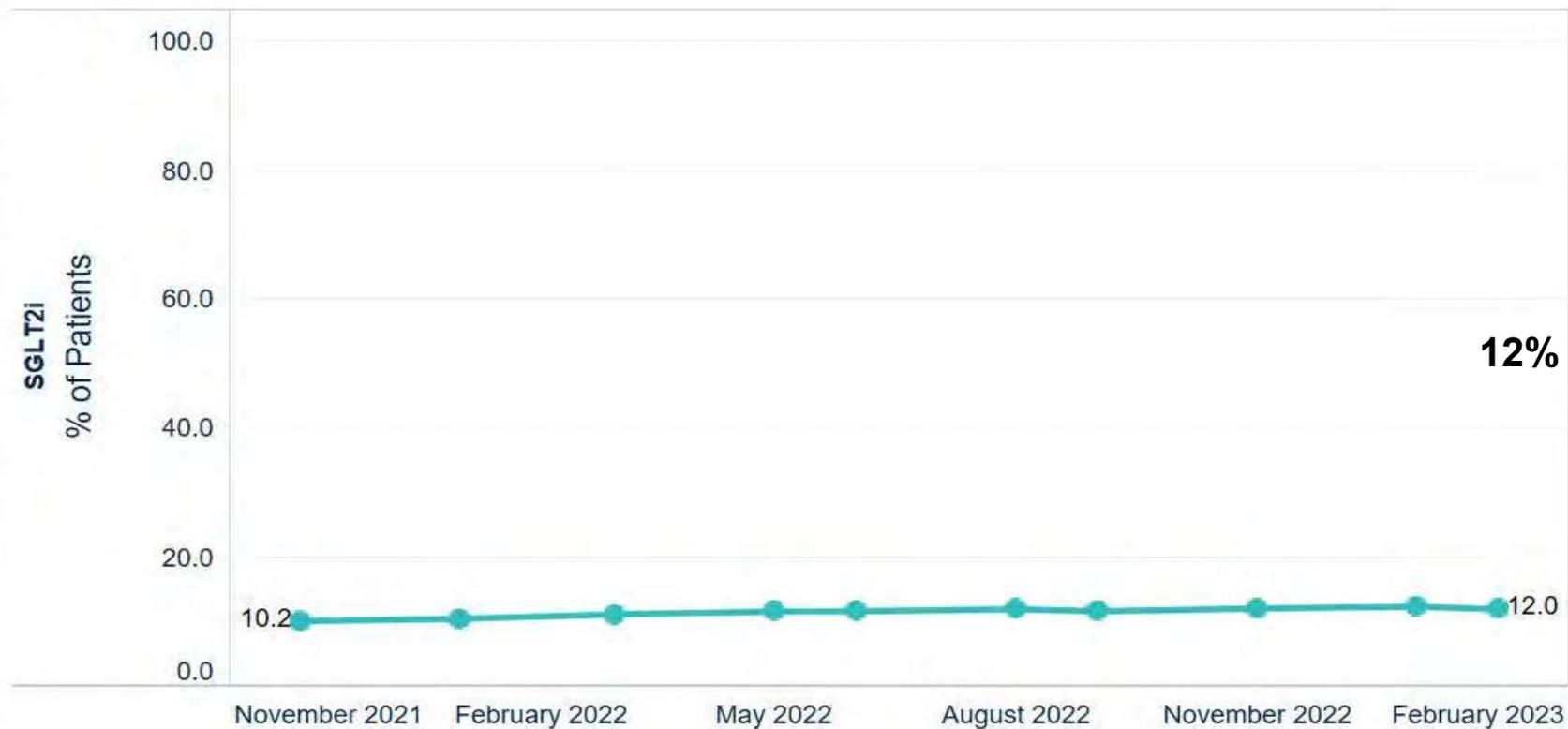
June 1, 2021 - February 28, 2023



Rx - All (Rx Fill in Last 6 Months)

Collaborative

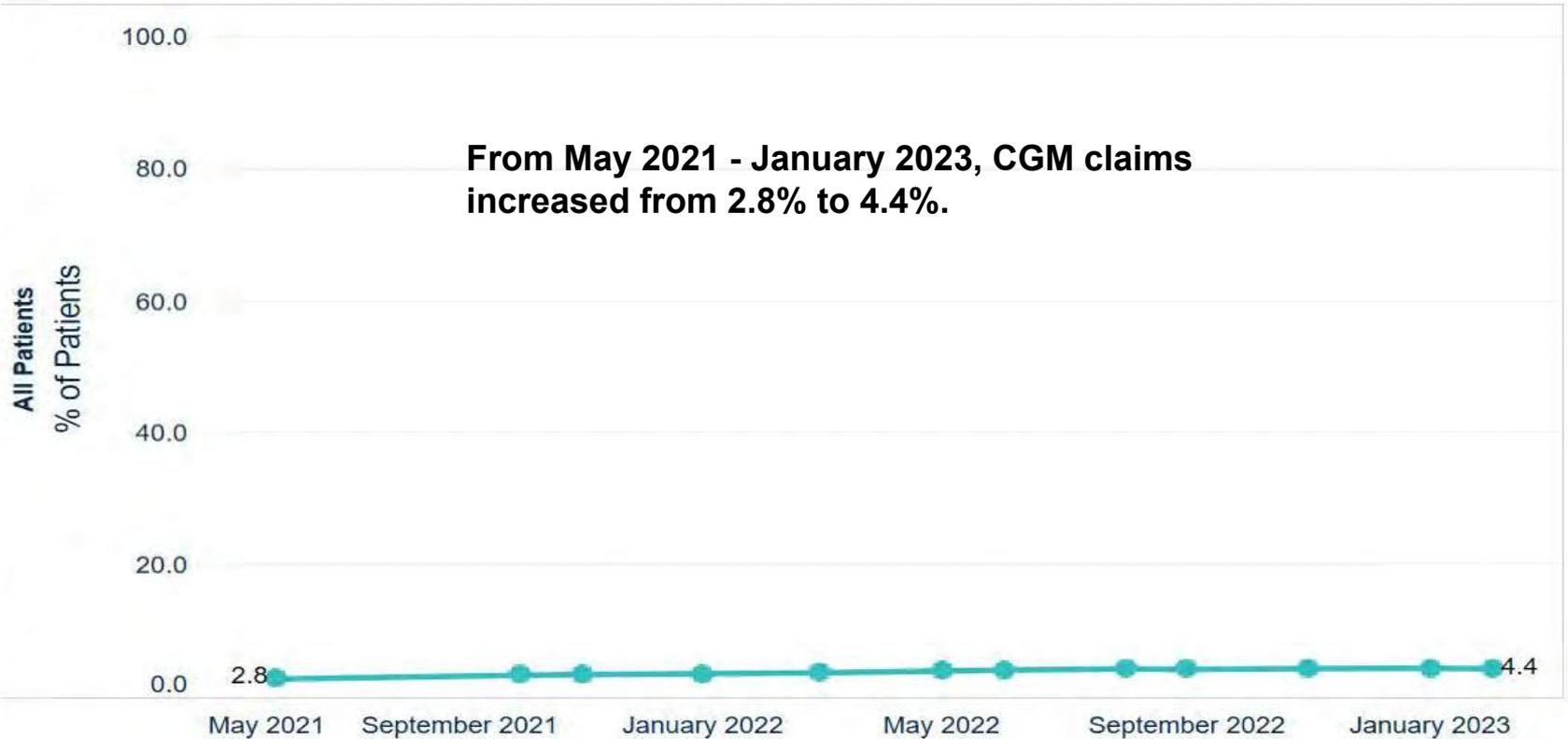
June 1, 2021 - February 28, 2023



CGM (Last 12 Months)

Collaborative

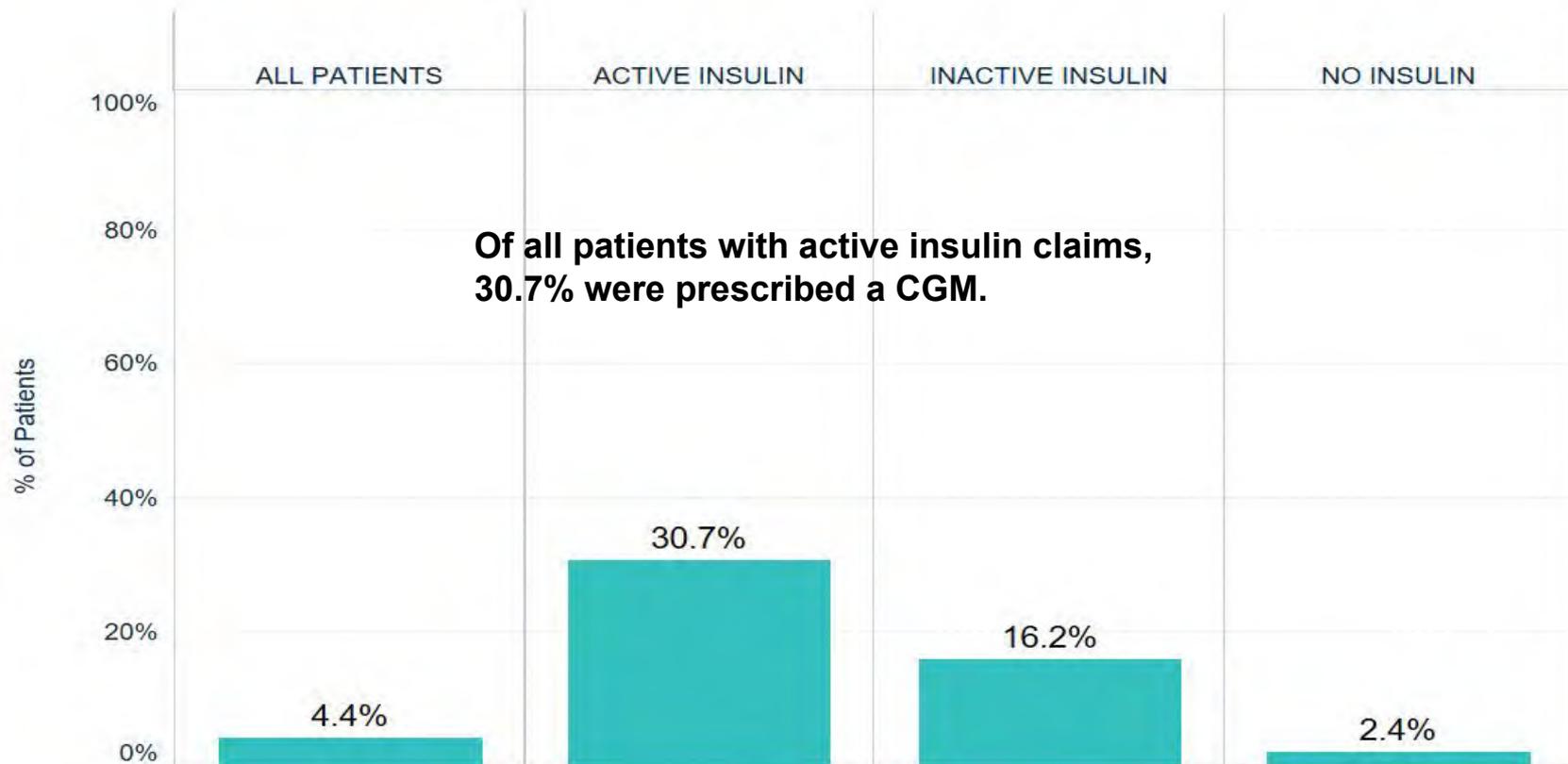
July 1, 2020 - February 28, 2023



CGM (Last 12 Months)

Collaborative

March 1, 2022 - February 28, 2023







MSHIELD

MICHIGAN SOCIAL HEALTH INTERVENTIONS
to ELIMINATE DISPARITIES

Health Equity & Social Determinants of Health

MCT2D 2023 Collaborative-Wide Meeting

Jordan Greene, MPH (she/her)
Clinical-Community Partnerships
Specialist

Sheryl Kelly, Ph.D., LP (she/her)
Equity Advisor

Matthias Kirch, MS (he/him)
Health Informatics Specialist

Agenda

1. What is MSHIELD?
2. Health Equity & Type 2 Diabetes
3. SDOH Data & Measuring Health Equity
4. Addressing Social Needs: Community-Clinical Partnerships
5. Resources & Opportunities to Engage with MSHIELD

MSHIELD is a partnering CQI

MISSION

We empower CQIs and their participating providers to lead the future of quality improvement, which achieves whole health for all people by integrating social care and clinical care, using data to drive health equity, and fostering a culture of anti-racism.

VALUES

Our work is:

EQUITABLE

COLLABORATIVE

DATA-DRIVEN

What we do

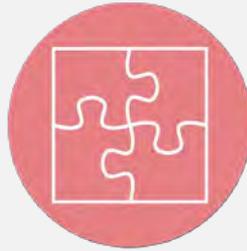
MSHIELD promotes whole health for all people through data-driven, community-partnered, equity-centered quality improvement:

Culture of Equity



Empowering CQIs as they root themselves in valuing, promoting, and demonstrating equity and anti-racism in quality improvement.

Community-Clinical Partnerships



Collaborating with community and clinical partners to close the gap between healthcare and social service systems across the state.

Data Strategy & Quality



Supporting CQIs to use their data to identify health inequities and develop equity-focused quality improvement goals.



Carol Gray, MPH
Program Manager



Dilhara Muthukuda, MPH
Community-Clinical
Partnerships Manager



John W. Scott, MD, MPH
Co-Director
Trauma and Acute Care Surgery



Jordan Greene, MPH
Community-Clinical
Partnerships Specialist



Lindsey Herrel, MD, MPH
Associate Director
Data Strategy & Quality



Matthias Kirch, MS
Health Informatics Specialist



Melissa Creary, PhD, MPH
Associate Director
Anti-Racism & Equity Initiatives



Renu Tipirneni, MD, MSc
Co-Director
Primary Care and Internal Medicine



Samantha Cooley, MSW
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Health Equity & Type 2 Diabetes

Shared Language

Concepts from AMA's Advancing Health Equity Guide

Equality v. Equity

Equity refers to fairness and justice and is distinguished from equality. While equality means providing the same to all, equity requires recognizing that we do not all start from the same place because power is unevenly distributed. The process is ongoing, requiring us to identify and overcome uneven distribution of power as well as intentional and unintentional barriers arising from bias or structural root causes.

Defining health equity

Health equity is the principle underlying a commitment to reduce – and, ultimately, eliminate – disparities in health and in its determinants, including social determinants. Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.

- Paula Braveman, MD, MPH

What is the goal?

Health equity, defined as optimal health for all, is a goal the AMA and AAMC will work toward by advocating for health care access, research and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling a commitment to health equity.

Examples of...

Social Equity

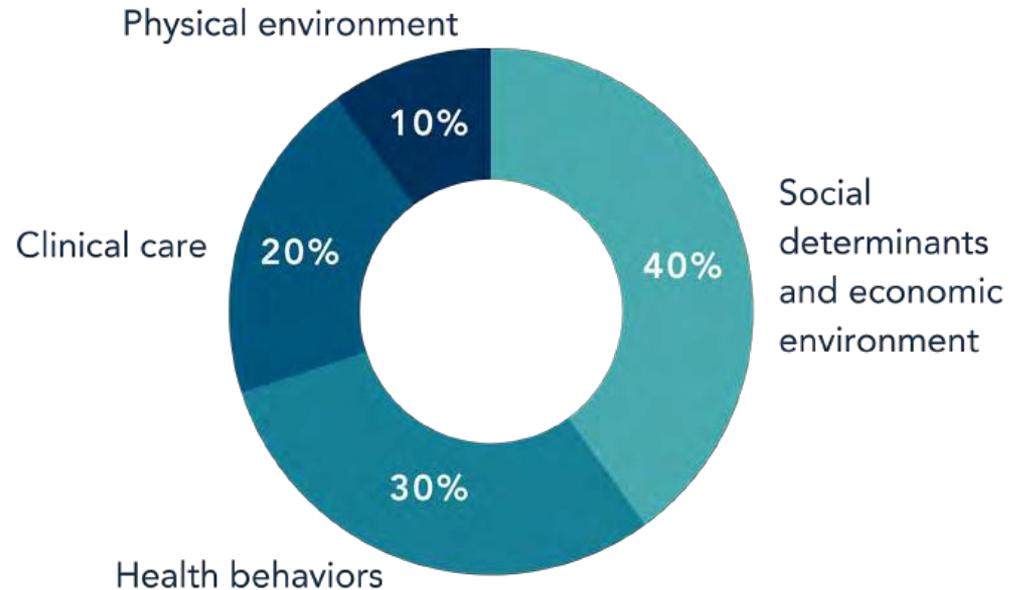
- Neighborhood revitalization instead of gentrification
- The unhindered ability to engage in political processes
- Access to homeownership
- Access to various food options
- Access to educational opportunities that allow for advancement

Health Care Equity

- Providing low-cost, basic health care services to low-income neighborhoods.
- Mobile health screenings to provide treatment to those without transportation.
- Offering free health seminars targeted toward the health issues of historically marginalized populations.
- Providing health appointments after hours so that employees can see a doctor without taking time off work.
- Offering better employer-funded health care programs

To achieve the best outcomes for all patients, we must address the key drivers of health

80% of our health
is determined by
non-clinical factors



SDOH are the conditions in which we live, grow, work, and play



Neither present nor absent

Neither positive nor
negative

Language matters to guide
interventions

Social determinants of diabetes

Diet and exercise are only part of the issue...



Neighborhood & Built Environment

Where we live determines exposure to stressors like pollution, walkability and safety, and these factors have a significant impact on SDOH factors on the (BRCA) need and severity of T2D. People living in food swamps are 2x more likely to have a 2x higher T2D mortality rate than college educated adults.

County Health Rankings Model | Accessed June 8, 2023
Minnesota Department of Health | Accessed June 8, 2023

County Health Rankings Model. Accessed June 8, 2023.

Social determinants of health v. social health needs



Access to
food



Living
situation



Access to
transportation

Social Determinants
of Health

Social Health Needs

Food
Insecurity

Housing
Instability

Lack of
Transportation



Measuring Health Equity

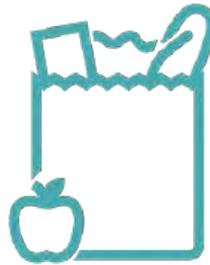
Exploring available data

- AHRO [Social Determinants of Health Database](#)
- CDC/ATSDR [Social Vulnerability Index](#)
- USDA [Food Access Research Atlas](#)
- Bureau of Transportation Statistics [Local Area Transportation Characteristics for Households \(LATCH\) data](#)
- United States Census [American Community Survey \(ACS\)](#)
- [National Neighborhood Data Archive \(NaNDA\)](#)
- Wayne State [PHOENIX Health Dashboard](#)
- [County Health Rankings](#)

Screening patients for unmet social health needs across these three domains can improve value and health equity:



Housing
Instability



Food Insecurity



Transportation
Needs

Housing screening

7 out of 7 screeners asked about housing



Past 12 months

In the past 12 months, have you struggled to keep a steady place to live?

Need help

Do you need help with housing?

Worry about housing

Are you worried about losing your housing?

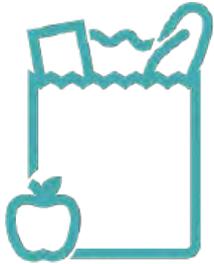
Are you worried that in the next 2 months, you may not have (stable) housing?

Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?

Are you worried that in the next few months, you may not have reliable housing that you own, rent or share?

Food screening

7 out of 7 screeners asked about food insecurity



Current problem

Do you struggle to get the food you need?

Do you ever eat less than you feel you should because there is not enough food?

Past/Ever experienced

In the past 12 months, did you ever eat less than you felt you should because there was not enough money for food? *[multiple versions]*

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed?

Food

In the last 12 months, did you ever worry whether your food would run out before you had money to buy more? *[multiple versions]*

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

Transportation screening

7 out of 7 screeners asked about transportation



Current need

Do you need a dependable way to get to work or school and your appointments?

Do you have trouble with transportation?

Do you put off or neglect going to the doctor because of distance or transportation?

Past/Ever experienced

In the past 12 months, has lack of transportation kept you from medical appointments, work or getting things needed for daily living?

Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

In the past 12 months, have you had trouble getting to school, work, or the store because you do not have a way to get there?

In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?

Recommendations

Care coordination

Focus on current needs screening
3-6 months max lookback
Ask about outlook (2-4 months)

Examine purpose
of social needs data
collection

Program evaluation

Longer lookback window
Consider asking validated questions
Compare to population estimates

More specific

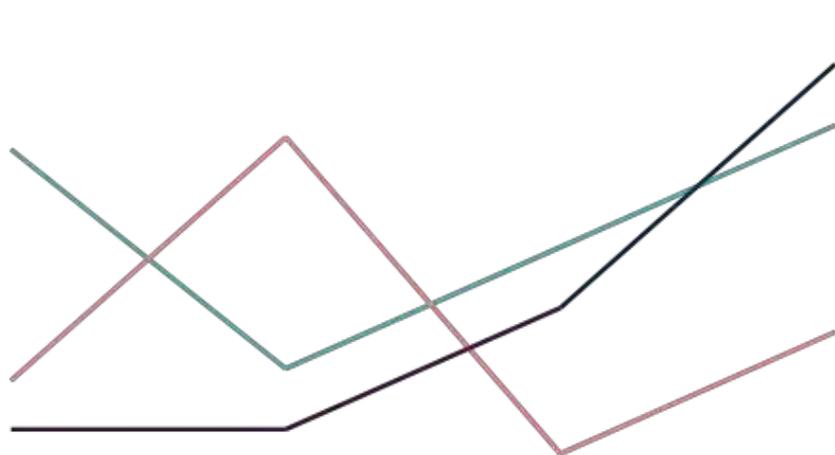
Can you match the need to a program?
What information is needed to provide help today?

Pick a level of
specificity
of social needs
questions

Less specific

Does the question encompass all possible needs in a certain domain?
Will the measure hold up over time?

Next steps—measuring health equity



Reference point?

Absolute vs. relative comparison?

Favorable vs. adverse outcomes?



Addressing Social Needs

Case study



- 62-year-old woman
- Diagnosed with T2D, many comorbidities
- Poor access to care
- Untreated stomach ulcer



- Presents to ER with septic shock from perforated ulcer
- Emergency surgery
- Intensive Care Unit



Discharged to same environment:

- No assistance at home
- Limited access to healthy food
- Lack of transportation, misses follow-up care



- Exacerbation of underlying medical conditions
- Readmitted for DKA, dehydration, and a wound infection

How can we build on the work that's already happening?

Ask, Assist, Align: Addressing social health needs is an iterative process

ASK

Screen all patients for unmet social health needs to identify the specific areas of intervention for each individual patient.

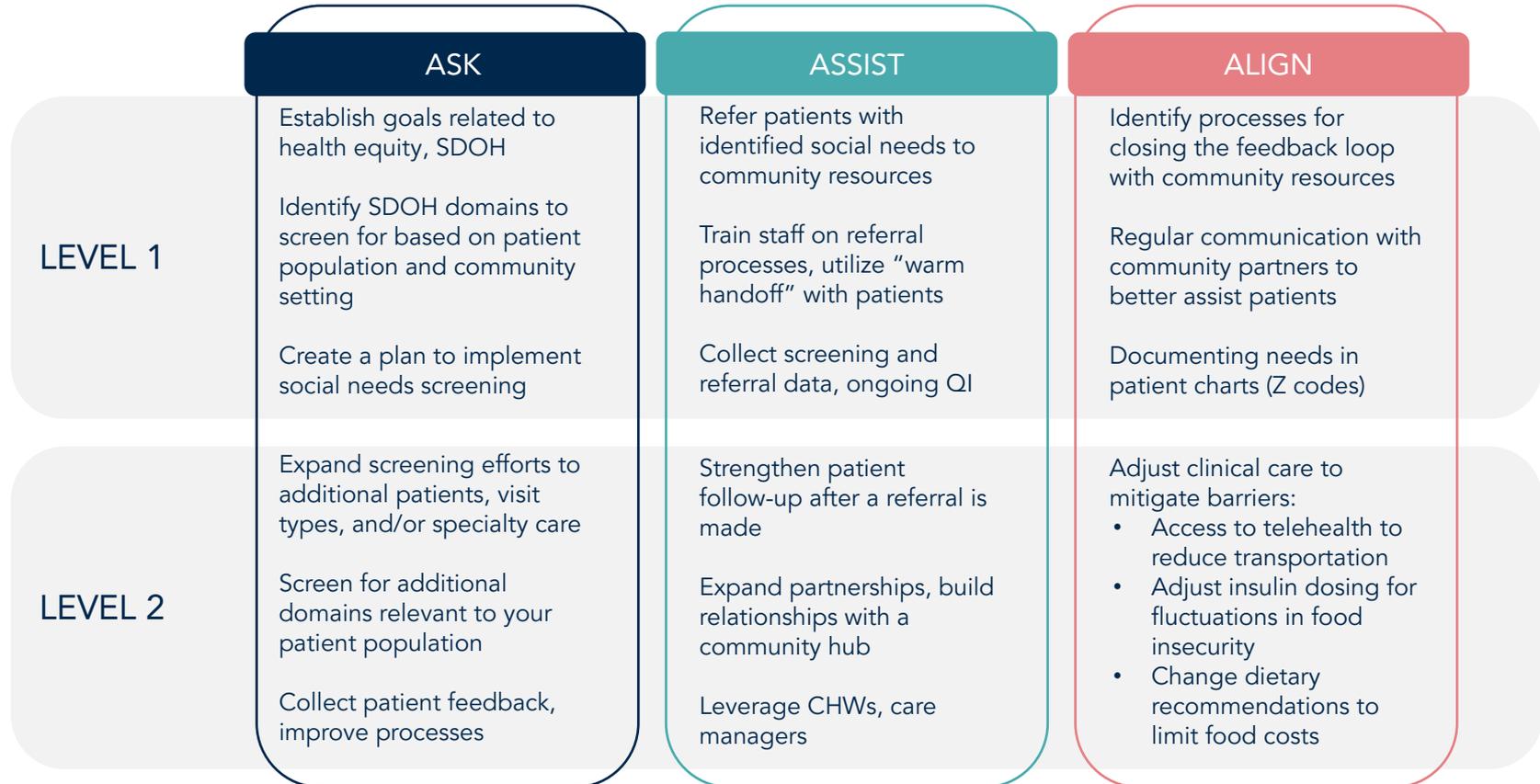
ASSIST

Refer patients who screen positive for social health needs to the specific community partners that provide the specific services that they need.

ALIGN

Work with both patients and community partners to ensure availability and follow-through after referral so that these efforts are truly aligned with patients' needs.

Leveling up SDOH interventions



Community-clinical partnerships

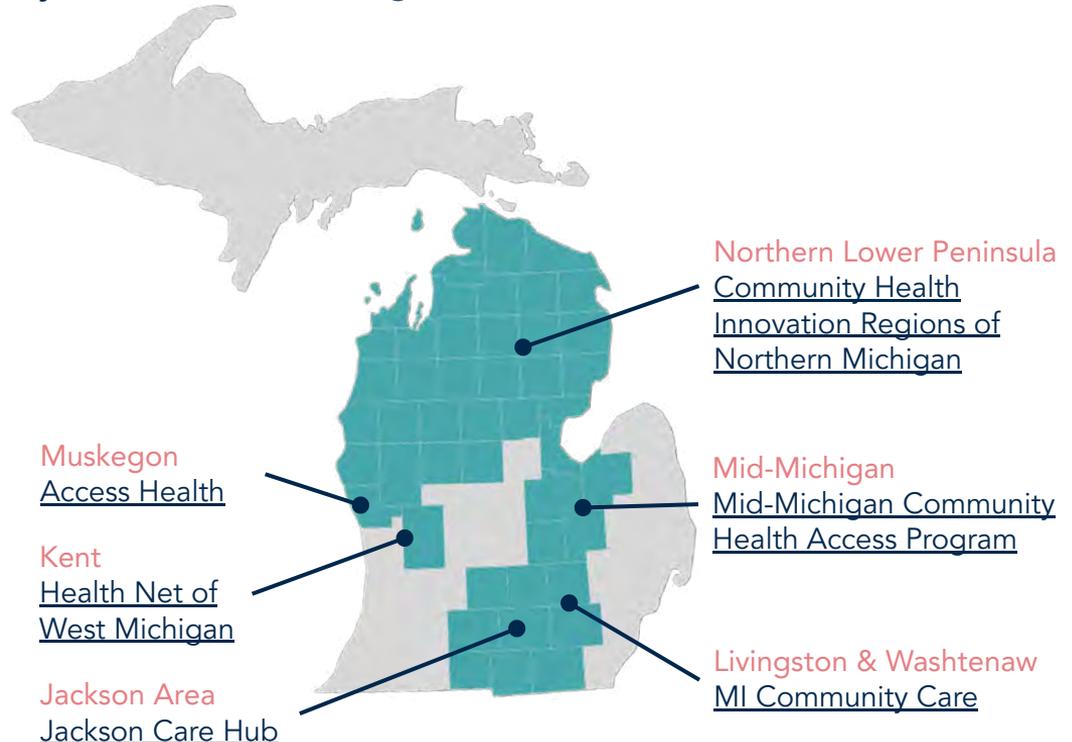
We work with transformative community hubs across Michigan:

- Community hubs are networks of community-based organizations that connect patients with local resources for social health needs
- **Already have existing referral processes?** Adding community hubs to your resource “rolodex” creates more opportunities to support patients, especially those with complex needs needs

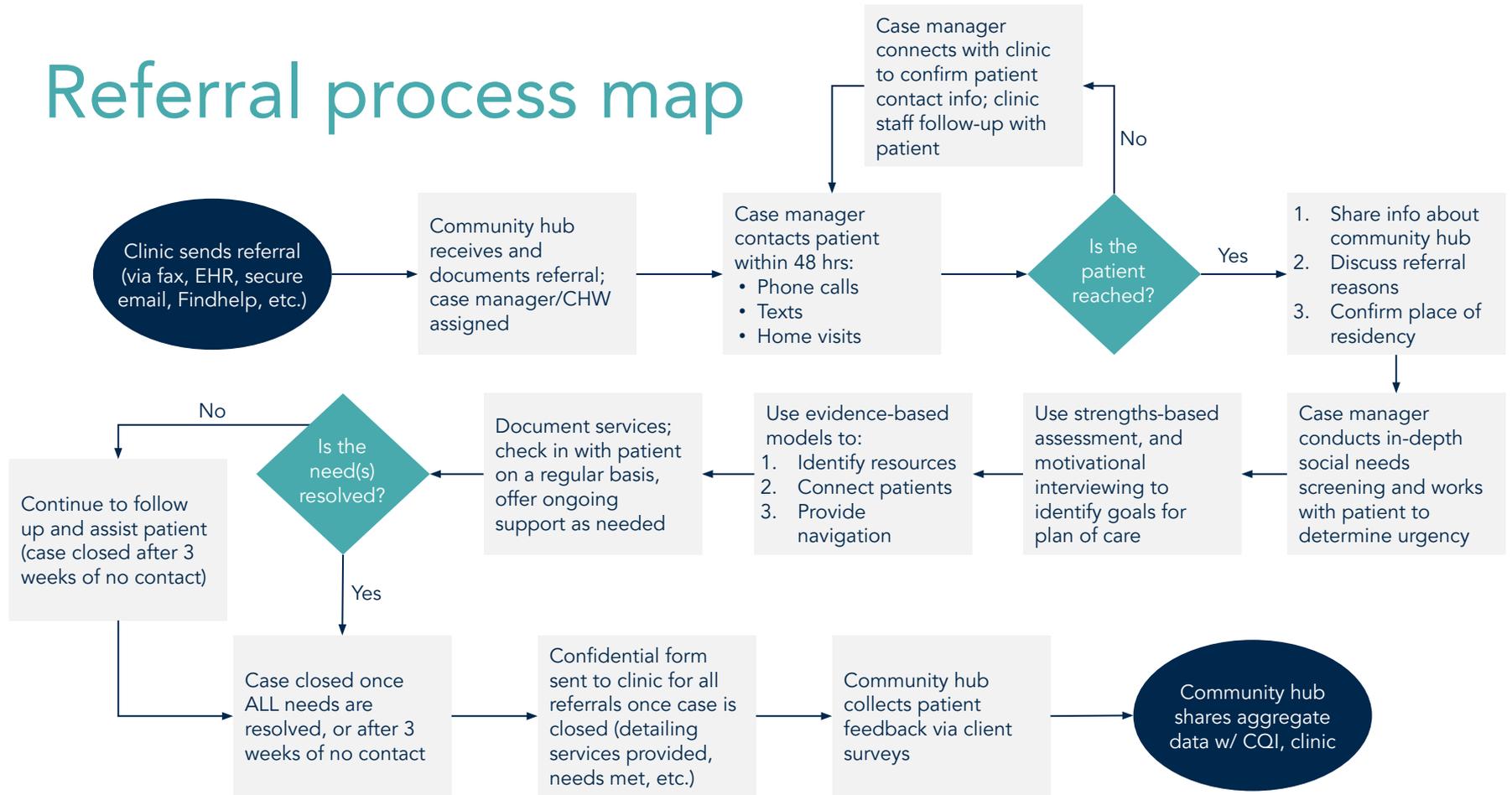
To learn more about our partners, visit:



michiganshield.org/partners



Referral process map



Partnering with community hubs



READY

- Determine whether your practice is within a community hub's service area
- Reach out to MCT2D & MSHIELD to get started
- Establish agreements to share patient info with the community hub (MOU, BAA)



SET

- Identify which patients are eligible for referrals to the community hub
- Clinical and non-clinical staff attend training with the community hub
- Develop a plan for sending referrals to the community hub



GO

- Complete referral form, begin sending referrals to the community hub
- Receive closed-loop communication, outcome information for each patient
- Participate in process evaluation with MSHIELD and community hub

Early success in mid-Michigan

Along with the Michigan Bariatric Surgery Collaborative and Mid-Michigan CHAP, MSHIELD built a referral pathway to community resources for bariatric surgery patients throughout Mid-Michigan.



1,000+

patients screened for unmet social health needs



< 2 days

Average time to link patients to community resources



85%

of all referrals resolved

Addressing SDOH, health equity

MSHIELD supports CQIs and providers with:



HEALTH EQUITY GOALS

Building capacity to center health equity and anti-racism in healthcare delivery and quality improvement initiatives



SOCIAL NEEDS SCREENING

Supporting CQIs and their members to implement or expand social needs screening and facilitate closed-loop referrals



COMMUNITY-CLINICAL PARTNERSHIPS

Connecting providers to vetted community hubs and other resources that link patients to the services they need



EVALUATION & QUALITY IMPROVEMENT

Consulting with CQIs and their members to assess current processes, evaluate interventions, and identify opportunities for process improvement



MSHIELD

MICHIGAN SOCIAL HEALTH INTERVENTIONS
to ELIMINATE DISPARITIES

Thank you!

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Blue Cross
Blue Shield
of Michigan

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



Health Equity within
MCT2D:
Vision and Goals



We want to prioritize health equity as a collaborative

This is where we start:
beginning with
discussions like these



Health Equity Champion (HEC)



Larrea Young, MDes
Design Project Manager

The role of each HEC is to grow their collaborative's knowledge on health equity and antiracism and identify opportunities to incorporate this approach into their work.



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EVALUATING SOCIAL DETERMINANTS OF HEALTH

Best Practices, Opportunities, and Resources for Collaborative Quality Initiatives

July 2022

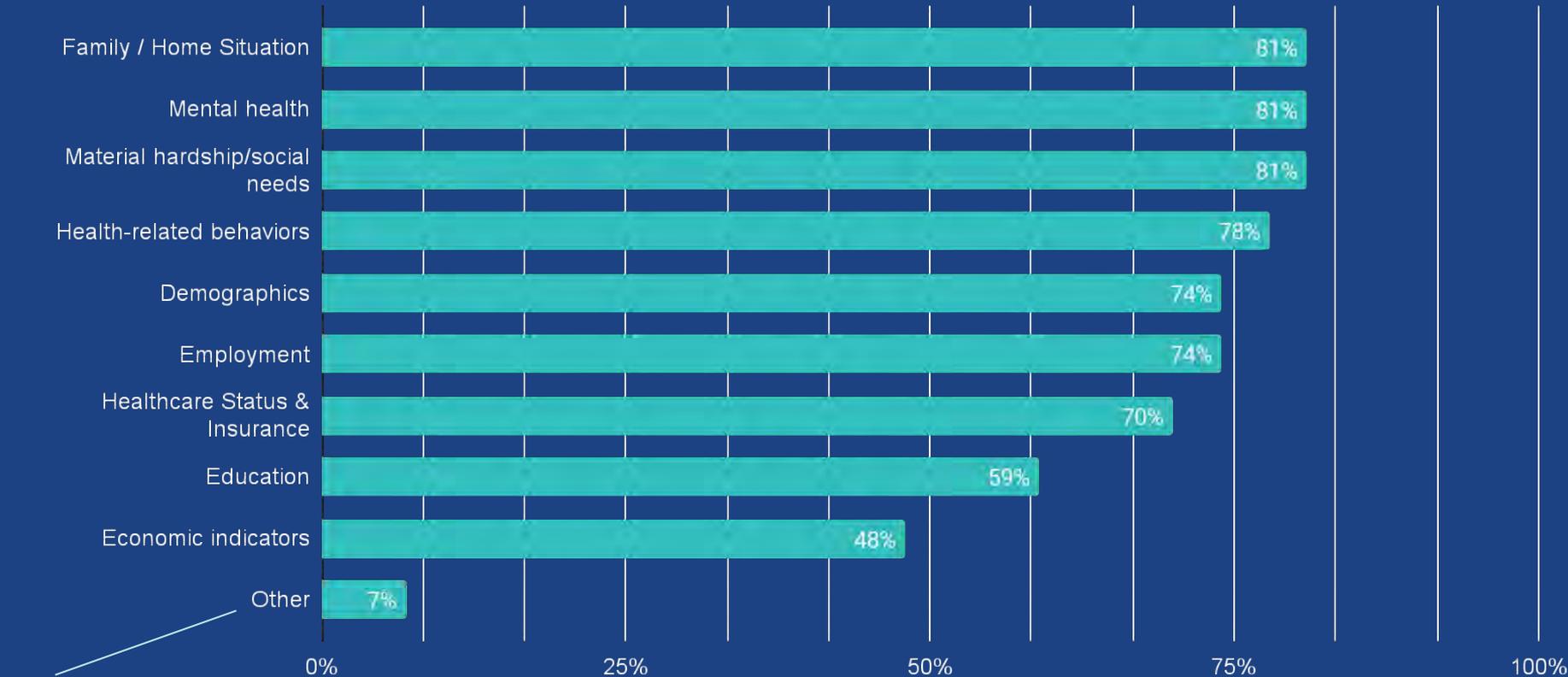


The MSHIELD Five Recommended Starting SDOH Screening Questions



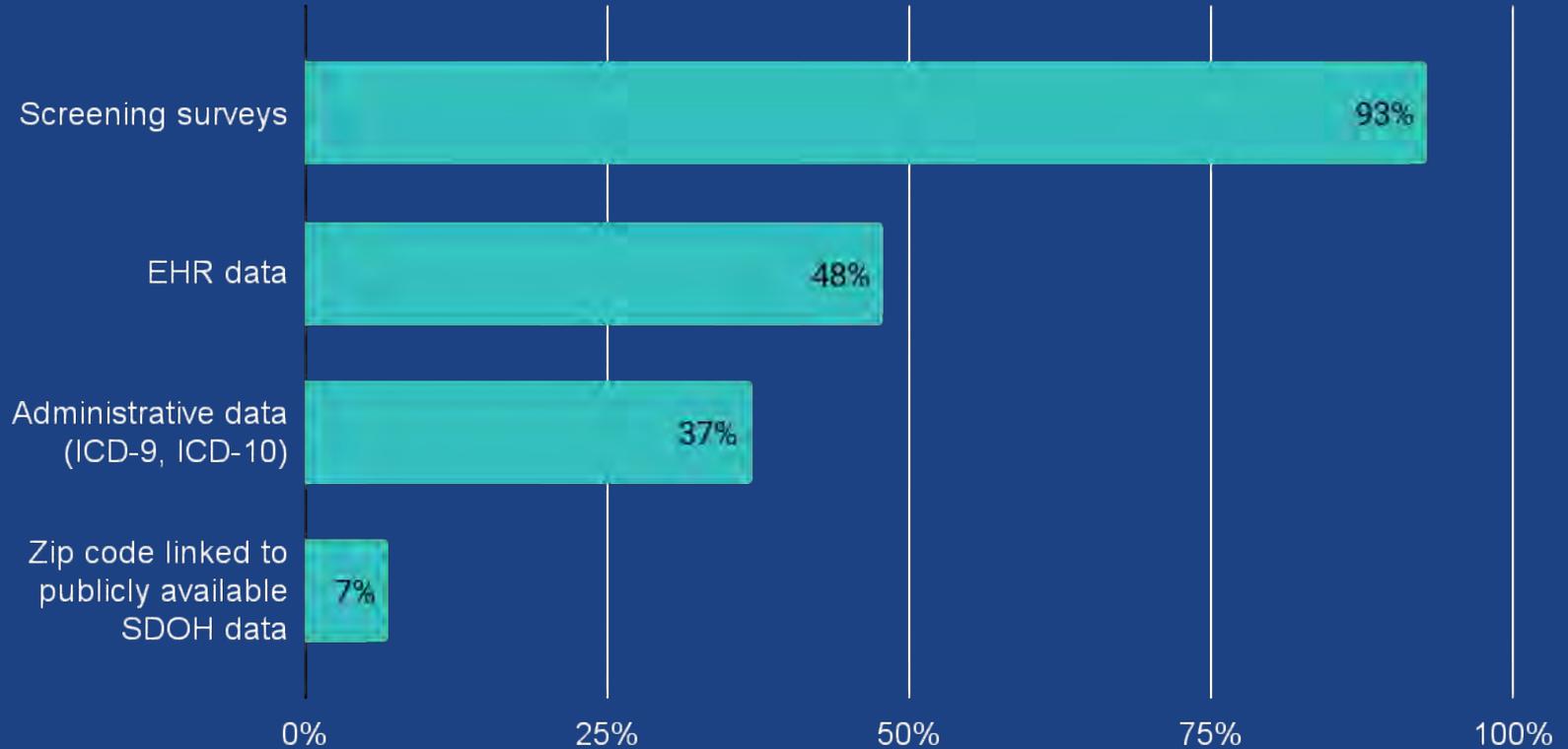
1. "Within the past 12 months we worried whether our food would run out before we got money to buy more."
 Often true Sometimes true Never true
2. "Within the past 12 months the food we bought just didn't last and we didn't have money to get more."
 Often true Sometimes true Never true
3. What is your living situation today?
 I have a steady place to live
 I have a place to live today, but I am worried about losing it in the future
 I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
4. Think about the place you live. Do you have problems with any of the following?
CHOOSE ALL THAT APPLY
 Pests such as bugs, ants, or mice
 Mold
 Lead paint or pipes
 Lack of heat
 Oven or stove not working
 Smoke detectors missing or not working
5. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?
 Yes No

Are at least 1/2 of your MCT2D participating practices collecting SDOH information in the following domains? (Check all that apply)



Loneliness
Tech equity to access your health care

In what ways do you identify patients' social needs? (check all that apply)



When/how often are patients screened for social needs?

- New patients
- Minimum Annually, some items on each visit
- Two plus no shows
- Following in-patient discharge
- High Emergency Department utilization

★ *Variation between practices*

Social Determinants of Health

Name _____ Birthdate _____ Today's Date _____

Social and environmental factors can impact your health. Part of screening for your health includes checking for needs other than medical concerns. Based on your answers to these questions, someone from our office may contact you to talk to you about resources that can help.

*For pediatric patients, please answer for the parent/guardian

Question	Very hard	Hard	Somewhat hard	Not very hard	Not hard at all	Do not want to answer
How hard is it for you to pay for the very basics like food, housing, medical care, and heating?						
In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?	Yes	No				Do not want to answer
Within the past 12 months have you worried that your food would run out before you get money to buy more?	Never true	Sometimes true	Often true			Do not want to answer
Within the past 12 months, has the food you bought just didn't last and you didn't have money to get more?	Never true	Sometimes true	Often true			
Do you need help finding or paying for care of loved ones? Such as child care or day care for an older adult?	Yes	No				
Would you like to be contacted for additional resources?	Yes	No				

Patient Screening Questionnaire

This form is to help assist our providers to determine what form of assistance any type of resources our office can assist you with, to ensure that you are meeting basic needs and maintaining a quality of life. Please fill this form out and return front desk. Our office will follow up with you. Thank you!

DOMAIN	QUESTION	No	Yes
Health Care	In the past month, did your physical or mental health keep you from doing your usual activities, like work, school, or hobby?		
	In the past year, was there a time when you needed to see a doctor but could not because it cost too much?		
Food	Do you ever eat less than you feel you should because there is not enough food?		
Employment & Income	Do you have a job or other steady source of income?		
Housing & Shelter	Are you worried that in the next few months, you may not have safe housing that you own, rent or share?		
Utilities	In the past year, have you had a hard time paying your utility company bill?		
Child Care	Does getting child care make it hard for you to work, go to school or study?		
Education	Do you think completing more education or training, like learning a GED, going to college, or learning a trade, would be helpful for you?		
Transportation	Do you have a dependable way to get to work or school, or your appointments?		
Clothing & Footwear	Do you have enough household supplies for you, like clothing, shoes, blankets, mattresses, diapers, toothpaste, and shampoo?		
General	Would you like to receive assistance with any of these needs? Any of your needs urgent?		
Abuse	Do you feel unsafe or scared of harm or chronic physical or mental health issues?		

Screening Identifiers

Screened only
 Patient Spouse Significant Other Parent Foster Parent Legal Guard

Financial Resource Strain

How hard is it for you to pay for the very basics like food, housing, medical care and heating?

Very hard Hard Somewhat hard Not very hard Not hard at all

Housing Stability

In the past 12 months, was there a time when you were not able to pay the mortgage or rent on time? Yes No

In the past 12 months, how many places have you lived? 1 2 3 4 5 6 7 8 9 10 11 12

In the past 12 months, was there a time when you did not have a steady place to sleep or sleep in a shelter (including) now? Yes No

Transportation Needs

In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications? Yes No Patient or caregiver

In the past 12 months, has lack of transportation kept you from meetings, work or from getting things needed for daily living? Yes No

Food Insecurity

Within the past 12 months, you worried that your food would run out before you get the money to buy more

Never true Sometimes true Often true

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

Never true Sometimes true Often true

Stress

Do you feel stress - tense, restless, nervous, or anxious, or unable to sleep at night because your mind is troubled all the time - these days?

Not at all Only a little Some extent Fairly much Very much

Social Connections

In a typical week, how many times do you talk on the phone with family, friends or neighbors?

Never Once a week Twice a week Three times a week More than three times a week

How often do you get together with friends or relatives?

Never Once a week Twice a week Three times a week More than three times a week

How often do you attend church or religious services? Never 1 to 4 times per year More than 4 times per year

Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups, or school groups? Yes No

How often do you attend meetings of the clubs or organizations you belong to? Never 1 to 4 times per year More than 4 times per year

Are you married, widowed, divorced, separated, never married or living with a partner?

Married Widowed Divorced Separated Never married Living with partner

Intimate Partner Violence

Within the last year, have you been afraid of your partner or ex-partner? Yes No

Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner? Yes No

Tech Equity

How would you describe your comfort level with using technology (smart phones, mobile apps, patient portals) to access your health care?

Not comfortable Comfortable Very comfortable

Do you have access to internet and a device (i.e. laptop, computer, smart phone or tablet) that would allow you to participate in a real time video visit?

Yes No

Are any of your needs urgent? Yes No

DOB: 01/15/1988
 500H Screen (0)
 Patient: [Name]
 Address: [Address]
 City: [City] State: [State] Zip: [Zip]
 Phone: [Phone]
 Email: [Email]
 Insurance: [Insurance]
 Financial Resource Strain: [Response]
 Food Insecurity: [Response]
 Transportation Needs: [Response]
 Housing: [Response]
 PRAPA: Protocol for Responding to and Assessing Patients' Responses to Standardized Patient Assessment (PRAPA) - 08/17/2020
 Patient Name: [Name]
 Address: [Address]
 Race: [Race]
 Ethnicity: [Ethnicity]
 Insurance Class: [Insurance Class]
 Income Level: [Income Level]
 Education: [Education]
 Employment: [Employment]
 Money & Resources: [Response]
 Social Connections: [Response]
 Intimate Partner Violence: [Response]
 Tech Equity: [Response]

SOCIAL SURVEY

We are dedicated to you, our patient and your family. If you are comfortable, please take a moment to answer the following questions so that we can help connect you with local community resources. Our staff is ready to answer any additional questions that you may have.

Patient's Name: _____ Patient's Date of Birth: _____

Patient's Gender: Male Female Nonbinary Prefer not to respond

Survey Completed By (if not patient): _____

Telephone Number: _____ Visit Date: _____

Patient's Physician Name: _____

Please check Yes or No to the following questions:

	Yes	No
1. In the past month, did Poor Physical or Mental Health keep you from doing your usual activities, like work, school or a hobby?		
2. In the past year, was there a time when you needed to see a doctor but could not because it Cost too much?		
3. Do you ever eat less than you feel you should because there is not enough Food?		
4. Do you need a job or other Steady Source of Income?		
5. Do you think completing more Education or Training, like learning a high school diploma, going to college, or learning a trade, would be helpful for you?		
6. Are you worried that in the next few months, you may not have reliable Housing that you own, rent or share?		
7. In the past year, have you had a hard time paying your utility company Bills?		
8. Do you need help Finding or Paying for Care for Loved Ones? For example, child care or day care for an older adult.		
9. Does getting Child Care or Care for Loved Ones make it hard for you to work, go to school or study?		
10. Do you need a dependable Way to Get to Work or School and your appointments?		
11. Do you need Household Supplies? For example, clothing, shoes, blankets, mattresses, diapers, toothpaste, and shampoo.		
12. If you take Medication, are you not taking it because it is too expensive?		
13. Do you ever Feel Unsafe in your home or neighborhood?		

If you answered YES, would you like to receive assistance with any of these needs?

Are any of your needs URGENT?

If YES, please write the Number of the Need (1-13): _____

02: Are you worried or concerned that in the next 2 months you may not have stable housing that you own, rent, or stay in as part of a household? No Yes

03: In the past year, was the utility company shut off your service for not paying your bills? No Yes

04: In the last 12 months, did you skip medications to save money? No Yes

05: In the last 12 months, have you ever had to go without health care because you didn't have a way to get there? No Yes

06: Do problems getting child care or elderly care make it difficult to work or study? No Yes

07: Do you need any assistance with finding a local career center or job training? No Yes

08: Have trouble understanding my doctor's written instructions. No Yes

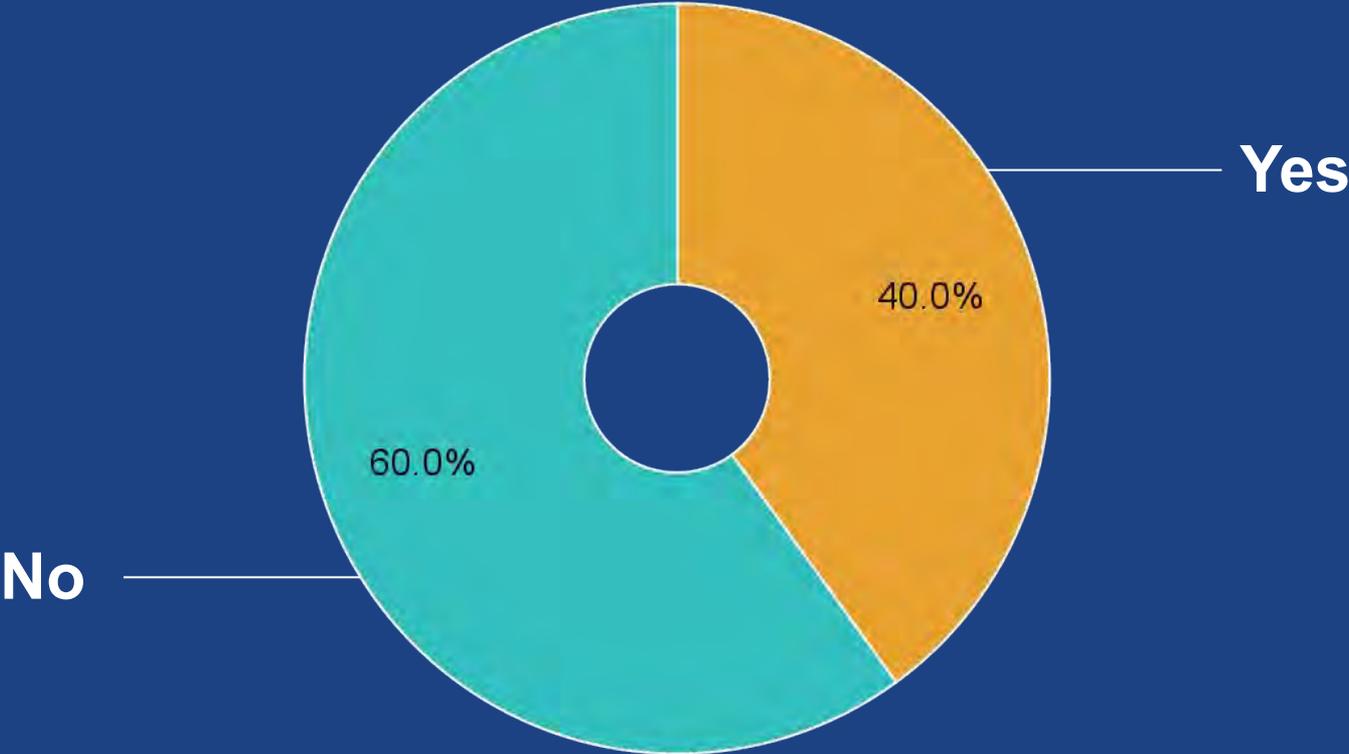
09: How often do you feel lonely? Often Fairly often Sometimes Never

10: Do you ever feel unsafe in your home or neighborhood? No Yes

11: For these needs identified, which would you like the help with? Access to Child Care Access to Elderly Care Financial Assistance Food Insecurity Housing Instability Laundry Social Transportation Difficulty Utility Needs 11 Other 10 Employment 9 Finding Child Care 8 Behavioral Health 14 Sexual Assault 18 Support Care 18 SUD Treatment 20 Diabetes Programs 19 Chronic Conditions 19 PT & OT 19 Yes

12: Can we share this information with organizations to whom we make referrals to address these needs? Yes No

Has your PO identified any health equity goals related to type 2 diabetes?



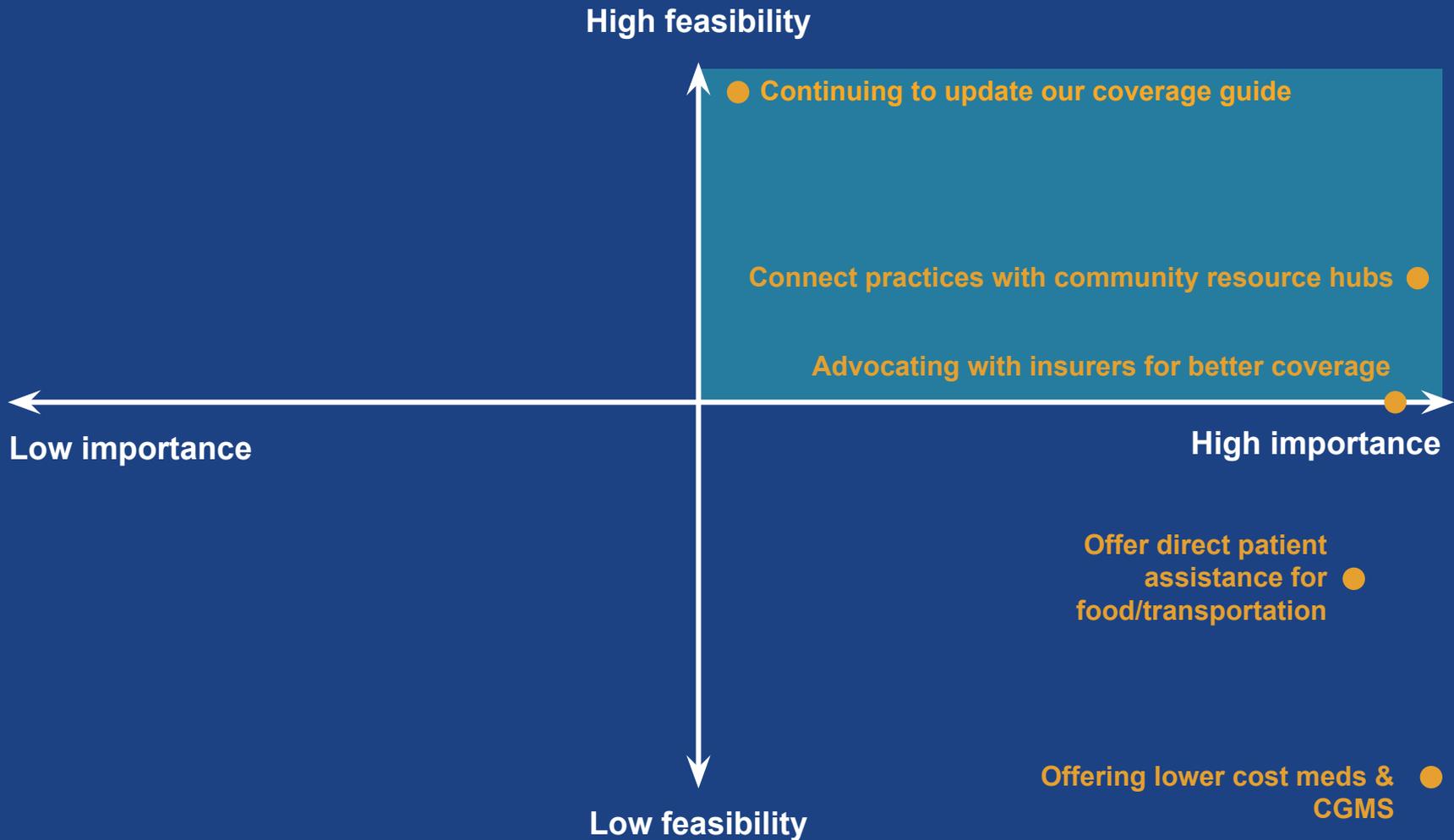
“GLPO intends to directly improve access to medical care for all patient populations. By addressing access to care, we can further impact inequalities and other identified disparities. Success will be demonstrated by all patient populations being wholly cared for by encounters at the provider office or within their home or community.”

What support do POs need to expand their health equity work?

- Support to expand and enhance the process of screening and referral for social determinants of health (SDOH), including increasing the frequency of screening, expanding relationships with community partners, and implementing screening in specialty clinics.
- The ability to incentivize data collection to increase participation.
- The need for financial support to sustain and expand SDOH programs, including the hiring of community health workers (CHWs) and support staff, as well as IT support for electronic implementation and communication.
- Resources, training, and best practices for coding SDOH and connecting patients with appropriate community resources.
- Help closing the feedback loop with community resources to ensure follow-up and resolution of identified needs.
- Support to standardize processes across multiple practice units and integrate with other healthcare organizations.

How could MCT2D support this health equity work?

- Increasing awareness and access to CGM and diabetes education
- Offering lower cost diabetes medications, monitoring devices, and access to RDs for all patients regardless of payer
- Connect with patients with higher diabetic screening scores, to see if there are resources we can provide.
- Continued assistance with med and cgm coverage.
- Continue to provide the coverage map for DM medications. Continue to advocate for Medicaid coverage.
- Resources for medication assistance programs, transportation resources, food insecurity resources.
- Continue with providing resources, evidence-based guidelines, advocating for access to medication therapies, offering support through MCT2D to implement and maintain the work.
- Work with payors to improve coverage for members with commercial plans.



Discussion

Questions:

- 1) Consider the matrix in the handout at your table. Plot the items on the screen based on what you think is the most important and most feasible. Please feel free to add your own. Then share one thing that MCT2D could do as a collaborative to help advance health equity that is both highly feasible and highly important (in the blue quadrant).

Text MCT2D945 to 22333 to join the response session and then text in your response to this question to that same number.

Optional as time allows

- 2) Which of the SDOH domains do you think will have the **biggest impact on type 2 diabetes**? What SDOH data would be important to be able to compare and contrast populations on our dashboard?
- 3) Take a moment to review the example SDOH forms at your table and **discuss what your PO is doing well and where there might be gaps or room for improvement.**



Please plot the following, as well as any additional ideas you have for MCT2D to support your health equity work.

- Developing an interactive version of our coverage guide instead of a PDF
- Work with MSHIELD to offer consultations and other support to our practices
- Offering additional information about contacting community resource hubs on our website
- Developing additional resources for patients with SDOH needs
- Continuing to advocate with payors for better coverage
- Increasing access to and awareness of CGMs
- **Your own ideas...**

What is one thing that MCT2D could do as a collaborative to help advance health equity that is both highly feasible and highly important?





MCT2D

SDOH Screening Consultations with MSHIELD

🕒 30 min

If you are interested in learning more about integrating SDOH screening into your practice, finding ways to improve your screening forms, or getting support connecting with community resources, sign up for a consultation! **Please email your SDOH screening form and any questions at least 24 hours before the meeting.**

Each consultation is 30 mins and counts for Practice Level Learning Community VBR.

MSHIELD is a CQI promoting whole health for all people through data-driven, community-

[Cookie settings](#)

Select a Date & Time

< July 2023 >

SUN	MON	TUE	WED	THU	FRI	SAT
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

Time zone

🌐 Eastern Time - US & Canada (11:35am) ▼

🔧 Troubleshoot

SDOH Screening Consultations with MSHIELD

Counts for practice level learning community VBR.

<https://michmed.org/mQMmA>



Findhelp.org

Available through the MCT2D website
along with other food assistance
programs

<https://michmed.org/47ZGY>



MCT2D is committed to helping our participants support patients with type 2 diabetes and unmet social need.

We have partnered with FindHelp.org to offer a robust community resource search to help connect patients with the support they need. The FindHelp network includes 613,630 verified programs. Simply enter your zip code and a keyword or program name below to start searching for resources

Search for free and reduced cost services like food, housing, financial assistance, and more in your area!

SEARCH

Powered by  findhelp.org

Search for free and reduced cost services like food, housing, financial assistance, and more in your area!

SEARCH





CGMs: What's new, Inspiration, & Panel

Heidi L. Diez, PharmD, BCACP
Program Co-Director and Lead Pharmacist, MCT2D

CGM Coverage

■ Medicare



■ Michigan Medicaid

- Revised Standards of Coverage
 - Care for DM provided by: Endocrinologist, MD/DO, NP, PA, Clinical RN specialist
 - On insulin
 - Patient/Caregiver: Educated on use of device. Willing/able to use CGM
- For patients with T2D: Prior authorization still required

Freestyle Libre 3

- Real time readings: 1 minute
- Transmission range: 33 feet
 - No longer need to scan every 8 hours
- Reader:
 - *Cell phone*
 - Reader approved in April
 - Not yet eligible for Medicare
- Sensor: Smaller (0.83 in (d) x 0.11 in (h))
- COST: ~\$140/month
 - Commercial patients ONLY: Max of \$75/month
 - Voucher for free sensor
 - Ineligible: Medicaid/Medicare patients
 - Coupon: ~ \$130 - \$148



Dexcom G7

- Real time readings: 5 minutes
- Transmission range: 20 feet
- Receiver:
 - Cell phone
 - Reader (optional)
- All-in-one Sensor:
 - Smaller (1.08 in (d) x 0.18 in (h))
- Covered by Medicare
- COST: unavailable per Dexcom
 - Coupon: ~ \$164 - \$188



Questions



 **Abbott**

dexcom

Keith McIntyre

MCT2D Patient Advisory Board Member





A1c



Date	A1C
10/16/2019	9.1
1/9/2020	10.6
6/15/2020	8.5
9/21/2020	7.8
3/8/2021	8.7
6/11/2021	7.3
9/8/2021	7.1
12/6/2021	8.8
2/28/2022	8.9
5/23/2022	7.8
9/6/2022	7
1/14/2023	7.3



Aug-Sept 2020

A1c down
to 7.8%
compared
to 9.1%
about a
year ago.

How?

6/19-7/22 FBG = 148, dinner = 212, post-dinner = 235
7/23-9/2 FBG = 125, dinner = 187, post-dinner = 191

Home blood glucose readings: uses commas between meals, b = bike; w = walk (placement is timing)
9/15-10/7 FBG = 114, Dinner = 193, post-dinner = 197

	FBG	Dinner	P Dinner	Meals	Walk?	Bike?	Notes
15-Sep	125	205	117	01:30 am chocolate 5g pistachios 8g M&J's 12g bs= 124, B= French toast trout, 14:30 granola bar 27g, M&J's 12g.		Yes x2	
16-Sep	92	301	275	B=waffles, Late Lunch 3pm corned beef sandwich chips (2) beers cannoli			275 really 2 hours after a meal? 2 beers. 275 was after an early lunch/dinner. Lots of driving that day.
17-Sep	88	215	250	B= waffles, L= hot dogs Mac and cheese, D= crab and pasta canoli,	Yes		Says he gets shaky below 90. OJ 'cut pretty thin' usually, but will drink whole OJ on days when sugars are low.
18-Sep	154	244	175	No drugs last nite B= eggs toast oj 12g cookies 10g , L= pb sandwich 23g Cheetos 15 g, ss ginger ale 12g, D= cashew shrimp and lobster rolls		Yes x2	Pretty uncommon to forget meds. Usually snack at 10, 3, and 8. Usually picks snacks with a fair amount.
19-Sep	141		263	B= cereal, L= grilled cheese tomato soup, D= pizza salad chocolate chip cookies			
20-Sep	109		170	B= pb toast pretzel,			
21-Sep	110	234	248				
22-Sep	107	228		B= Pretzel oj, L= hot dog and fries, D= hamburger and fries	Yes	Yes x2	Walks usually take about 30 minutes
23-Sep	118	203	161	B= waffle 15g oj 12g, L= pasta pudding 22g, D= scallops spinach and salad, jello 38g	Yes		
24-Sep	147	147	195	B= cereal, cheese and crackers, D= chili corn bread, jello 340mg/dl + 2 hours = 197	Yes		Started meal planning; planning on sundays. Trying to limit the number of pasta containing meals
25-Sep	109		172	B=waffle oj 12g, L= fish sandwich seafood chowder pudding 12g,			
26-Sep	112	104	217	B= English muffin with egg and cheese oi, L=	Yes x2		

May 2021

Tries CGM (Dexcom), with first reading interpretation. Logging meals consistently. TIR is 86%.

“Pt is elated about Dexcom and Truulicity.”

6/19-7/22 FBG = 148, dinner = 212, post-dinner = 230
7/23-9/2 FBG = 125, dinner = 187, post-dinner = 191

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WARNING
CAUTION: DO NOT OPERATE THIS AIRCRAFT WITH THE ENGINE OIL PRESSURE LOW. SEE THE PILOTS OPERATING HANDBOOK FOR MORE INFORMATION.

N00000

Average Glucose

140 mg/dL

Standard Deviation **38** mg/dL
6.6

Time in Range

1% Very High
12% High
86% In Range
+1% Low
0% Very Low

Target Range
70-180 mg/dL

Sensor Usage

Days with CGM data
93%
13/14

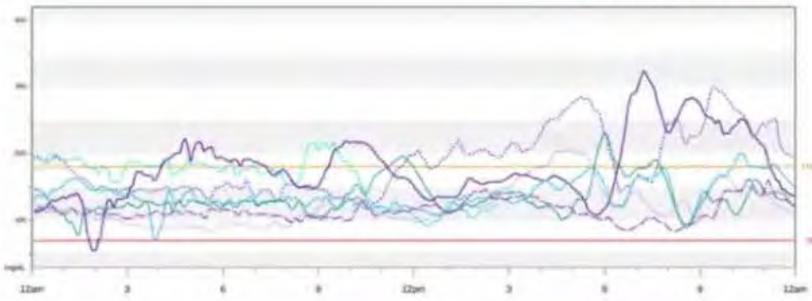
Avg. collection per day
20

Overlay

14 days | Fri May 2, 2021 | Thu May 20, 2021
Week 1 | Fri May 7, 2021 | Thu May 13, 2021

Glucose
Kath Monaghan

Mon Tue Wed Thu Fri Sat Sun

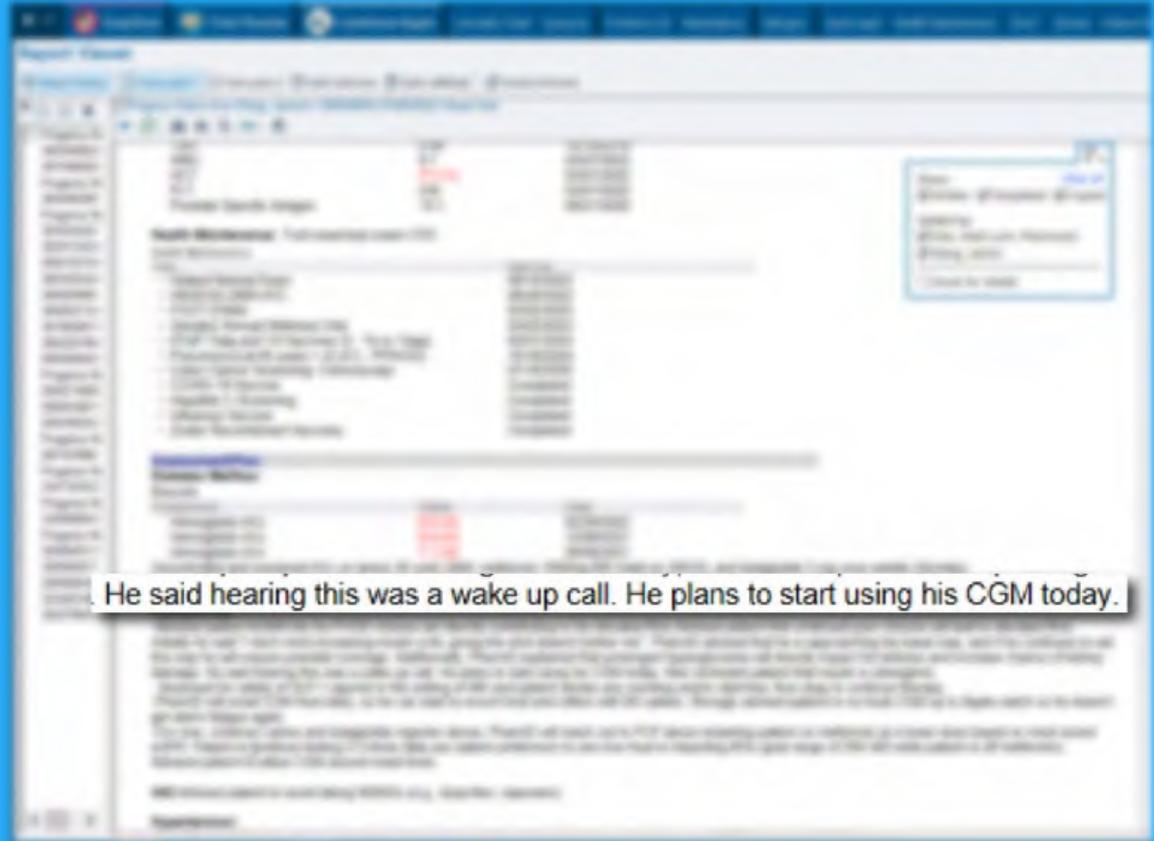


CAUTION!
CONTROL LOCK
REMOVE BEFORE
STARTING ENGINE

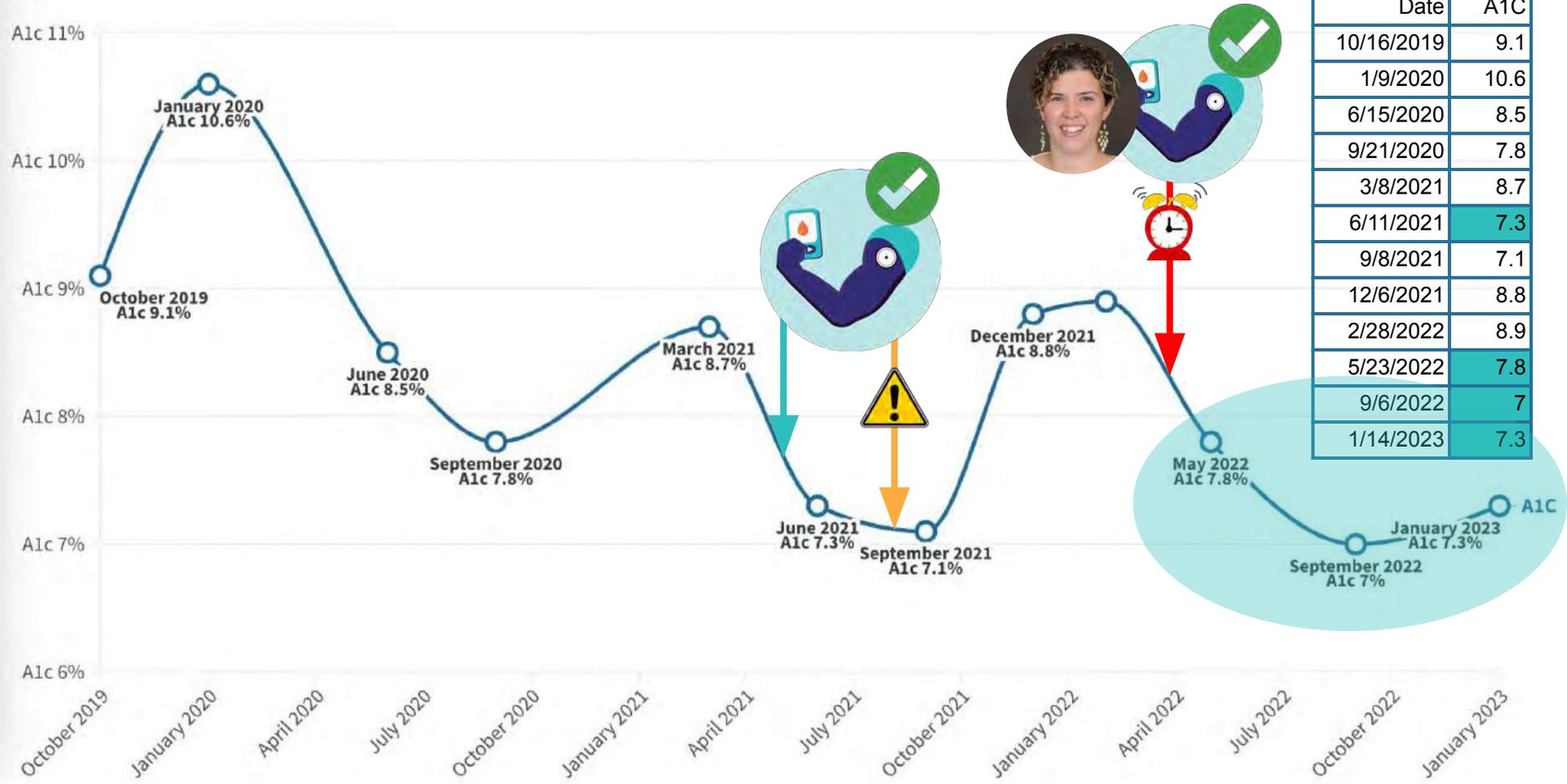
March 2022

A1C 7.1 to
8.8.

Considers
resuming
CGM in the
new year.



A1c



Date	A1c
10/16/2019	9.1
1/9/2020	10.6
6/15/2020	8.5
9/21/2020	7.8
3/8/2021	8.7
6/11/2021	7.3
9/8/2021	7.1
12/6/2021	8.8
2/28/2022	8.9
5/23/2022	7.8
9/6/2022	7
1/14/2023	7.3



Panelists



Saira Sundus, MD
Endocrine Consultants of
Mid-Michigan



Kelsey Mapes, RN
Alma Family Practice



Bobby DaBicci, PharmD
Lakeland

**What has your PO done to
help your practice more
effectively incorporate
CGMs into patient care?**

What support does your PO offer on identifying patients who may qualify for a CGM?

If none, would this be helpful for you?

Has your practice worked with any outside sources (vendors, device companies, DMEs) which have helped with CGM implementation?

What advice do you have on incorporating these outside sources that is accepted by your institution?

Who in your practice handles:

- Educating patients on CGM
- Submitting prior authorizations
- Downloading CGM data and ensuring it is ready for review

Which of these steps does your practice handle most efficiently?

**What components of
CGM implementation
require continued support or
workflow adjustments to gain
efficiencies at your practice?**

Story Sharing: How a CGM has helped a patient outside of glycemic improvement.

PO Discussion

- **How does your PO support the implementation of CGMs within your practices?**
- **Do you plan to offer additional support in the future? What will this look like?**
- **What has been helpful for your practices in increasing their CGM use?**

Supporting System Level Change

Amir A. Ghaferi, MD, MSc, MBA

Professor of Surgery
President & CEO, Physician Enterprise
Senior Associate Dean for Clinical Affairs
Froedtert & Medical College of Wisconsin

 @AmirGhaferi



MCT2D Collaborative Wide
Meeting
June 16, 2023



Disclosures

- Received salary support as the Director of the Michigan Bariatric Surgery Collaborative; currently as Strategic Advisor
- Received research funding from Patient Centered Outcomes Research Institute (PCORI), Agency for Healthcare Research and Quality (AHRQ), and the National Institutes of Health (NIH)

Disclaimers/Experience

- Statewide quality improvement
- Research focus on organizational structure/dynamics
- Departmental clinical program building and operations
- Health system leadership and change management

Disclaimers/Experience

- **Statewide quality improvement**
- Research focus on organizational structure/dynamics
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- **Health system leadership and change management**



MICHIGAN BARIATRIC SURGERY COLLABORATIVE



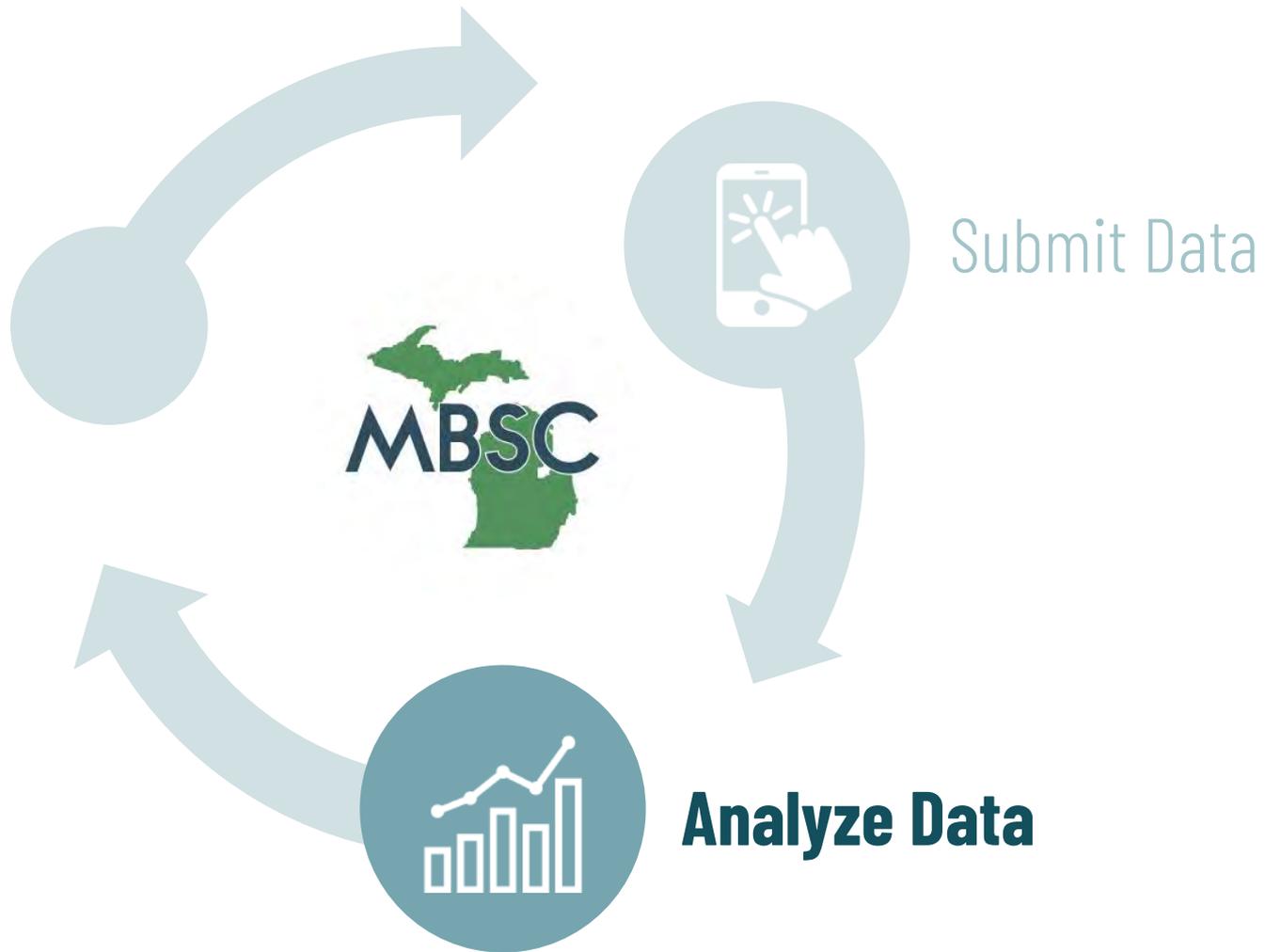
MBSC

15 YEARS
& counting





Submit Data



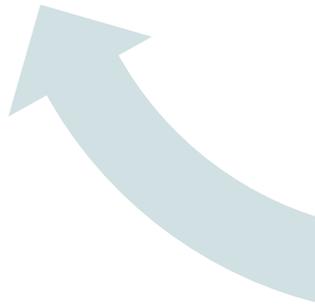
**Design
Strategy**



Submit Data



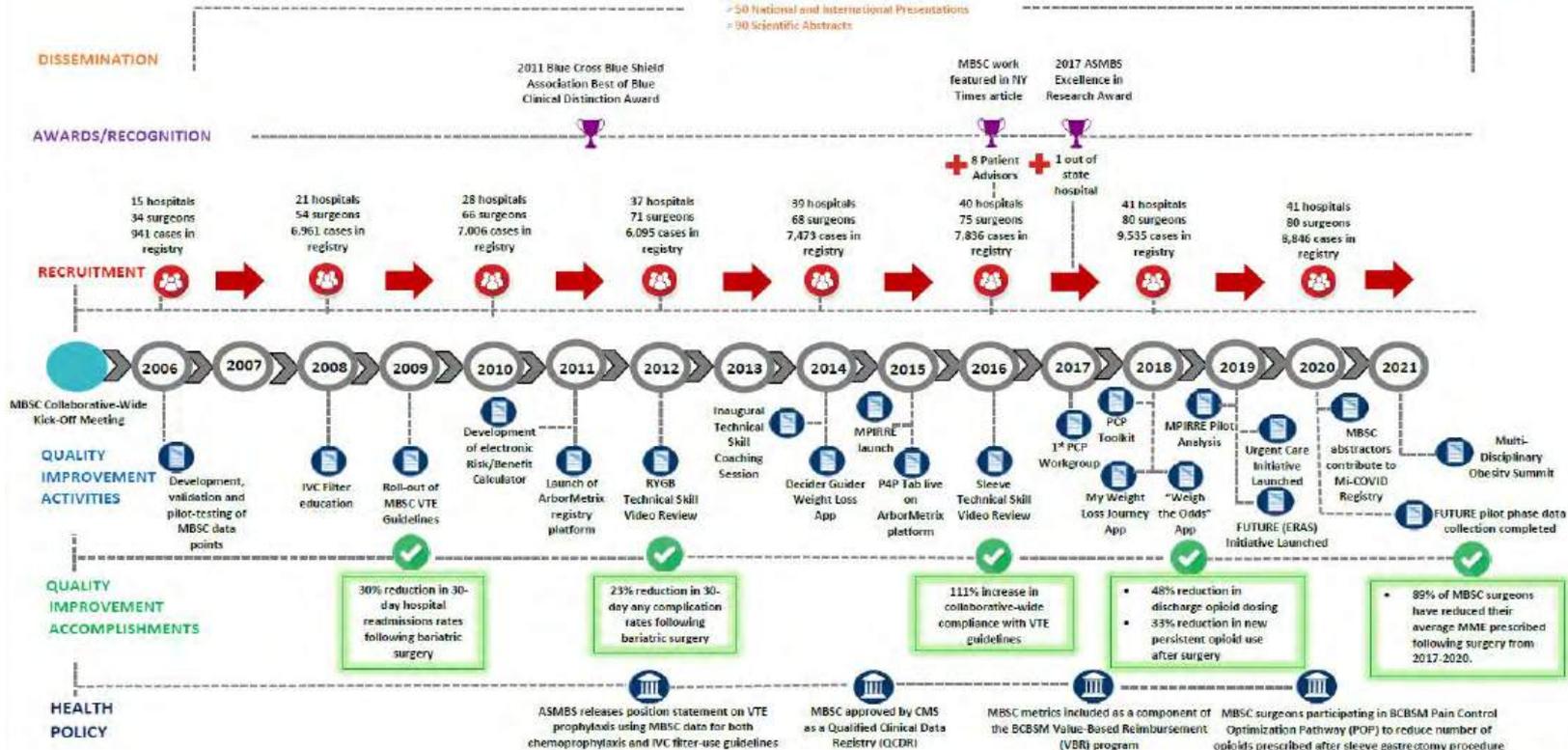
Analyze Data



MBSC Timeline



> 30 Peer-Reviewed Manuscripts
 > 50 National and International Presentations
 > 30 Scientific Abstracts

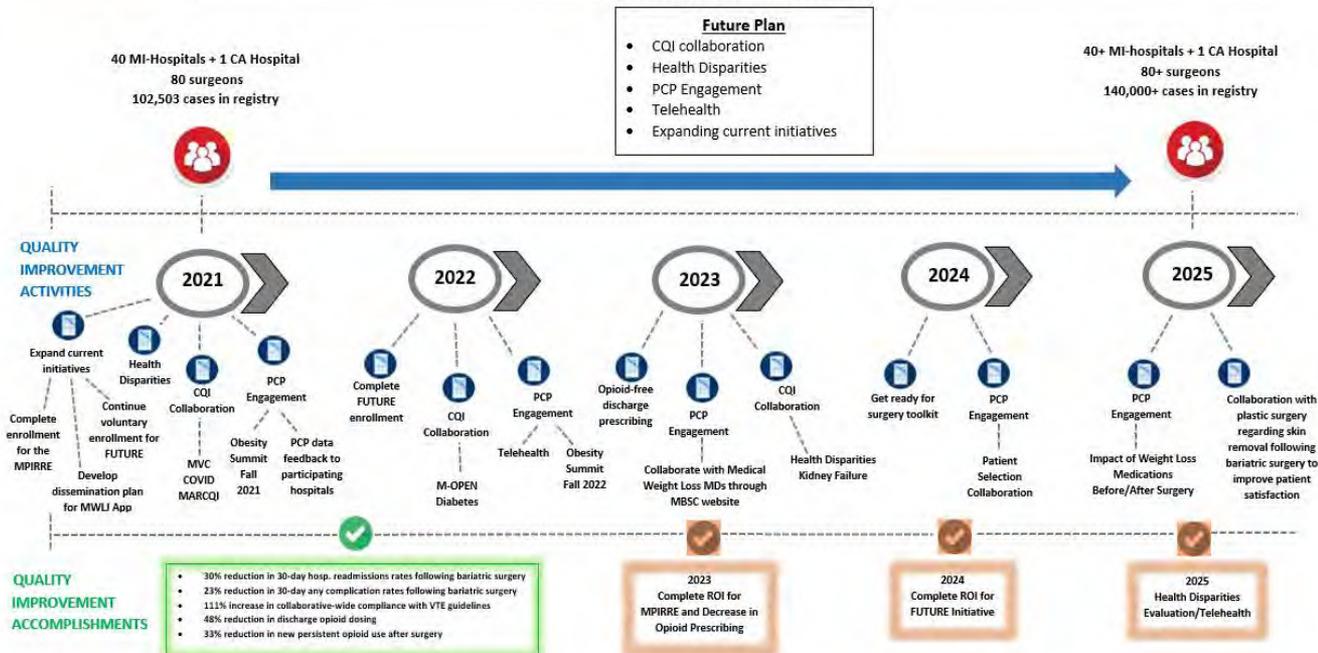


MBSC 5-Year Timeline



- > Manuscripts, Presentations, Scientific Abstracts
- > CQJ Collaboration
- > BCBSM Advocacy (PCPs, PO groups, purchasers, membership)

DISSEMINATION





Leadership and Change Management

- Principled
- Data Driven
- Collaborative



Leadership and Change Management

- Principled
- Data Driven
- Collaborative





Mission

MCT2D's mission is to engage and empower clinicians and patients across Michigan to accelerate dissemination and implementation of evidence-based strategies to prevent and reverse progression of Type 2 diabetes and its complications

Vision

A world where Type 2 Diabetes is no longer a progressive disease.

Values

Integrity: We are honest, fair, genuine, open, and ethical in all that we do. We keep our word and act in accordance with our values.

Collaboration: We believe the best work is work done together. We constructively share ideas and input both inside and outside of the program to achieve shared goals.

Empowerment: We trust that with the right tools and information, people can achieve their goals.

Respect: We show respect for all people, their culture, and the communities in which they live. We demonstrate high regard for one another, our partners, and our stakeholders. We act with empathy and seek to understand.

Diversity and Inclusion: We know that people with diverse backgrounds, beliefs, ideas, cultures, and strengths are what make us great and we recognize and acknowledge our differences. We strive to ensure that everyone feels welcome, included, and heard.



MBSC Mission Statement

MBSC aims to advance the science and practice of bariatric surgery—
in Michigan and across the United States.

MBSC rests on the core pillars of collaborative quality improvement: collection of detailed clinical data on outcomes and practice; timely, rigorous performance feedback to clinicians; and continuous improvement based on empirical analysis and collaborative learning.

MBSC Core Values



- Collegiality
- Confidential
- No “Billboards”
- Contribute
- Open-Minded
- Innovative

Technical Skill/Coaching

- Espouses the core values we hold as a collaborative
- All boats rise and fall together



Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association

The “Black Box” of Surgery



Technique and Technical Skill

The NEW ENGLAND JOURNAL *of* MEDICINE

SPECIAL ARTICLE

Surgical Skill and Complication Rates after Bariatric Surgery

John D. Birkmeyer, M.D., Jonathan F. Finks, M.D., Amanda O'Reilly, R.N., M.S.,
Mary Oerline, M.S., Arthur M. Carlin, M.D., Andre R. Nunn, M.D.,
Justin Dimick, M.D., M.P.H., Mousumi Banerjee, Ph.D.,
and Nancy J.O. Birkmeyer, Ph.D., for the Michigan Bariatric Surgery Collaborative

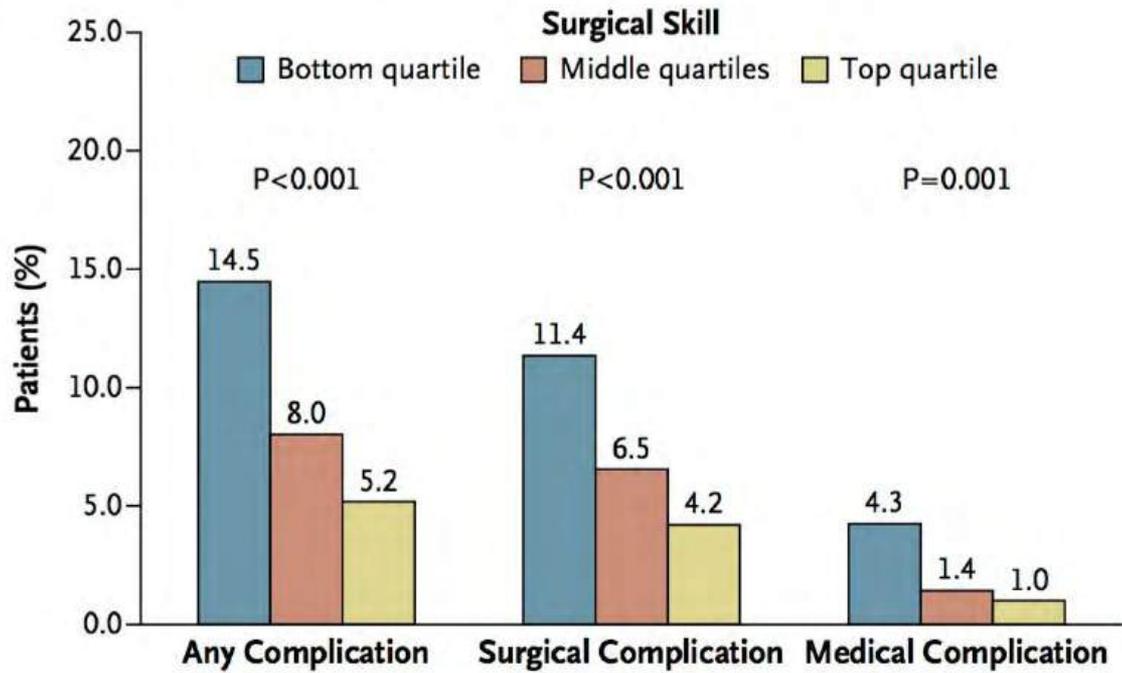


Figure 2. Risk-Adjusted Complication Rates with Laparoscopic Gastric Bypass, According to Quartile of Surgical Skill.

Value of using video to assess quality:

- Surveys of surgeon technique and operative reports may not be accurate
- What the surgeon thinks they did may not be what they actually did
 - Something was missed
 - Unable to recall
 - Perception gaps

Measuring & improving surgeon skill

- Surgeons submitted videotape of “typical” laparoscopic gastric video
- Blinded peer rating
- Technical skill rated according to modified OSATS instrument

MBSC Michigan Gastric Surgery Collaborative

Blue Cross Blue Shield Blue Care Network

Contact | admin

Home Data Management Reports Decision Support Administrative Help Reviews

Perform Review

Please take a moment to watch any media / video(s) and then complete the small questionnaire on the right to rate surgeon's skills. The answers to this survey will be kept completely anonymous.

Gastric Pouch

Gastro-jejunostomy

Jujuno-jejunostomy

Surgeon's skill review

Please rate the surgeon's skill in the following categories using 1 as the lowest score and 5 as the highest.

Respect for tissue * 1 2 3 4 5

Exposure * 1 2 3 4 5

Instrument handling * 1 2 3 4 5

Time and motion * 1 2 3 4 5

Flow of operation * 1 2 3 4 5

Overall technical skill * 1 2 3 4 5

Comments

Submit



MBSC
MICHIGAN BARIATRIC SURGERY COLLABORATIVE

Coach Resource Manual
*Prepared for MBSC
2015*



DEPARTMENT OF SURGERY
**Wisconsin Surgical Outcomes
Research Program**
UNIVERSITY OF WISCONSIN
SCHOOL OF MEDICINE AND PUBLIC HEALTH







Leadership and Change Management

- Principled
- Data Driven
- Collaborative





Is this an all-patient, all-payer initiative?

Yes, like all other collaborative quality initiative programs, MCT2D is an all-patient, all-payer initiative. When performance is measured, all patients that a practice sees will be part of the denominator, not just BCBSM patients. In regards to the data, the CQI Data Hub is working diligently to ensure that data from all payors will be available and is exploring multiple routes to ensure that this is the case. The initial launch of the data hub in November 2021 is based only on BCBSM data, but in 2022, MDC is adding all payor clinical data and Blue Care Network claims data.

IVC Filter Utilization

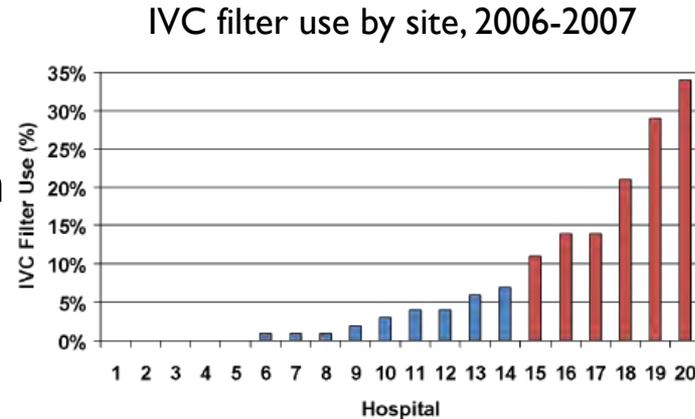
- Challenging to see the data
- Need trust and to share openly
- Rapid practice change can come about with strong data



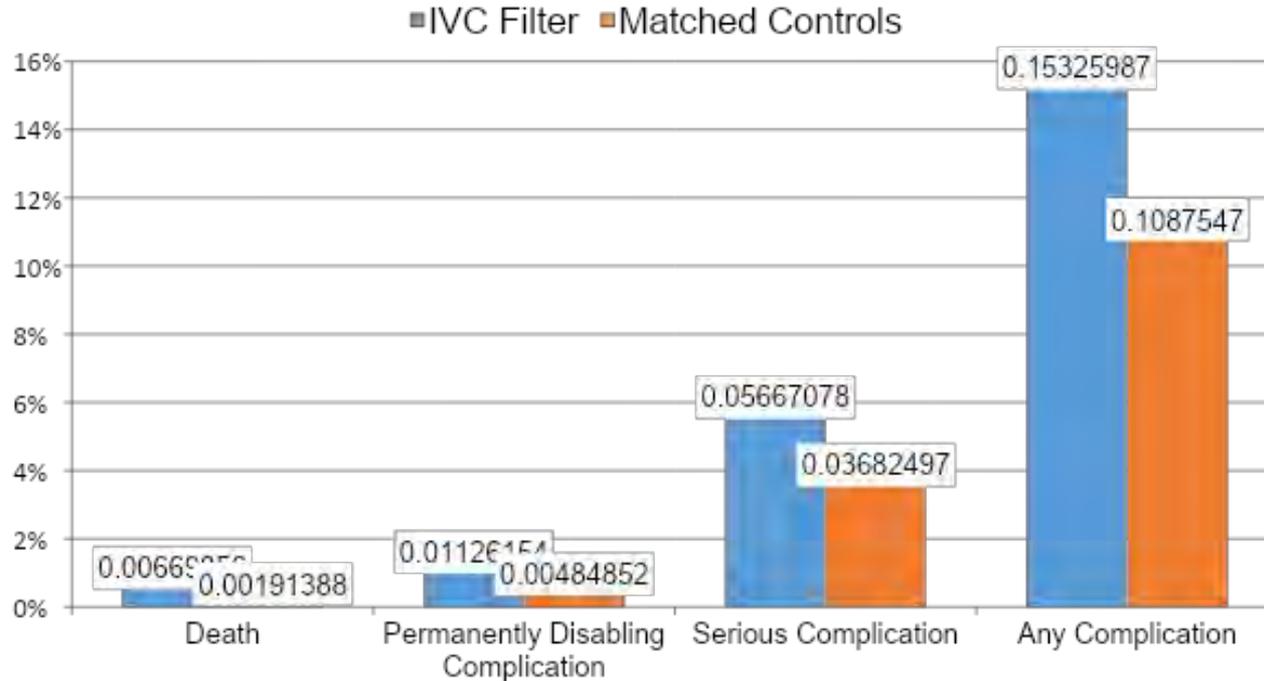
Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association

IVC Filter Utilization

- Prophylactic IVC filter placement in ~10% of patients
- Wide variation in use from 0% to 35% across hospitals



Adjusted rates of complications according to severity in IVC filter patients and in matched controls



Death/disabling complications in patients with IVC filters

Half of the IVC filter patients with the most serious complications, had a PE or a complication specifically related to the IVC filter

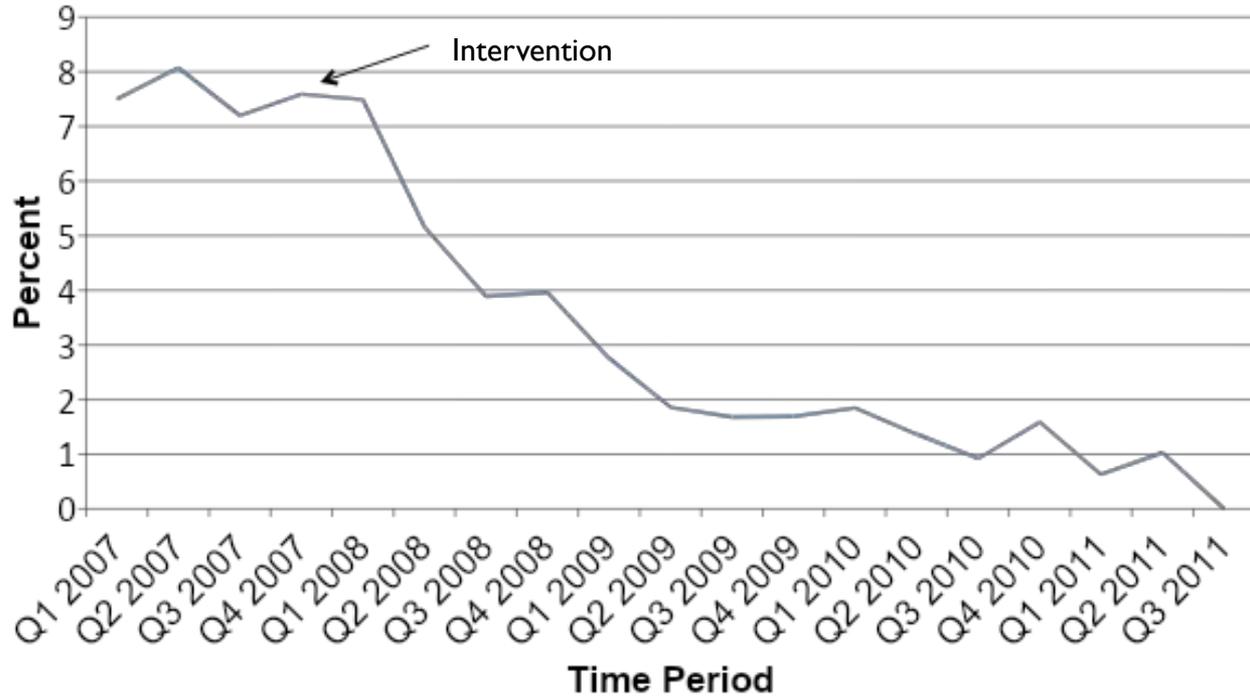
Specific Examples:
Filter migrated to R heart (POD #3), open heart surgery for removal
Bilateral lower extremity thrombosis, vena cava filter thrombosis (POD 4,5), reintubated (POD 5), <u>death</u>
ED (POD 14) for PE, reintubated, cardiac arrest, <u>death</u>
ED/readmitted (POD 13) for excessive anticoagulation and intra-abdominal bleeding, PE/cardiac arrest (POD 16), <u>death</u>
ED (POD 15), readmitted (POD 16) IVC filter occlusion leading to vascular collapse, shock (POD 17), cardiac arrest (POD 17, 18), <u>death</u>

ORIGINAL ARTICLES

Preoperative Placement of Inferior Vena Cava Filters and Outcomes After Gastric Bypass Surgery

Nancy J. O. Birkmeyer, PhD, David Share, MD, MPH,† Onur Baser, PhD,* Arthur M. Carlin, MD,‡
Jonathan F. Finks, MD,* Carl M. Pesta, DO,§ Jeffrey A. Genaw, MD,‡ and John D. Birkmeyer, MD*; for the
Michigan Bariatric Surgery Collaborative*

Trends in the Use of Prophylactic IVC Filters in Bariatric Surgery in Michigan



Effect of Intervention on Costs

Description	Cost	Annual # Averted	Savings
Excess cost IVC filter placement	\$13,500	456	\$5.2 million
Excess cost serious complication	\$12,000	22	\$264,000
Total			\$5.5 million

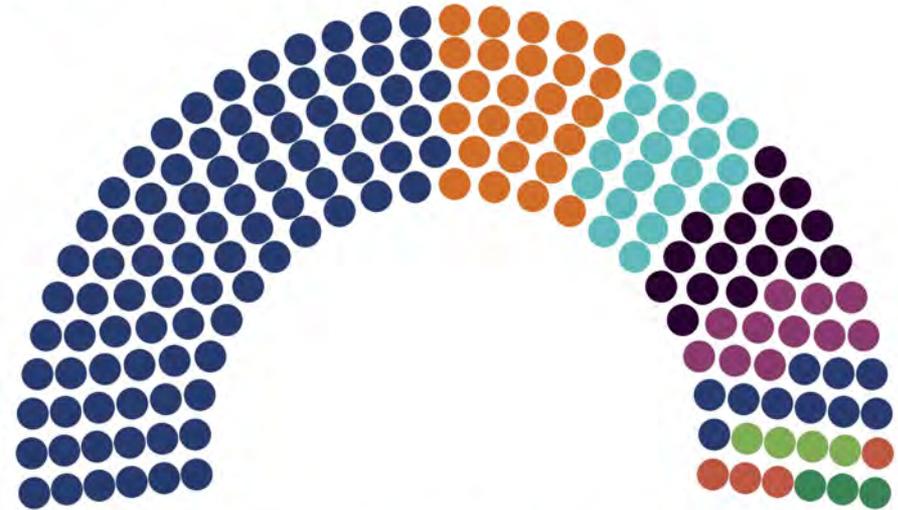
Leadership and Change Management

- Principled
- Data Driven
- Collaborative





2021 MCT2D Clinical Champions



Professions ● Primary Care Physician ● Nurse (RN, LPN) ● NP ● Care Managers/Navigators ● Pharmacist ● Registered Dietician
● Certified Diabetes Care & Education Specialist ● PA ● Other admin

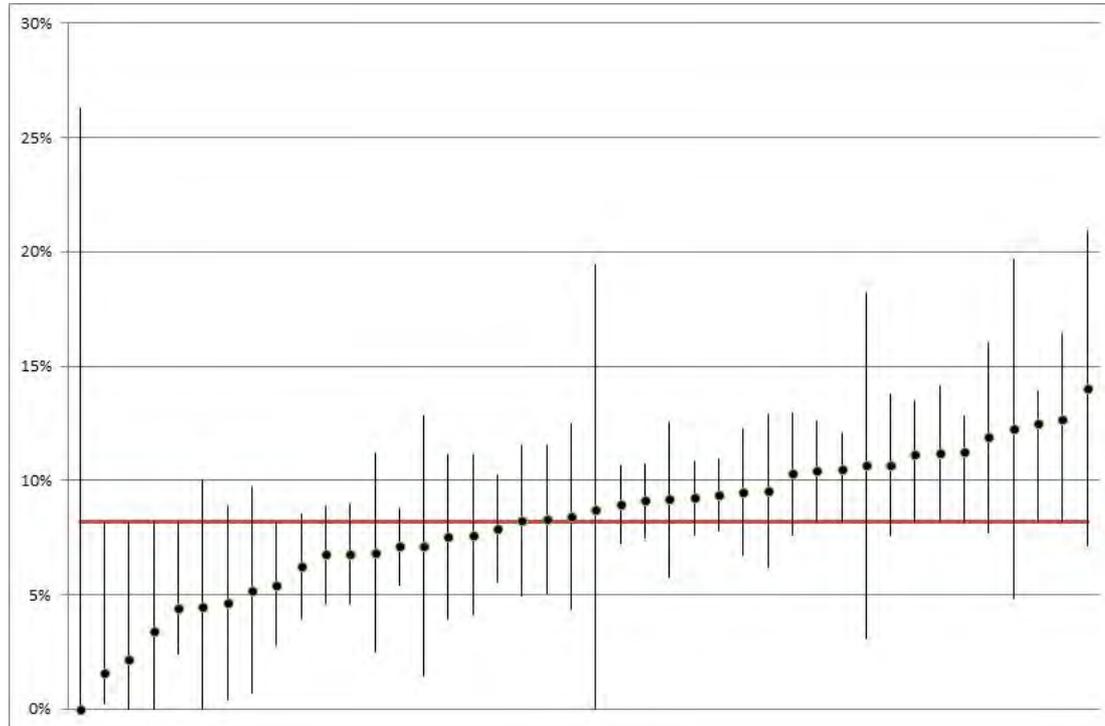
Emergency Department Visits

- Wide variation in rates
- Discovered best practices in high performers
- Developed toolkit, site visits, and interventions to help low performers





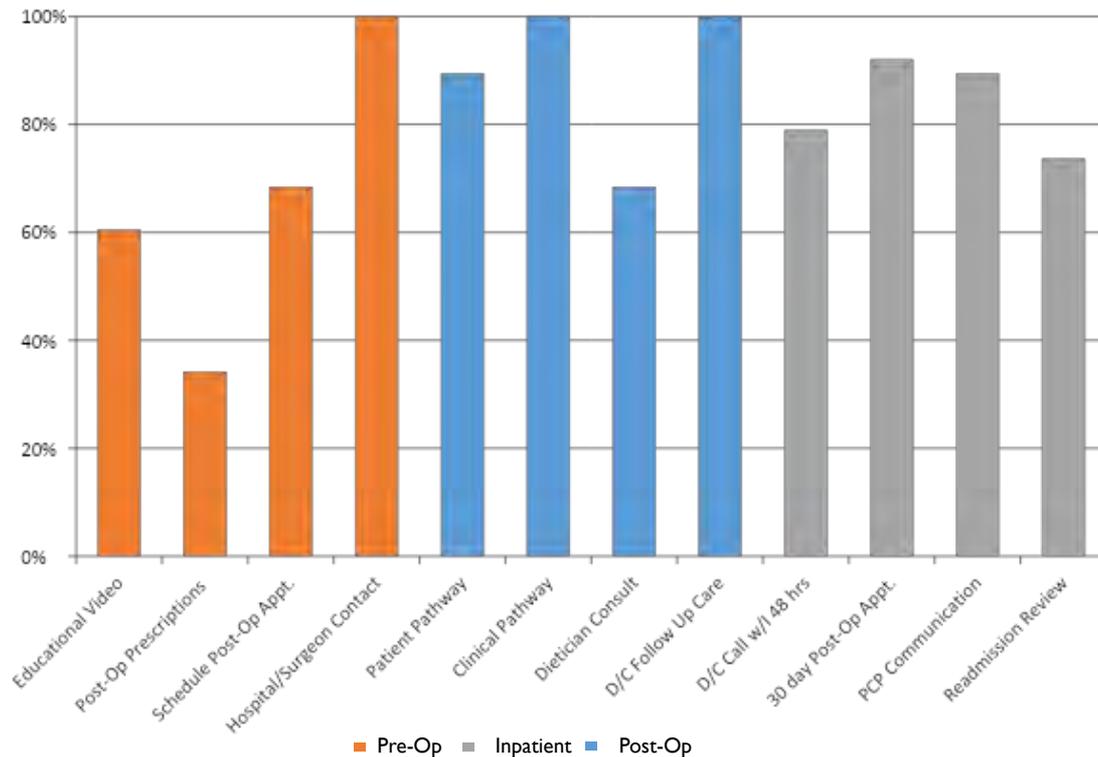
ER Visits Variation By Site



January 2012-December 2014
Average of 8%

Survey Results

Percentage of Sites Using Measure



Site-Specific Approach to Reducing Emergency Department Visits Following Surgery

Hassaan Abdel Khalik, BSc,* Haley Stevens, MPH,* Arthur M. Carlin, MD,†‡ Amanda Stricklen, RN, MS,‡
Rachel Ross, RN, MS,‡ Carl Pesta, DO,‡ Jonathan F. Finks, MD,*‡ Andrew Ibrahim, MD, MSc,*
and Amir A. Ghaferi, MD, MS*‡

Annals of Surgery 2017

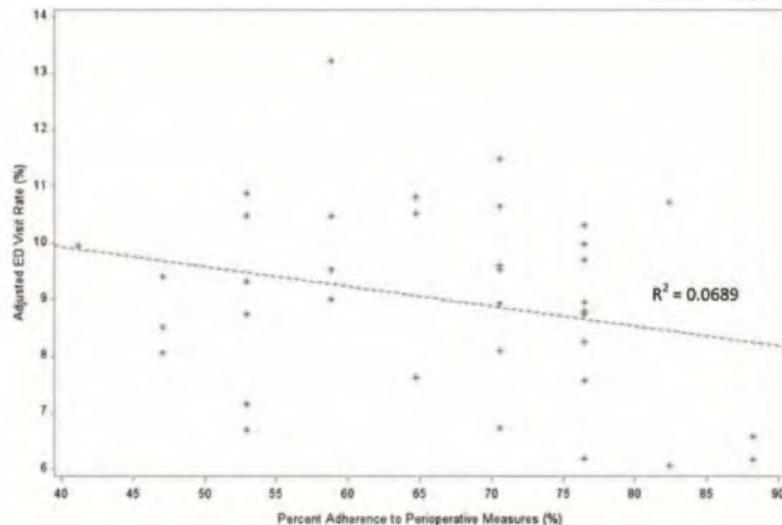


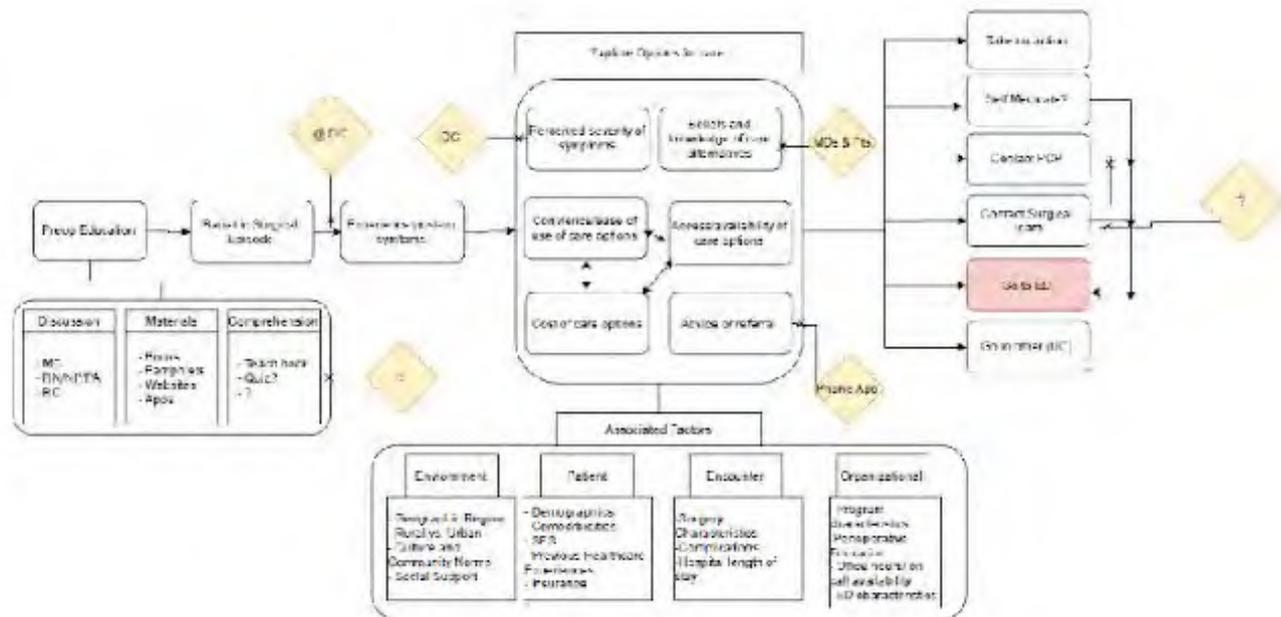
FIGURE 1. The relationship between a hospital's adherence to the perioperative measures surveyed for (Table 1) and ED visit rates.

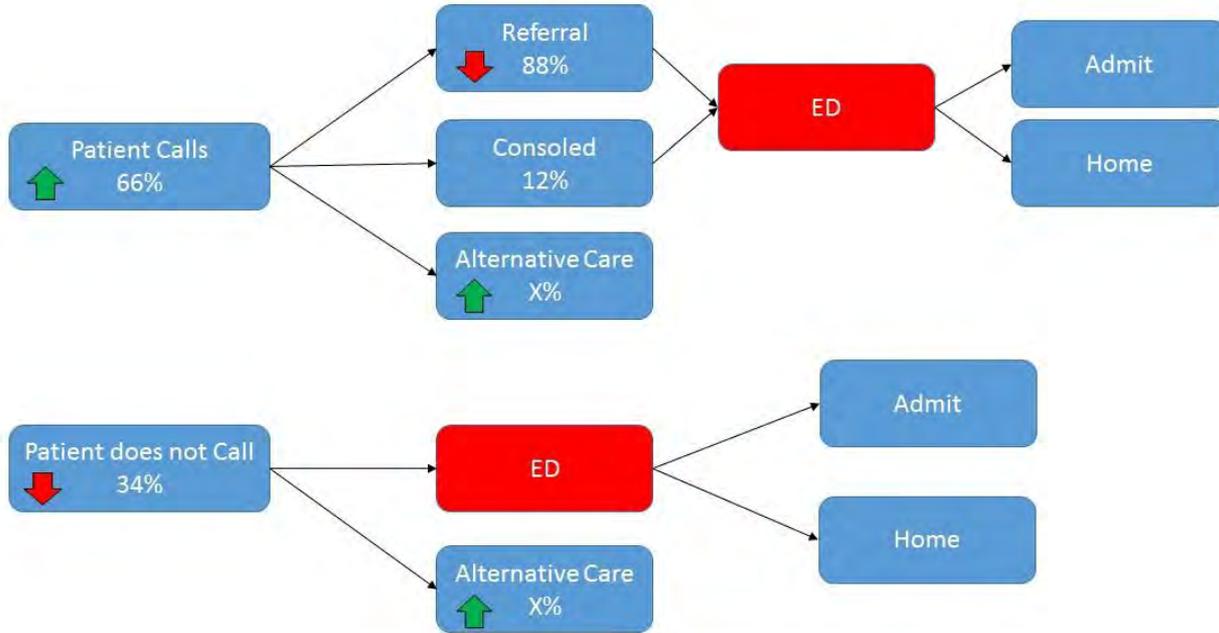
How to improve?

- Where can we intervene?
- What do we have control over?
- Where can we make the biggest impact in reducing rates?



Pathways for Non-Emergent ED Use





Points of intervention

- Reduce ED referrals by promoting alternative care use (urgent care, infusion center, other) and clinic visits when appropriate
- High utilizer prediction model
 - Target intervention efforts toward frequent fliers before they end up in ED
- Target remaining patients who are not calling?



Leadership and Change Management

- Principled
- Data Driven
- Collaborative





How can you develop a comprehensive change management plan utilizing the conceptual model of “Principled – Data-driven – Collaborative”?

Thank you!

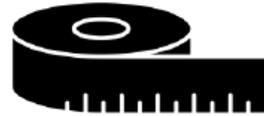
 **twitter** @AmirGhaferi

MichiganBSC.org



Appendix

5 ESSENTIALS OF A GREAT REDESIGN PITCH



5 ESSENTIALS OF A GREAT REDESIGN PITCH

Problem



Can You Clearly
Define It? It may be
a moving target

Most Big Problems are 1,000 Small Problems



ED overcrowding and Inpatient Capacity

- RN answer line ☐ keep pts out of the ED
- Virtual UC ☐ escalate care without sending pts to the ED
- Care @ Home ☐ inpatient level of care outside our 4 walls

5 ESSENTIALS OF A GREAT REDESIGN PITCH

Problem



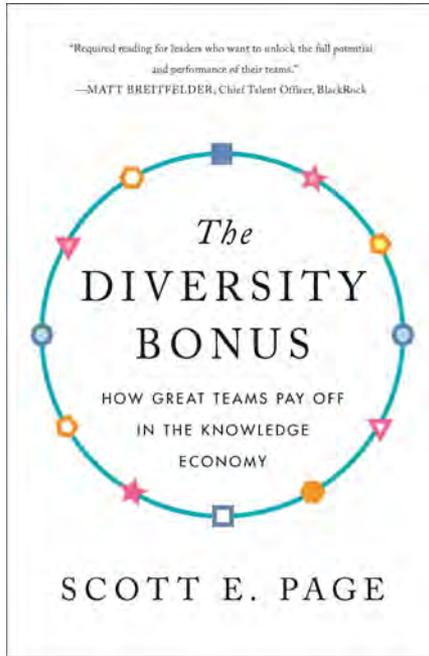
Can You Clearly Define It? It may be a moving target

Partners



Who Are They?
Who are the Critics?
Can you align them?

Engage Partners and Critics Early...



Minimize the term “physician-led”

Can you pre-empt critics?

More views (usually), the better!

5 ESSENTIALS OF A GREAT REDESIGN PITCH

Problem



Can You Clearly Define It? It may be a moving target

Partners



Who Are They?
Who are the Critics?
Can you align them?

Resources



What do you *actually* need?
Money? People?

Making "The Ask" Less Awkward...



- Focus on the things you need, not the amount
- Do not over-ask. This isn't a negotiation
- Start small, prove value, then scale up
- ROI can be more than financial...

5 ESSENTIALS OF A GREAT REDESIGN PITCH

Problem



Can You Clearly Define It? It may be a moving target

Partners



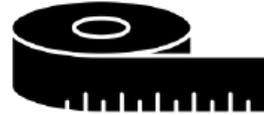
Who Are They? Who are the Critics? Can you align them?

Resources



What do you *actually* need? Money? People?

Evaluation



What are Your Measurable Outcomes?

What does Measurable success look like?

S

M

A

R

T



Specific



Measurable



Attainable



Relevant



Time Based

5 ESSENTIALS OF A GREAT REDESIGN PITCH

Problem



Can You Clearly Define It? It may be a moving target

Partners



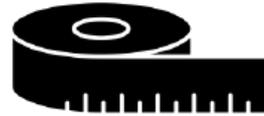
Who Are They? Who are the Critics? Can you align them?

Resources



What do you *actually* need? Money? People?

Evaluation



What are Your Measurable Outcomes?

Urgency



How Will You Keep Momentum to Finish?



When it gets hard (it will), how will you finish?

- Key Milestones to celebrate
- May need to recalibrate the team
- How close are you to your original problem?