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
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

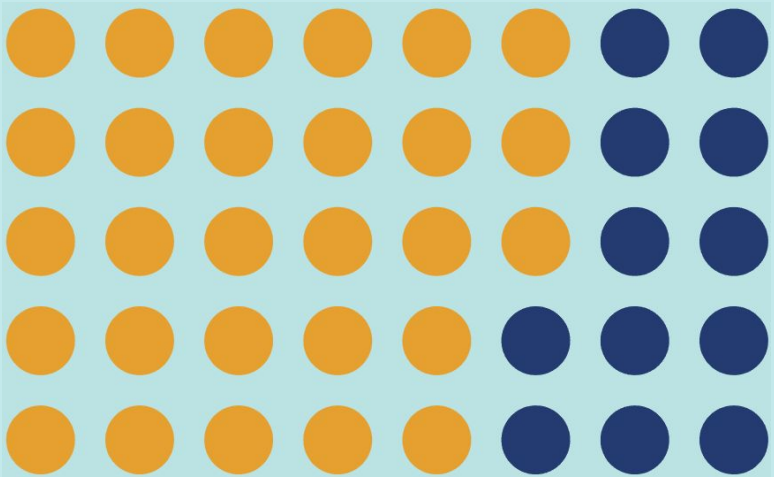
MCT2D: we're on a mission!

- **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

UM HEALTH Group

MedNetOne HEALTH SOLUTIONS

Metro Health Integrated Network

Who We Are
Practices

310
primary care practices

Added 79 practices in 2022

21
endocrinology practices

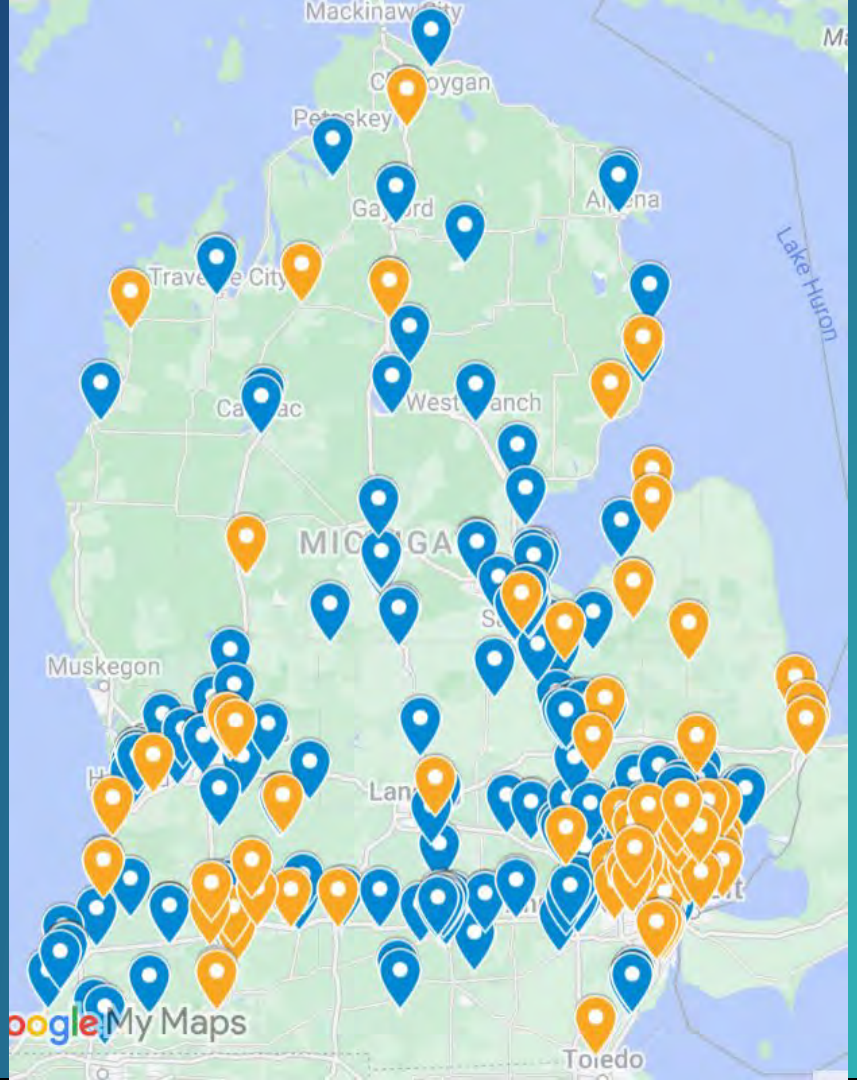
Added 6 practices in 2022

15
nephrology practices

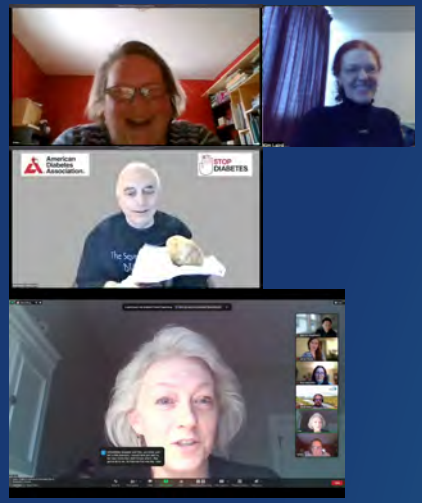
Added 6 practices in 2022

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

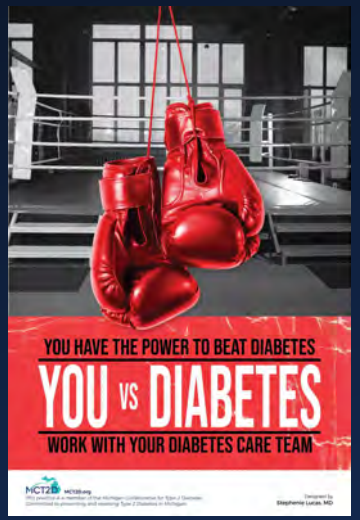
Topics: Tirzepatide updates, Coverage Quest, Insurance Coverage Tips & Tricks

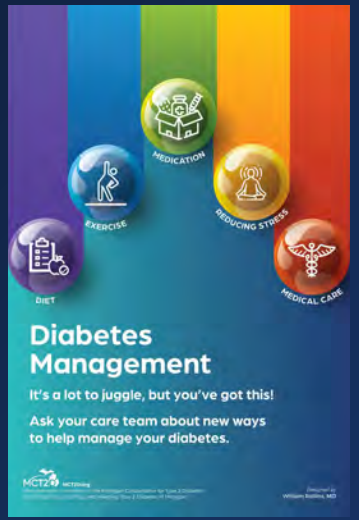
251 attendees across 7 regions

"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."

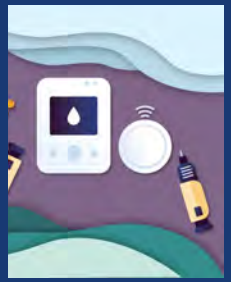
Posters

designed by members





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

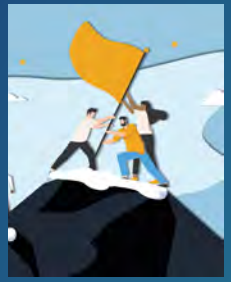
67

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

Navigating CGMs

Monday, Dec 11
12-1PM

Multidisciplinary Teams and Utilizing Diabetes Specialists

Friday, August 18
12-1 PM

Pharmacotherapy for Obesity

Friday, Nov. 17
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

MCT2D

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

MPCP
MICHIGAN PRIMARY CARE PARTNERS
INTERNAL MEDICINE | FAMILY MEDICINE | PAIN MANAGEMENT

MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

Great Lakes
PHYSICIANS ORGANIZATION

BRONSON
MEDICAL GROUP

UNITED PHYSICIANS
Advancing Physician Performance

holland pho
Physician Hospital Organization

JACKSON HEALTH NETWORK

Northern
Michigan Care
Partners

OSP
POWERED BY ADMINISTRATIVE NETWORK

My Michigan Health
UNIVERSITY OF MICHIGAN HEALTH

Metro Health
Integrated Network

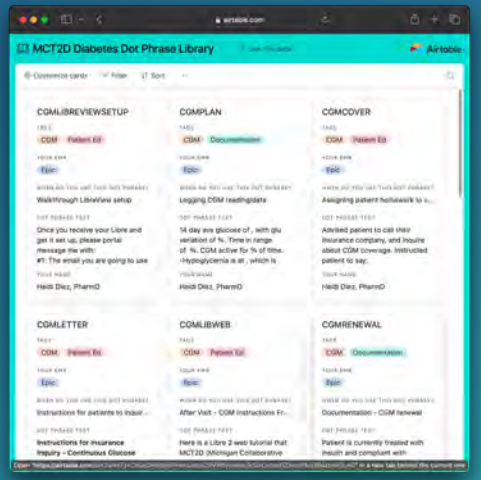
CIPA
Consortium of Independent Physician Associations

For helping make this program a success!

Launched since last June

Dietitian and Pharmacist 1on1 Consults

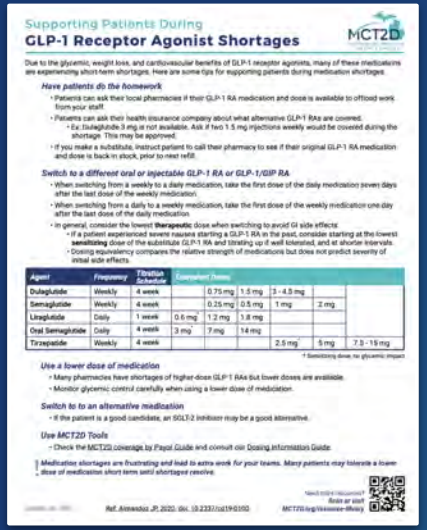
Best Practices Database



Dot Phrase Library

Coming Soon: Cooking Demo and Breadless Collaboration

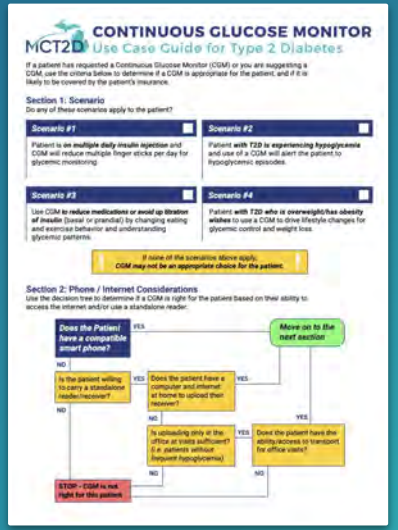
New tools since last June



GLP-1 Receptor Agonist Shortages

Guide for Starting Patients on a Low Carb Lifestyle

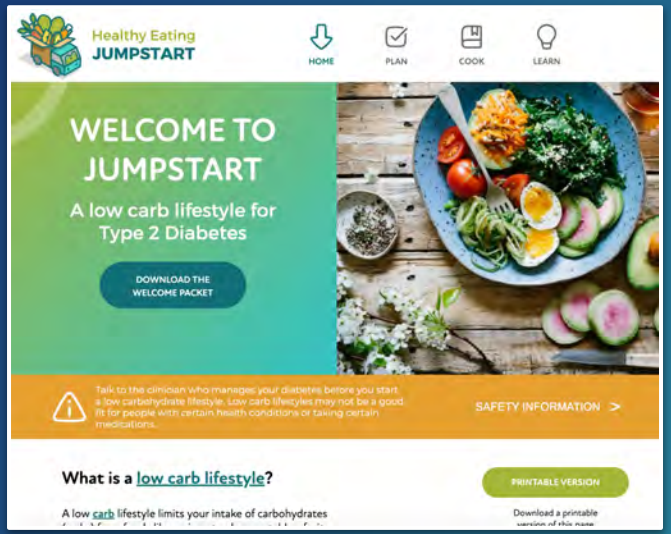
GLP-1 RA & SGLT2i Patient Handout



CGM Use Case Guide

New tools since last June

Top 10 Coverage Tips

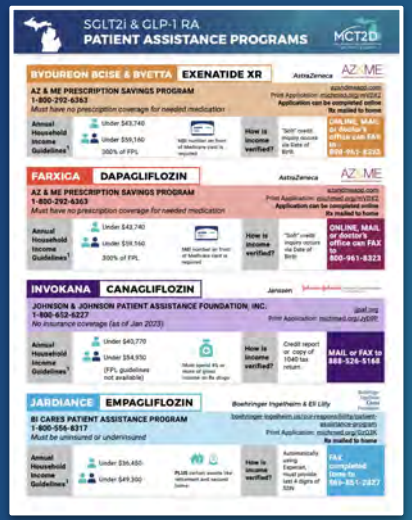


Jumpstart Low Carb Website and Tools

Injectable How-To Video Series

Updated tools since last June

Low Carb Cheatsheet and tracker

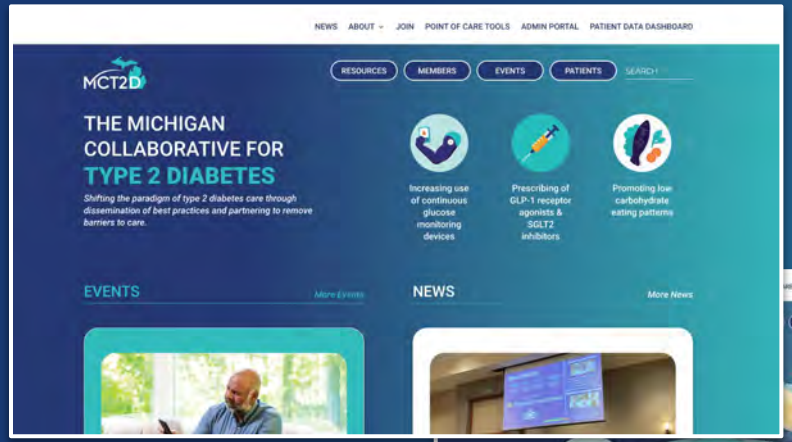


Patient Assistance Programs and Copay Savings Cards

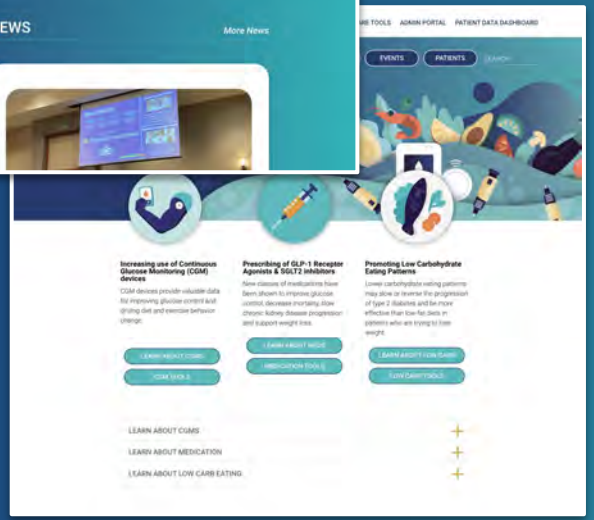
Affording Your T2D Care Toolkit

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!

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!

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:

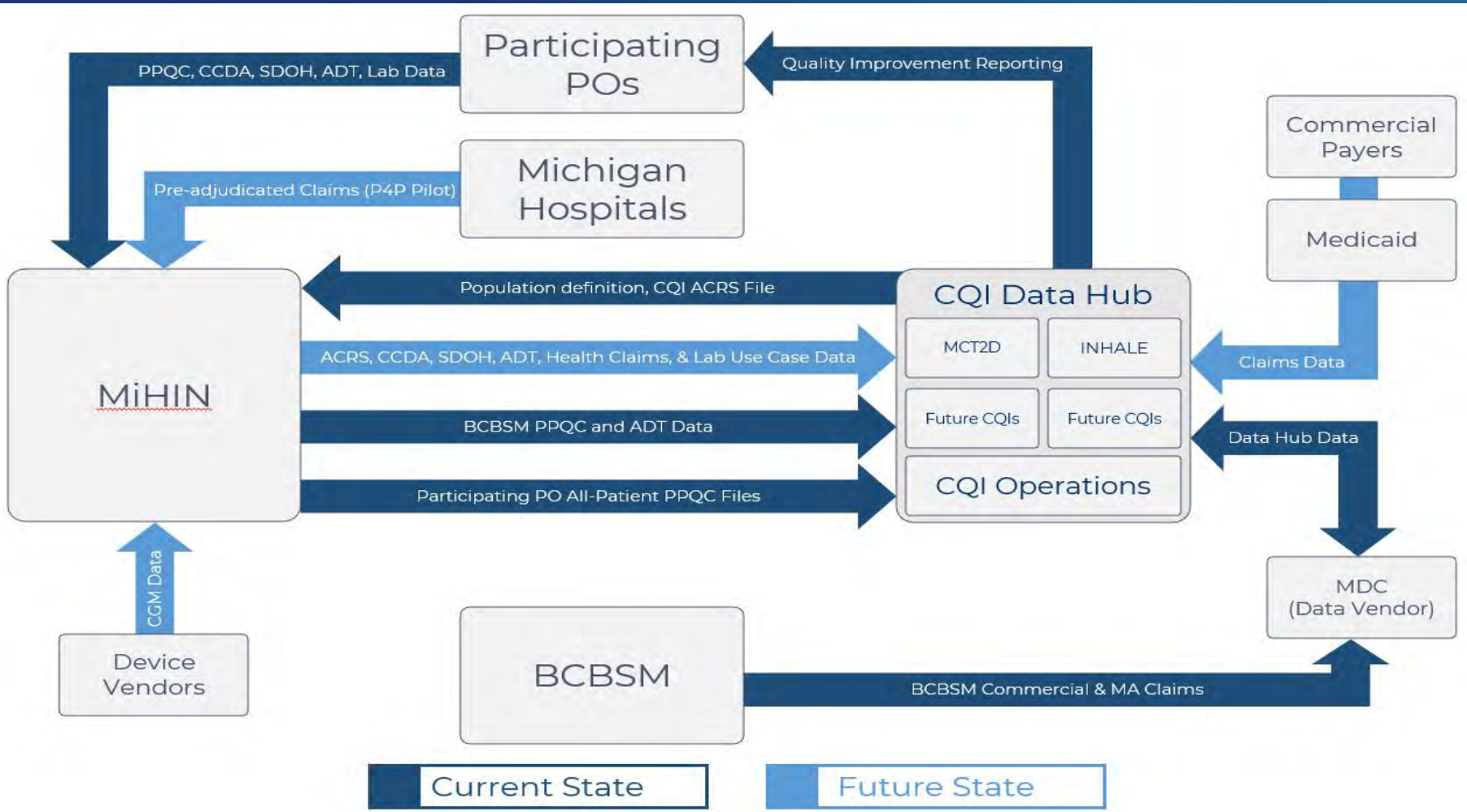
  1) ICD-9/ICD-10 Diagnostic Code for T2D

  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


Participating POs
PPQC, CCDA, SDOH, ADT, Lab Data
Quality Improvement Reporting
Michigan Hospitals
Pre-adjudicated Claims (P4P Pilot)
Commercial Payers
Medicaid
Population definition, CQI ACRS File
CQI Data Hub
MCT2D
INHALE
ACRS, CCDA, SDOH, ADT, Health Claims, & Lab Use Case Data
Claims Data
MiHIN
BCBSM PPQC and ADT Data
Future CQIs
Future CQIs
Data Hub Data
Participating PO All-Patient PPQC Files
CQI Operations
MDC (Data Vendor)
CGM Data
Device Vendors
BCBSM
BCBSM Commercial & MA Claims
Current State
Future State

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

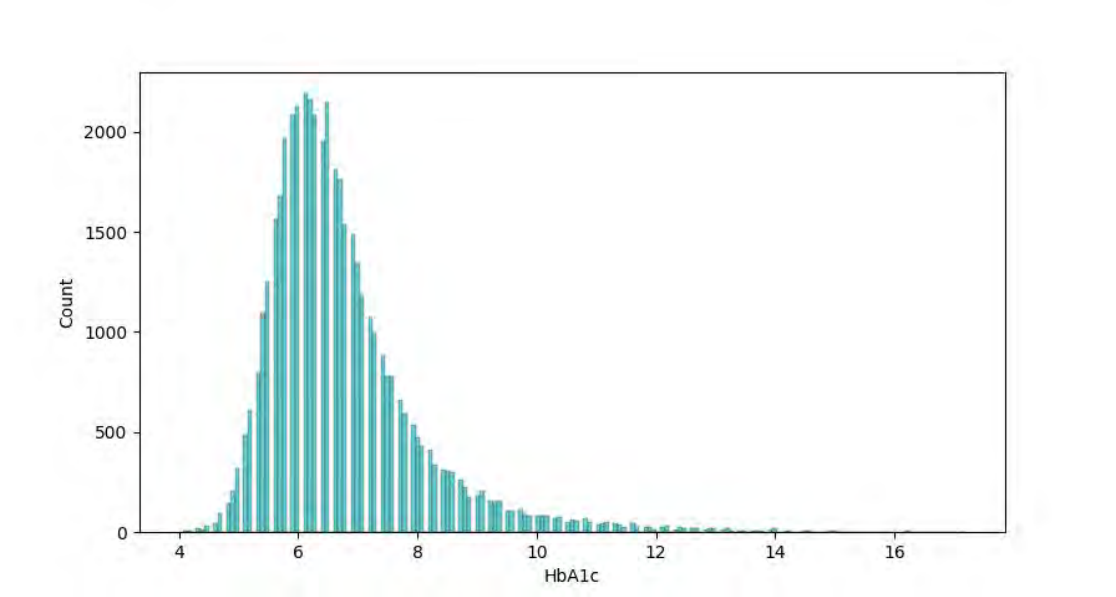
- 70,936 patients

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%

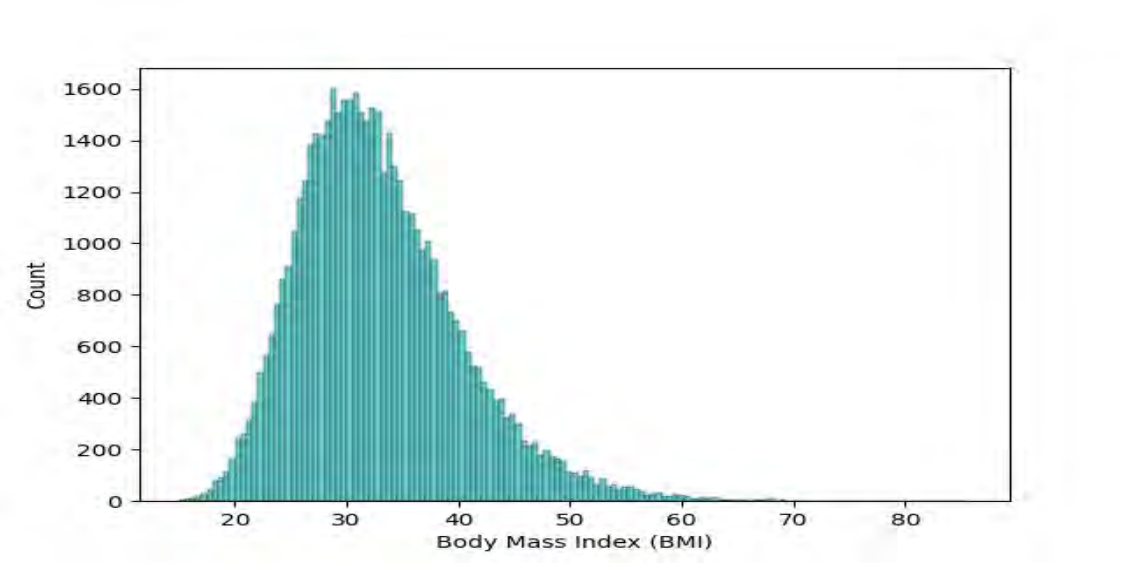
HbA1c

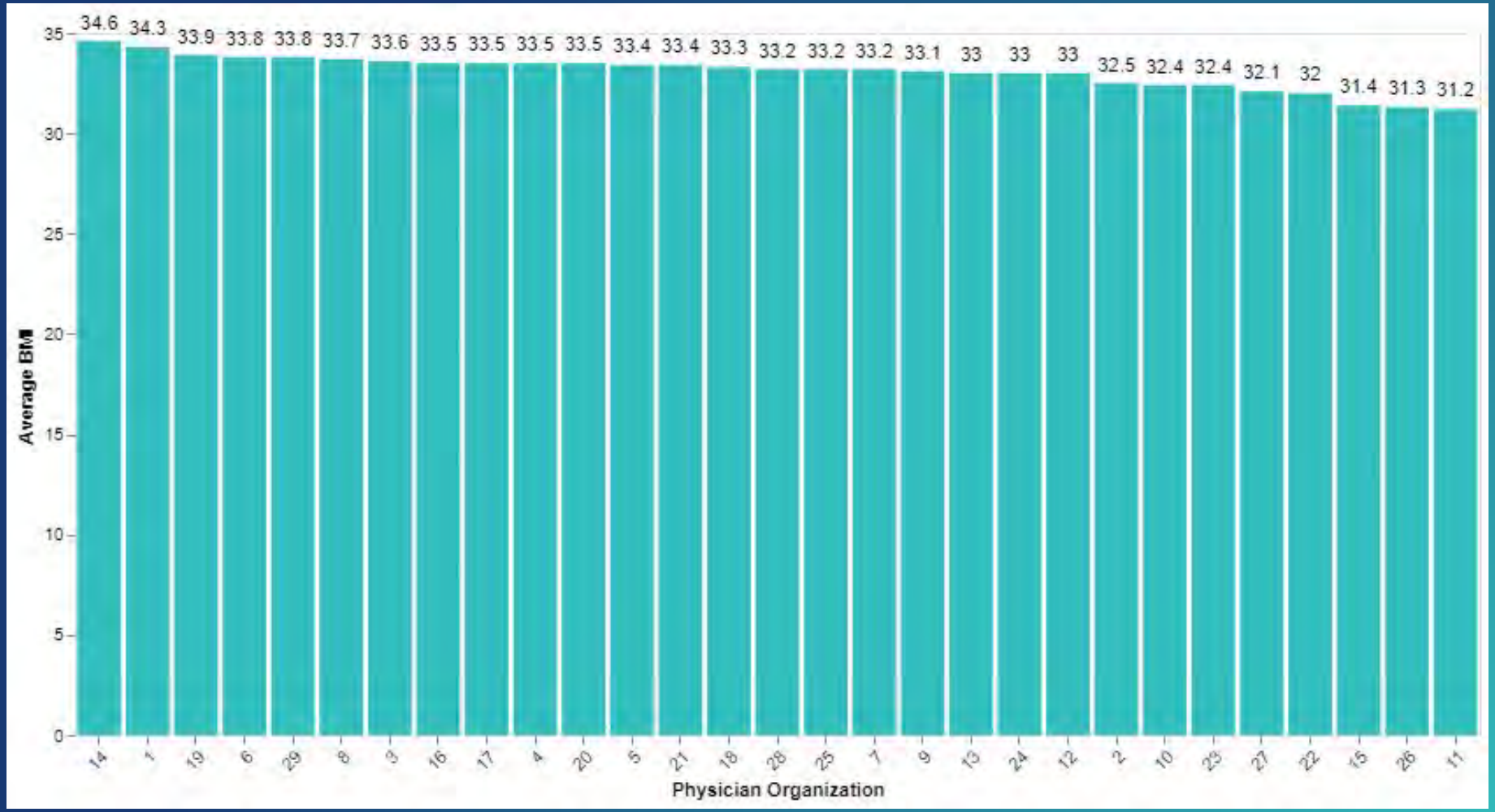
HbA1c	N	Mean	Median	Mode	Minimum	Maximum
	46621	6.75	6.50	6.10	4.0	17.2



BMI

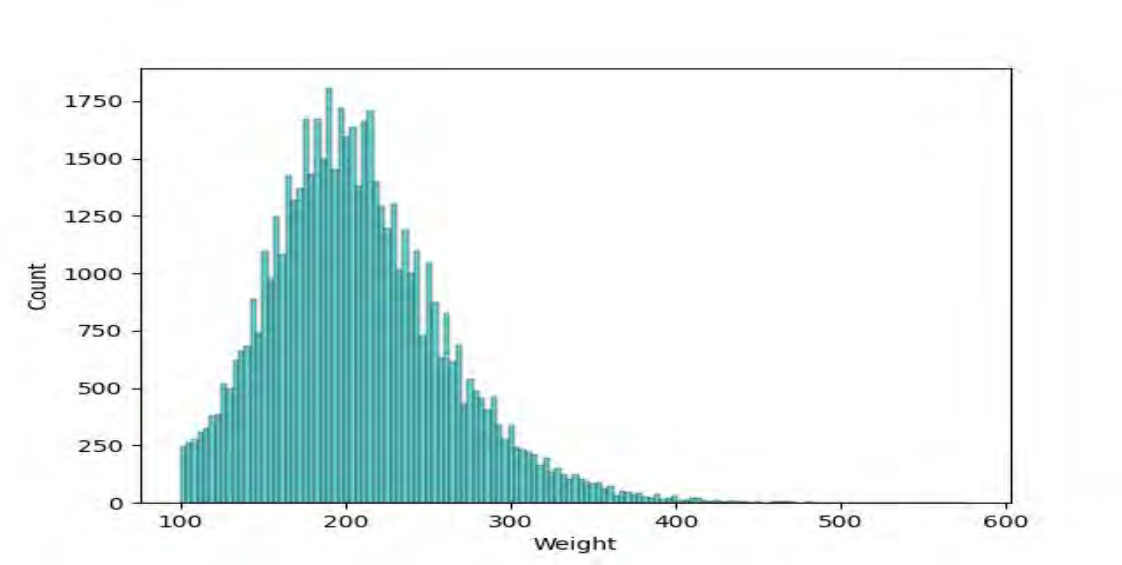
BMI	N	Mean	Median	Mode	Minimum	Maximum
	51400	32.96	31.98	31.00	15.00	85.82

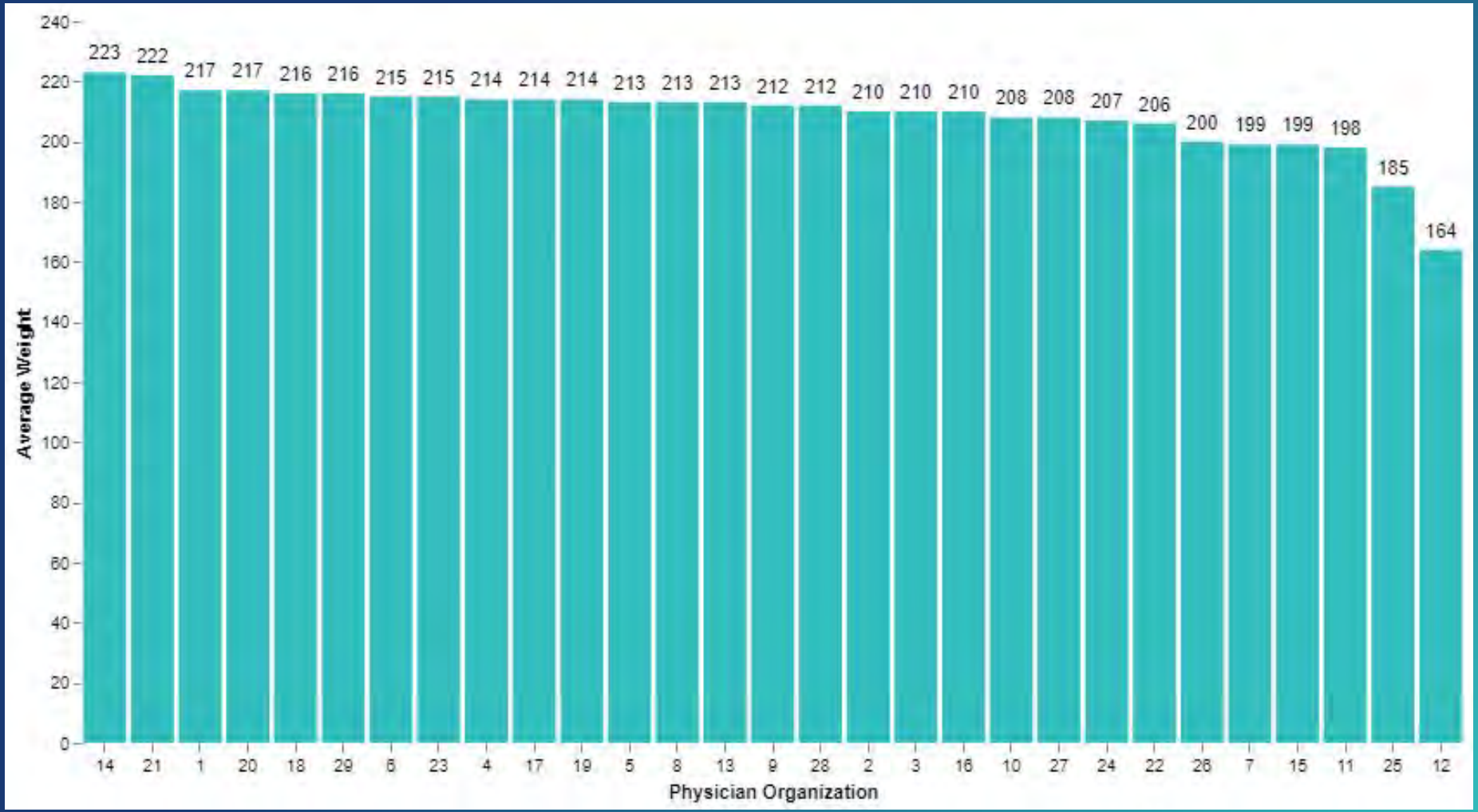



Average BMI
35
30
25
20
15
10
5
0
34.6
34.3
33.9
33.8
33.8
33.7
33.6
33.5
33.5
33.5
33.5
33.4
33.4
33.3
33.2
33.2
33.2
33.1
33
33
33
32.5
32.4
32.4
32.1
32
31.4
31.3
31.2
14
1
19
6
29
8
3
16
17
4
20
5
21
18
28
25
7
9
13
24
12
2
10
23
27
22
15
26
11
Physician Organization

Weight

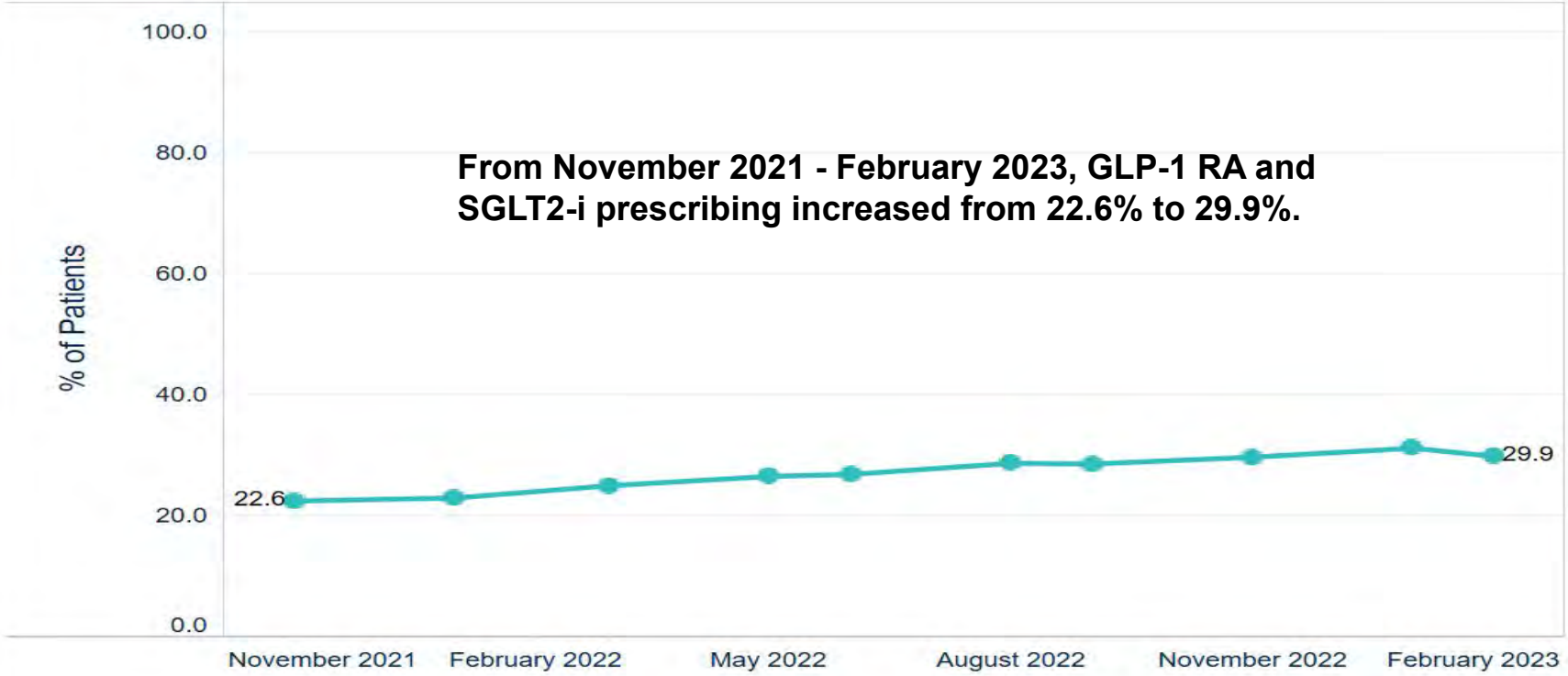
Weight	N	Mean	Median	Mode	Minimum	Maximum
	56160	208.15	202.40	200.00	100.00	578.80




Average Weight
240
220
200
180
160
140
120
100
80
60
40
20
0
223
222
217
217
216
216
215
215
214
214
214
213
213
213
212
212
210
210
210
208
208
207
206
200
199
199
198
185
164
14
21
1
20
18
29
6
23
4
17
19
5
8
13
9
28
2
3
16
10
27
24
22
26
7
15
11
25
12
Physician Organization

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

Collaborative
June 1, 2021 - February 28, 2023



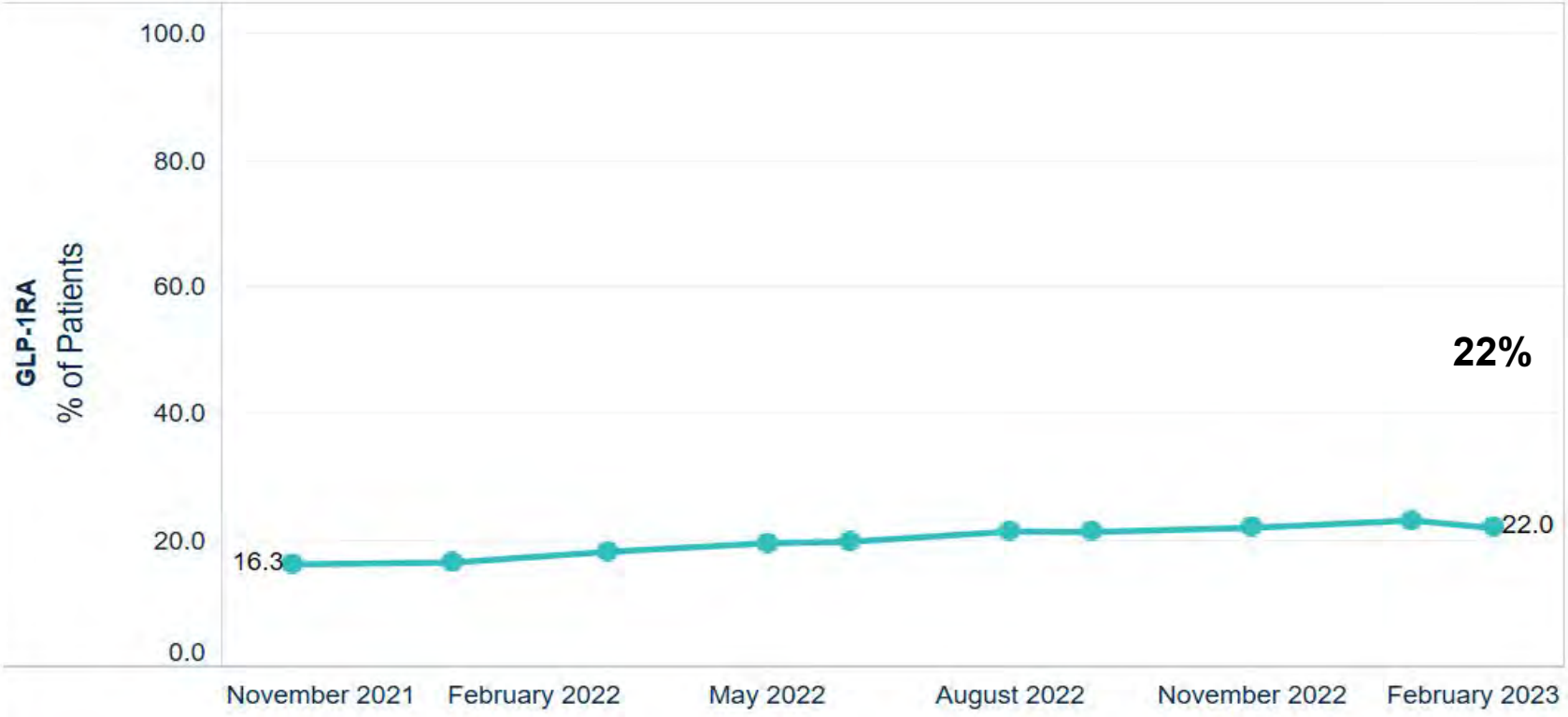
Note:

(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

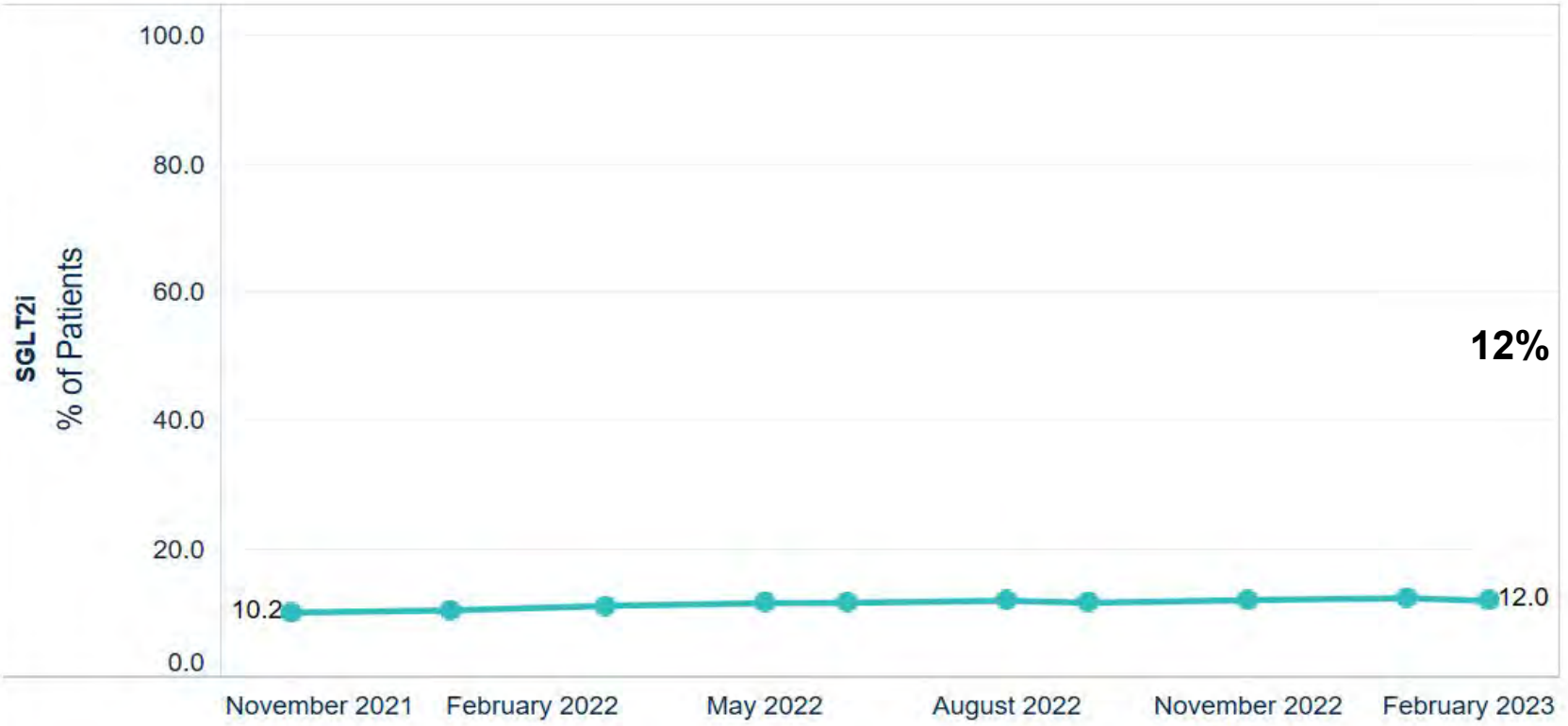
June 1, 2021 - February 28, 2023



Rx - All (Rx Fill in Last 6 Months)

Collaborative

June 1, 2021 - February 28, 2023



CGM (Last 12 Months)

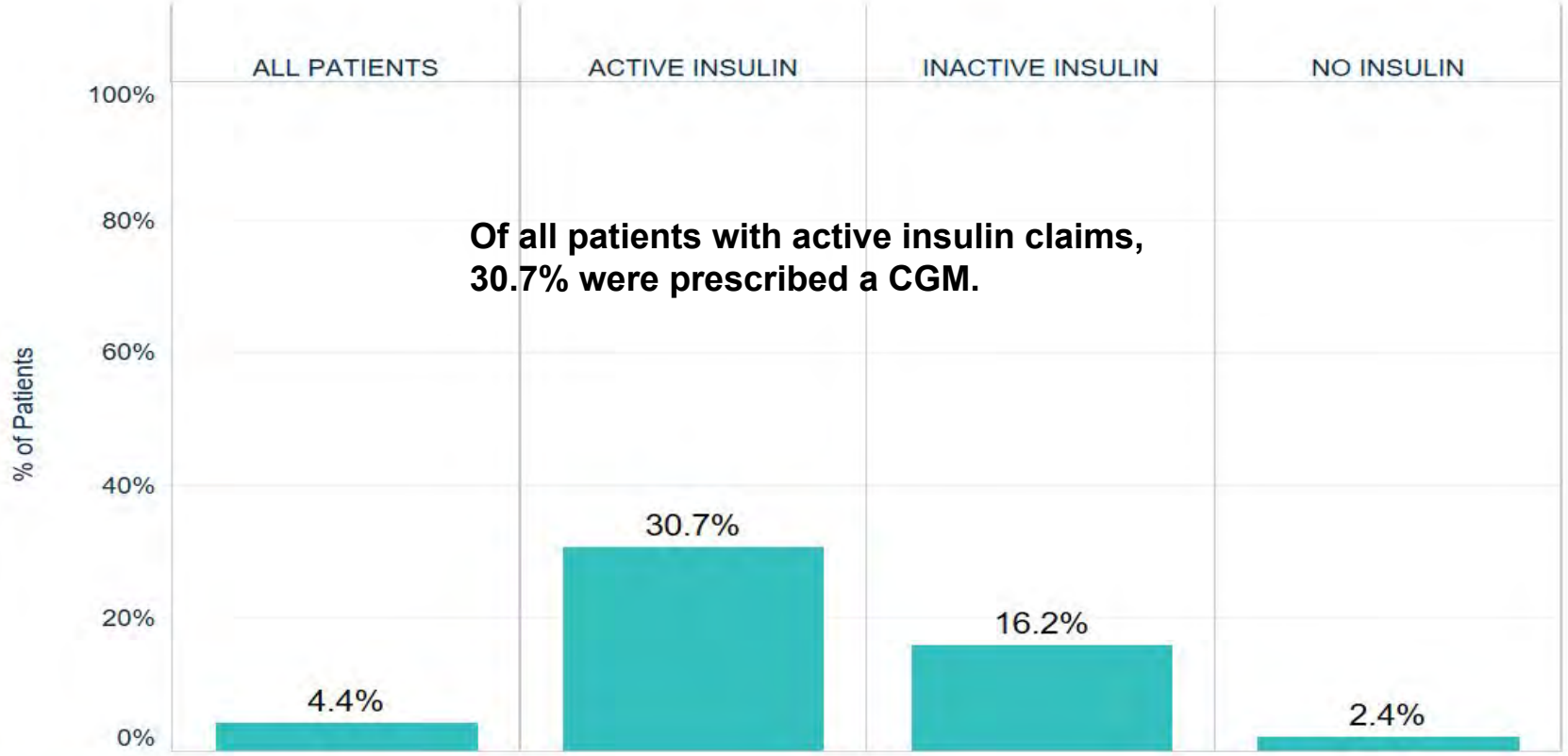
Collaborative

July 1, 2020 - February 28, 2023

From May 2021 - January 2023, CGM claims increased from 2.8% to 4.4%.

CGM (Last 12 Months)

Collaborative
March 1, 2022 - February 28, 2023



Of all patients with active insulin claims, 30.7% were prescribed a CGM.


View
MCT2D
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES
Larrea Young
Noa Kim (they/them)
Julian Weisensel (He/Him)
Jacqueline Rau
Katherine Lisa Khosrovaneh
Lypha Yang
Neha Bhomia
Rina Hisamatsu
Jake Reiss

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

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.

Our Team

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
Medical Student, Research Fellow

Sheryl Kelly, PhD, LP
Equity Advisor

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

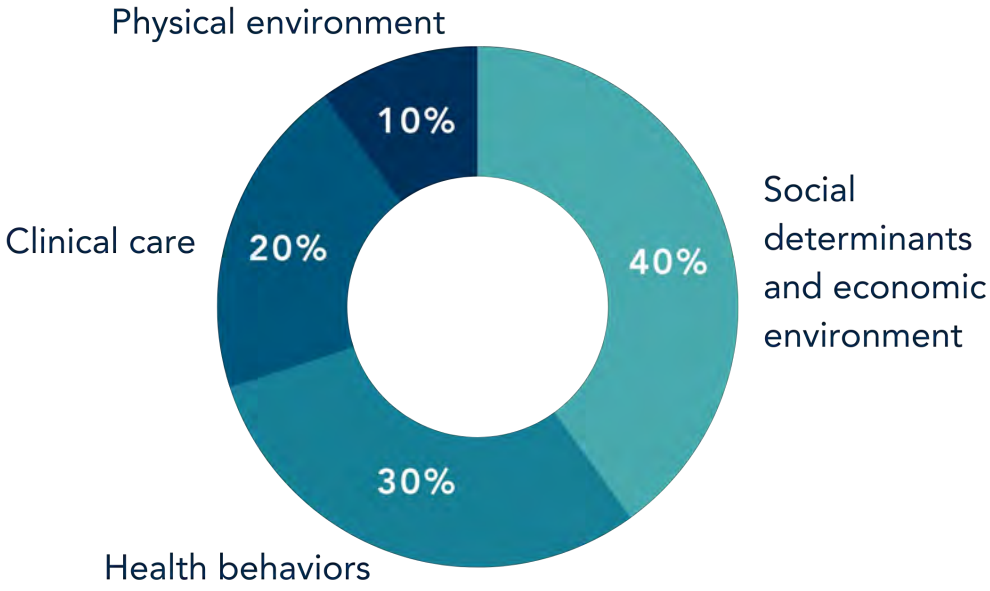
- Neighborhood revitalization instead of gentrification
- The unhindered ability to engage in political processes
- Access to homeownership
- Access to various food options
- Access to educational opportunities that allow for advancement

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

Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved 6/5/23, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

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 stress, pollution, walkable areas, fast food & grocery stores, and more…

County Health Rankings Model. Accessed June 8, 2023.

Income & Education

People with less than a high school education have a 2x higher mortality rate than college-educated adults

County Health Rankings Model. Accessed June 8, 2023.

Racism

Black, Indigenous and other people of color (BIPOC) are disproportionately burdened by T2D

A recent study from BCBS Minnesota found significant impacts of SDOH factors on the incidence and severity of T2D in the commercial population

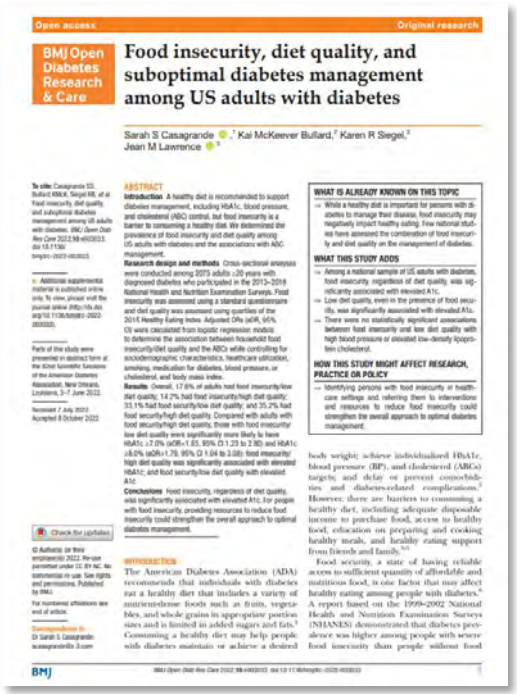
Studying the impact of social determinants on Type 2 diabetes. BlueCross BlueShield Minnesota. Accessed June 8, 2023.

County Health Rankings Model. Accessed June 8, 2023.

Social determinants of health v. social health needs

			
Social Determinants of Health	Access to food	Living situation	Access to transportation
Social Health Needs	Food Insecurity	Housing Instability	Lack of Transportation

Multiple studies show relationships between SDOH, social needs and T2D

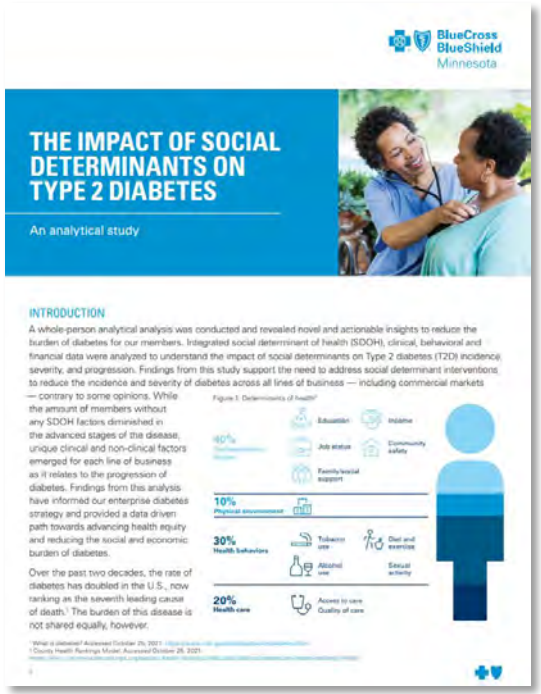


Open access Original research

BMJ Open Diabetes Research & Care

Food insecurity, diet quality, and suboptimal diabetes management among US adults with diabetes

Sarah S Casagrande, Kai McKeever Bullard, Karen R Siegel, Jean M Lawrence



BlueCross BlueShield Minnesota

THE IMPACT OF SOCIAL DETERMINANTS ON TYPE 2 DIABETES

An analytical study

INTRODUCTION

SCIENTIFIC REVIEW

258 Diabetes Care Volume 44, January 2021

Social Determinants of Health and Diabetes: A Scientific Review

Felicia Hill-Briggs, Nancy E. Adler, Seth A. Berkowitz, Marshall H. Chin, Tiffany L. Gary-Webb, Ana Navas-Acien, Pamela L. Thornton, and Debra Haire-Joshu

Diabetes Care 2021;44:258–279 | https://doi.org/10.2337/dci20-0053

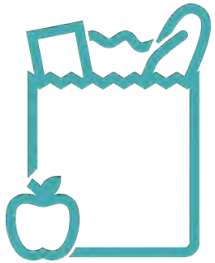
Measuring Health Equity

Exploring available data

- AHRQ 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?

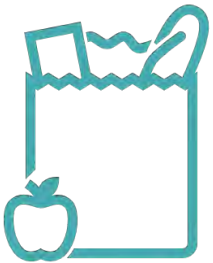
Are you worried that in the next 2 months, you may not have (stable) housing?

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

Examine purpose
of social needs data collection

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

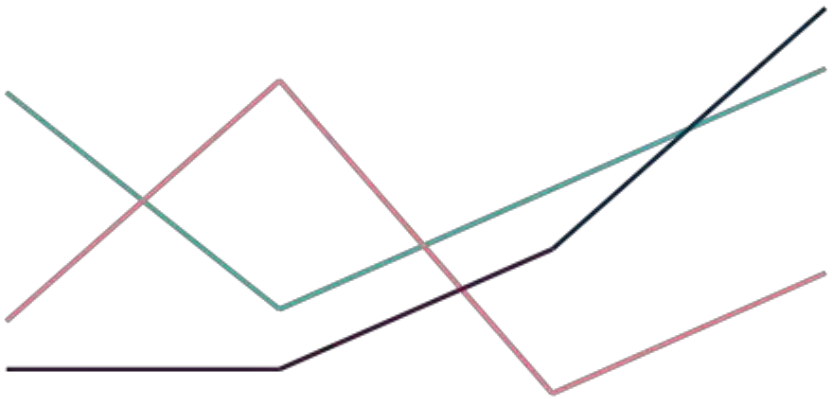
Program evaluation
Longer lookback window
Consider asking validated questions
Compare to population estimates

Pick a level of specificity
of social needs questions

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

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

	ASK	ASSIST	ALIGN
LEVEL 1	Establish goals related to health equity, SDOH Identify SDOH domains to screen for based on patient population and community setting Create a plan to implement social needs screening	Refer patients with identified social needs to community resources Train staff on referral processes, utilize "warm handoff" with patients Collect screening and referral data, ongoing QI	Identify processes for closing the feedback loop with community resources Regular communication with community partners to better assist patients Documenting needs in patient charts (Z codes)
LEVEL 2	Expand screening efforts to additional patients, visit types, and/or specialty care Screen for additional domains relevant to your patient population Collect patient feedback, improve processes	Strengthen patient follow-up after a referral is made Expand partnerships, build relationships with a community hub Leverage CHWs, care managers	Adjust clinical care to mitigate barriers: • Access to telehealth to reduce transportation • Adjust insulin dosing for fluctuations in food insecurity • Change dietary recommendations to limit food costs

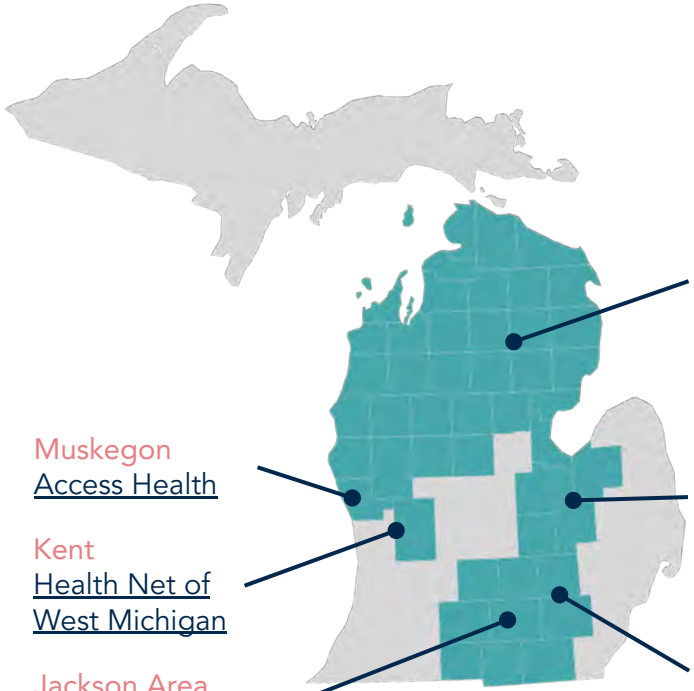
Community-clinical partnerships

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



Northern Lower Peninsula
Community Health Innovation Regions of Northern Michigan

Mid-Michigan
Mid-Michigan Community Health Access Program

Livingston & Washtenaw
MI Community Care

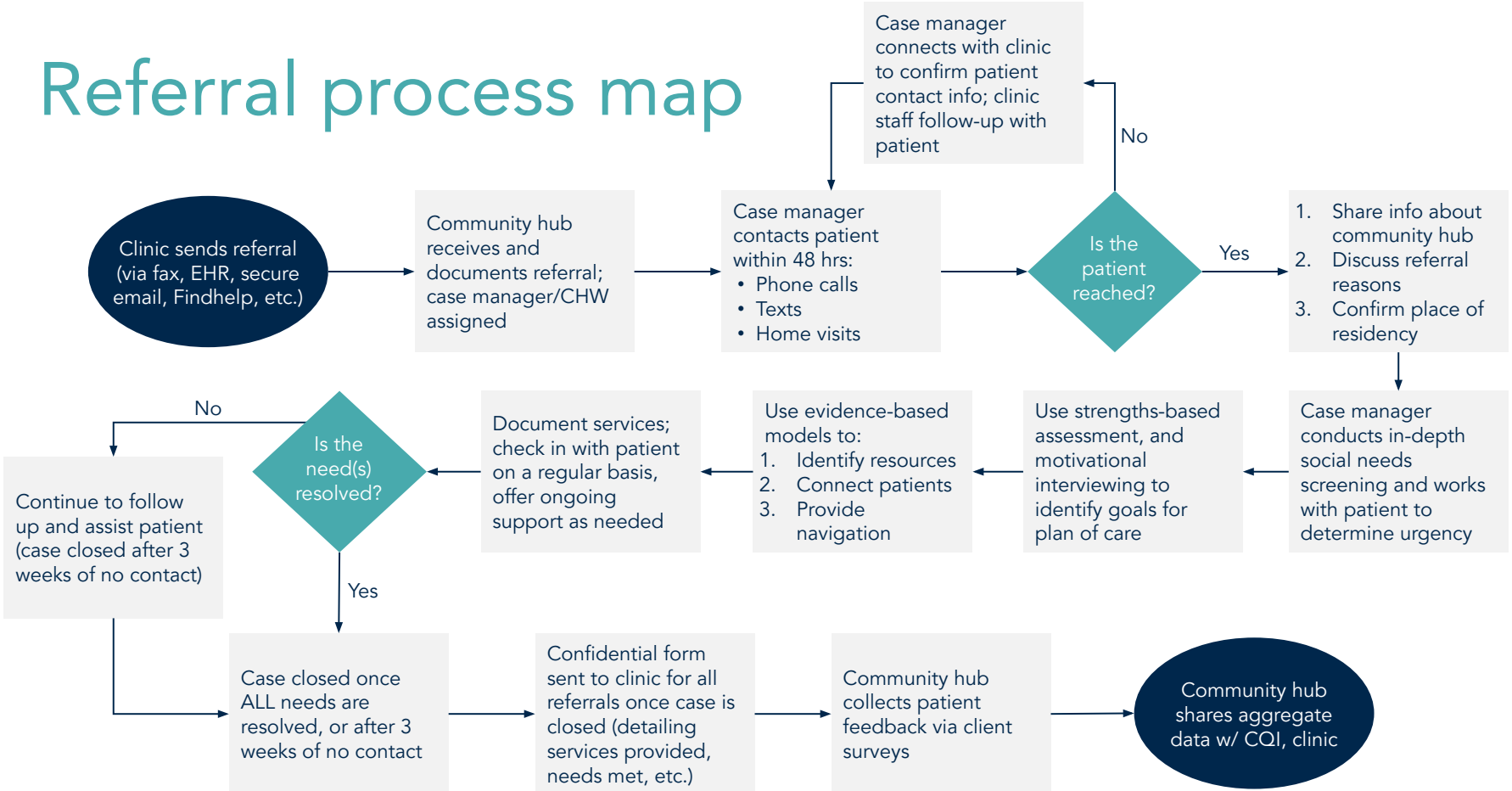
Muskegon
Access Health

Kent
Health Net of West Michigan

Jackson Area
Jackson Care Hub

MSHIELD

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!

Contact Us:

Jordan Greene (she/her)
Email | joleighp@med.umich.edu

Sheryl Kelly (she/her)
Email | ksheryl@med.umich.edu

Matthias Kirch (he/him)
Email | kirchm@med.umich.edu

Website | www.michiganshield.org

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

MSHIELD
MICHIGAN SOCIAL HEALTH INTERVENTIONS to ELIMINATE DISPARITIES

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.

MSHIELD
MICHIGAN SOCIAL HEALTH INTERVENTIONS to ELIMINATE DISPARITIES

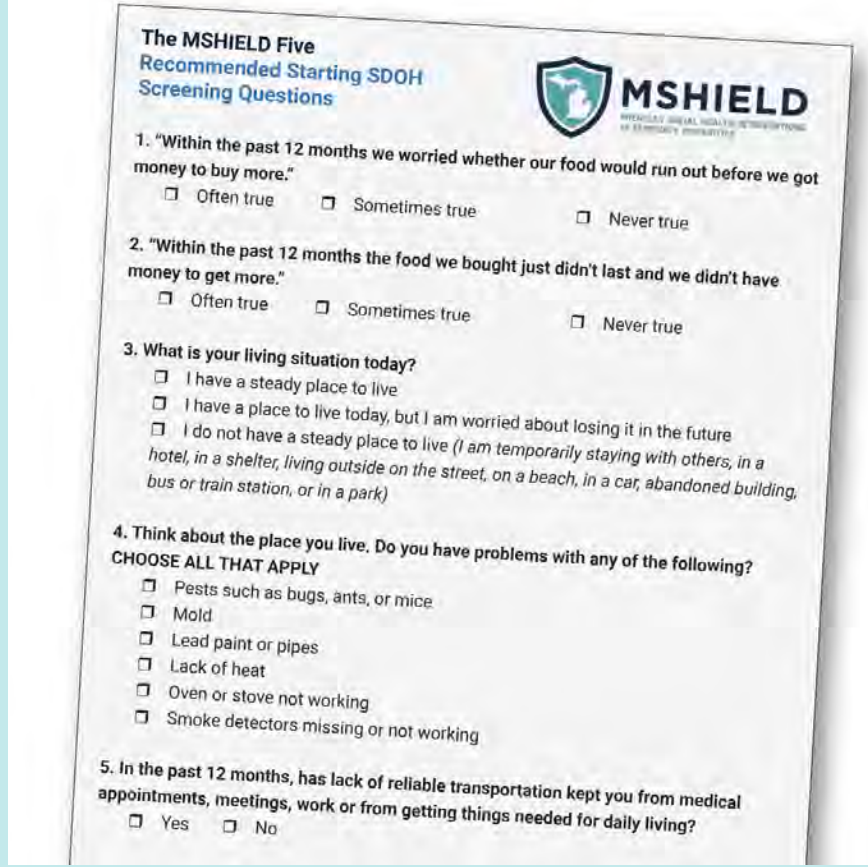
4251 Plymouth Rd,
Ann Arbor, MI 48105
Tel. 734-232-3018
admin@michiganshield.org

EVALUATING SOCIAL DETERMINANTS OF HEALTH

Best Practices, Opportunities, and Resources for Collaborative Quality Initiatives

July 2022

SCAN ME



The MSHIELD Five
Recommended Starting SDOH Screening Questions

MSHIELD

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)*

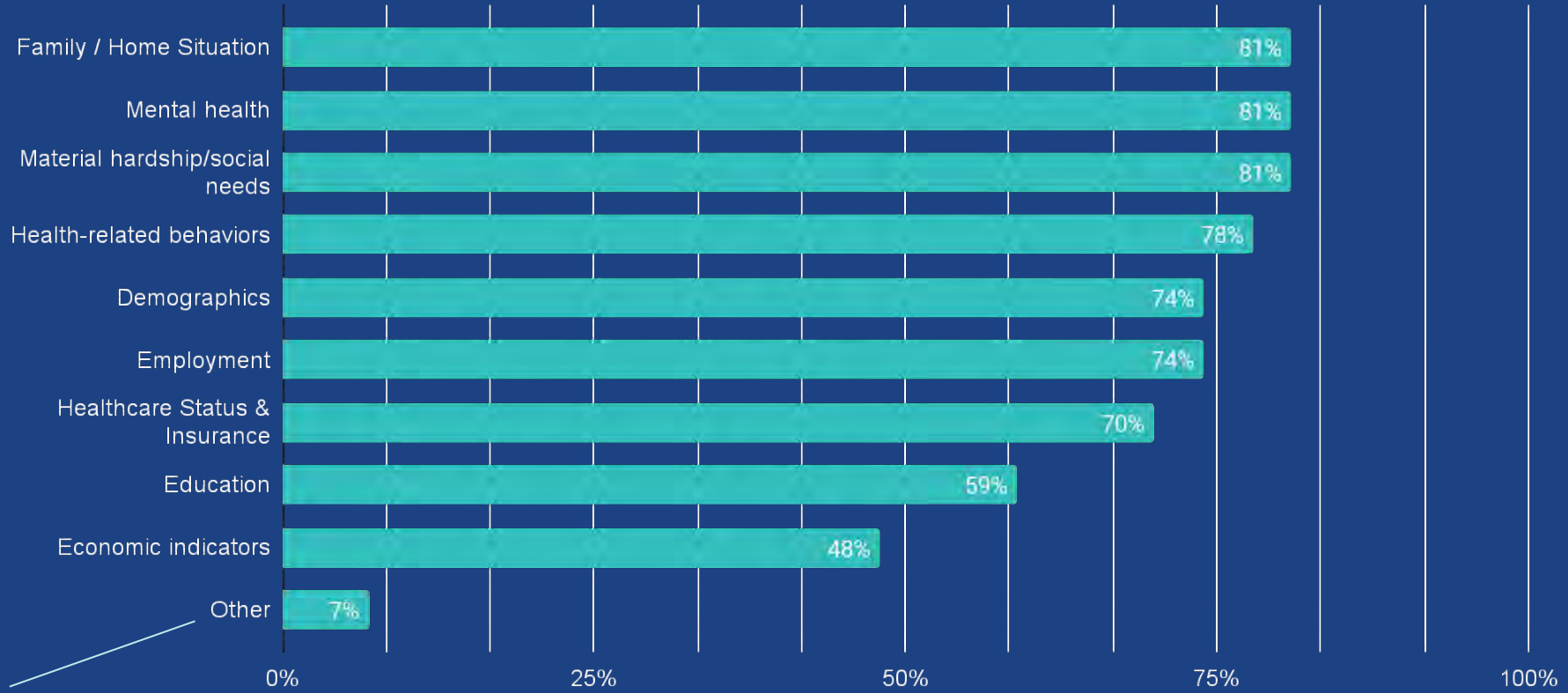
4. Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY

❒ 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

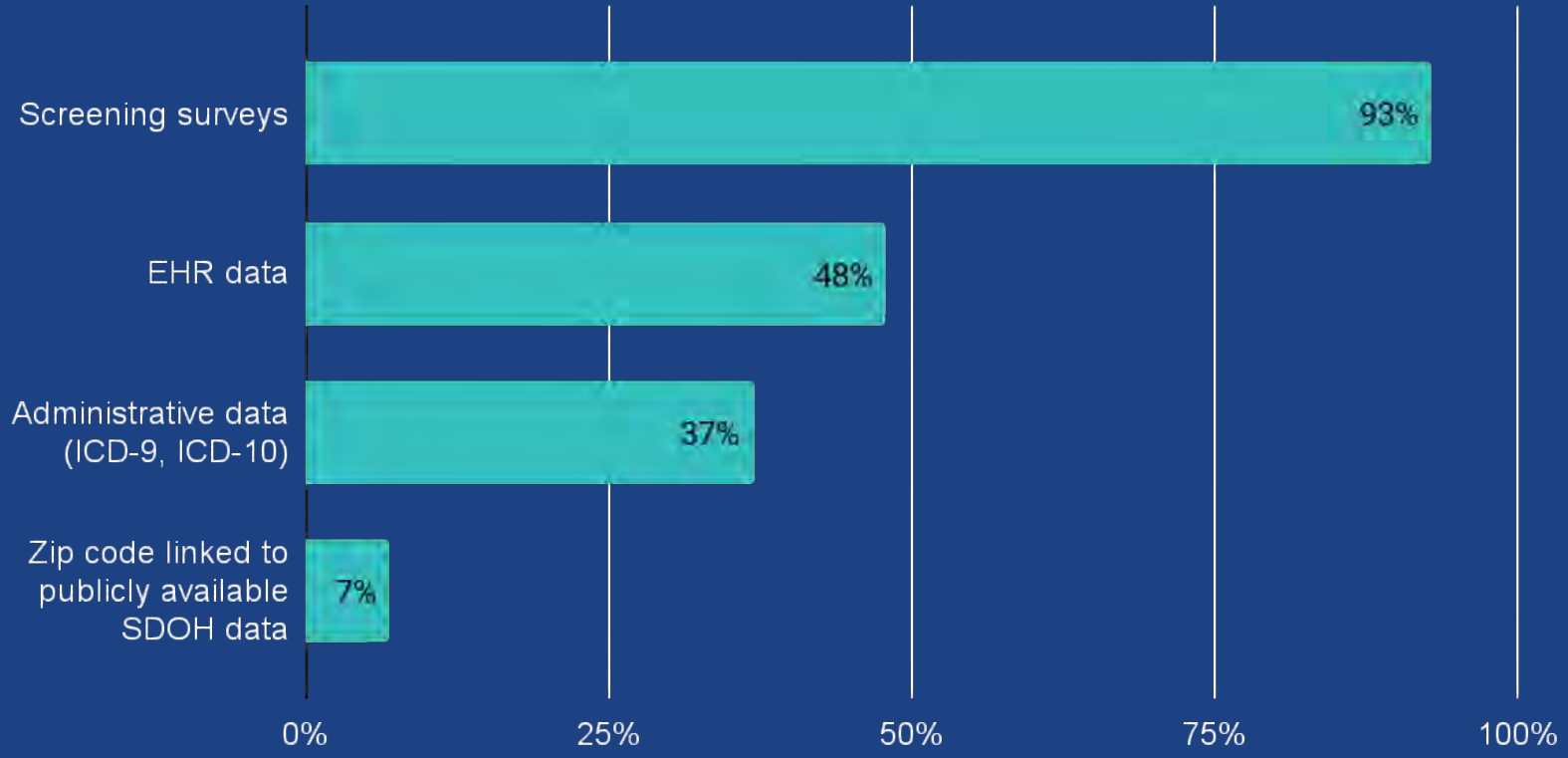
Are at least ½ of your MCT2D participating practices collecting SDOH information in the following domains? (Check all that apply)



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	Response					
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	Do not want to answer
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 got money to buy more?	Never true	Sometimes true	Often true			Do not want to answer
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	Oft			
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 and 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		
HealthCare	In the past month, did poor physical or mental health keep you from doing your usual activities, like work, school, or hobby?	No	Yes
	In the past year, was there a time when you needed to see a doctor but could not because it cost too much?	No	Yes
Food	Do you ever eat less than you feel you should because there is not enough food?	No	Yes
Employment & Income	Do you have a job or other steady source of income?	No	Yes
Housing & Shelter	Are you worried that in the next few months, you may not have safe housing that you own, rent or share?	No	Yes
Utilities	In the past year, have you had a hard time paying your utility company bills?	No	Yes
Child Care	Does getting child care make it hard for you to work, go to school or study?	No	Yes
Education	Do you think completing more education or training, like finishing a GED, going to college, or learning a trade, would be helpful for you?	No	Yes
Transportation	Do you have a dependable way to get to work or school and your appointments?	No	Yes
Clothing & Household	Do you have enough household supplies? For ex: clothing, shoes, blankets, mattress, diapers, toothpaste and shampoo.	No	Yes
General	Would you like to receive assistance with any of these needs?	No	Yes
	Any of your needs urgent?	No	Yes
Abuse	Do you feel unsafe or scared at home or anyone physically or mentally causing you harm?	No	Yes

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): _____

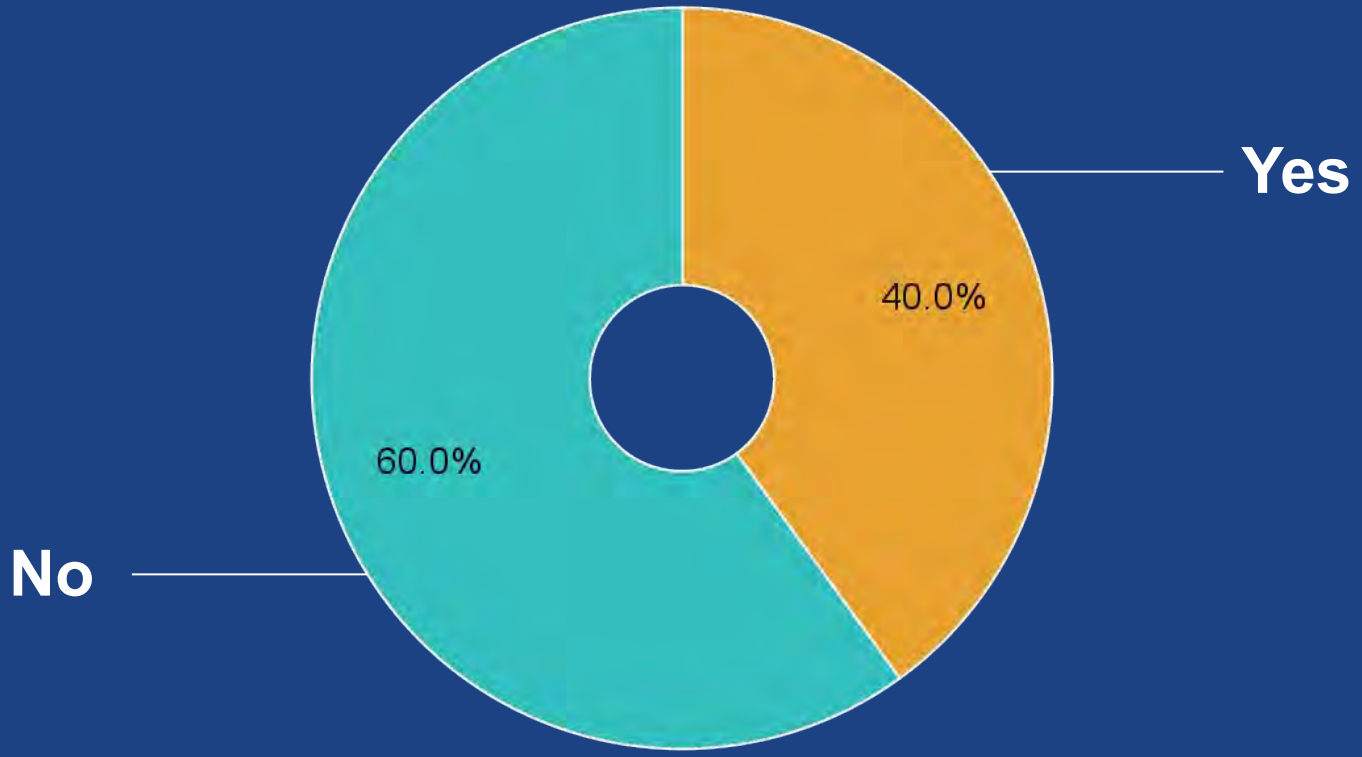
Telephone Number: _____

Patient's Physician Name: _____ **Visit Date:** _____

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 earning 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): _____		

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



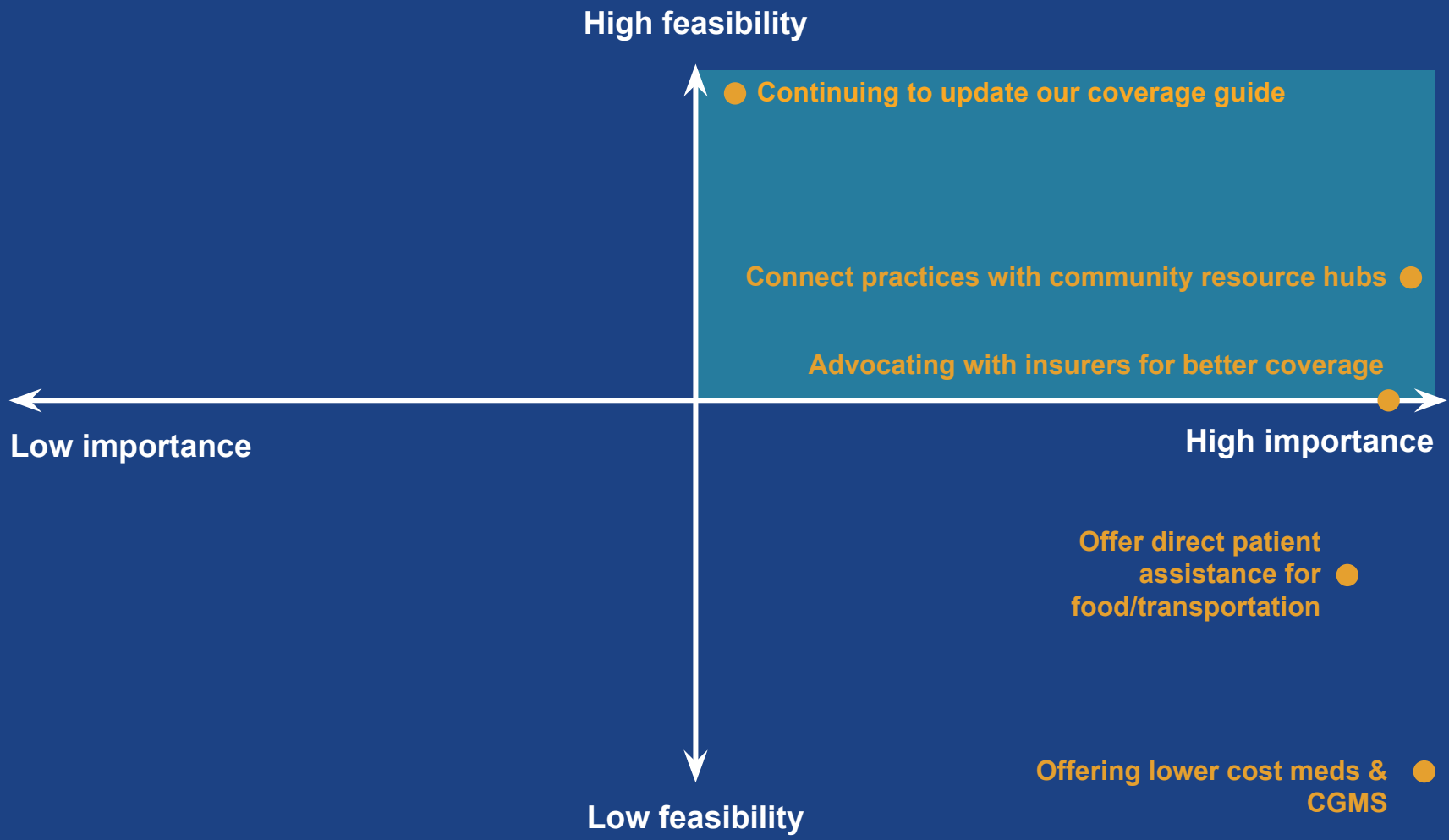
“GLPO intends to directly improve access to medical care for all patient populations. By addressing access to care, we can further impact inequalities and other identified disparities. Success will be demonstrated by all patient populations being wholly cared for by encounters at the provider office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


High feasibility
Continuing to update our coverage guide
Connect practices with community resource hubs
Advocating with insurers for better coverage
Low importance
High importance
Offer direct patient assistance for food/transportation
Offering lower cost meds & CGMS
Low feasibility

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

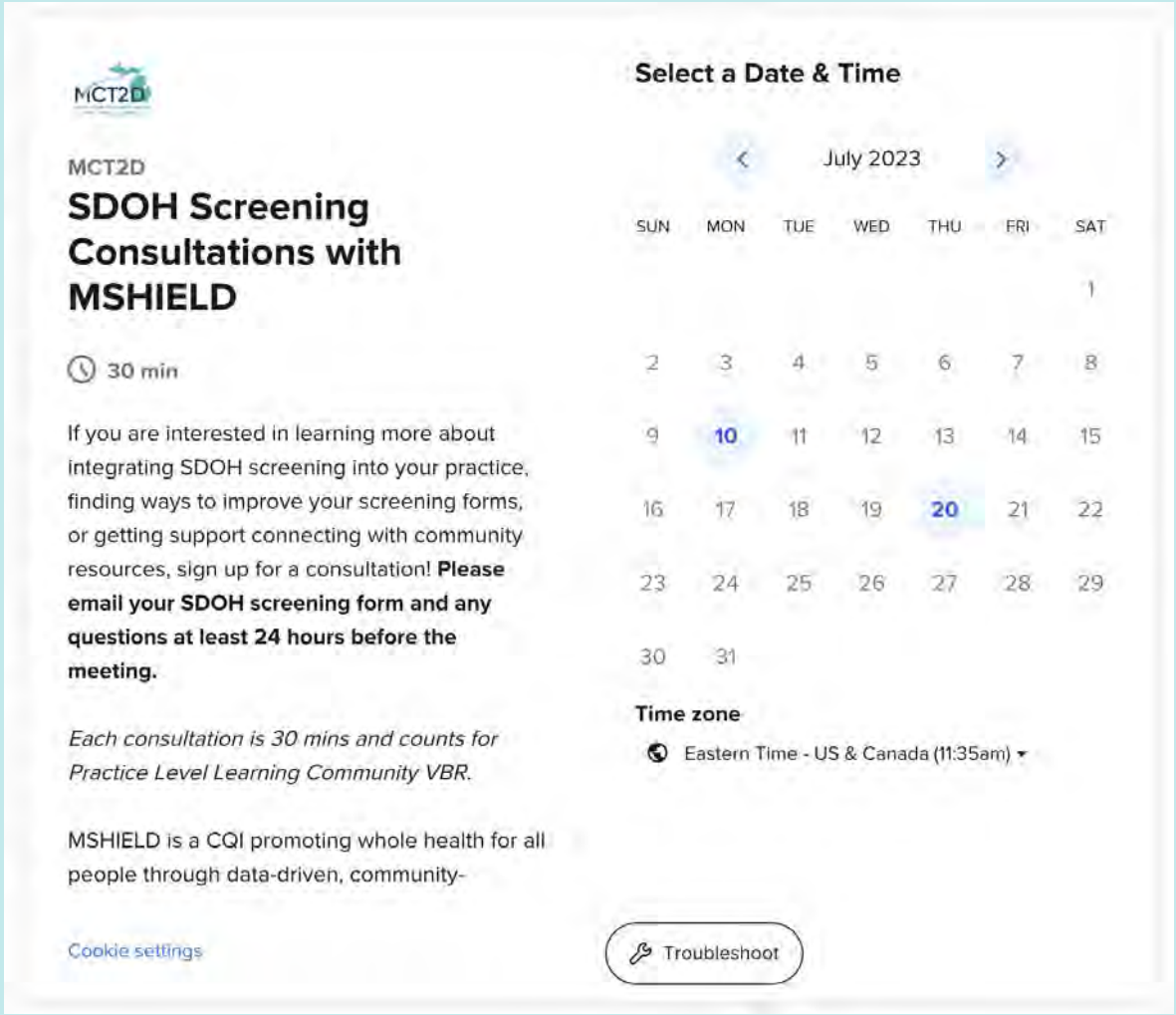
2) Which of the SDOH domains do you think will have the **biggest impact on type 2 diabetes**? What SDOH data would be important to be able to compare and contrast populations on our dashboard?

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?



SDOH Screening Consultations with MSHIELD

Counts for practice level learning community VBR.

https://michmed.org/mQMmA

SCAN ME

Findhelp.org

Available though 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 you zip code and a keyword or program name below to start searching for resources

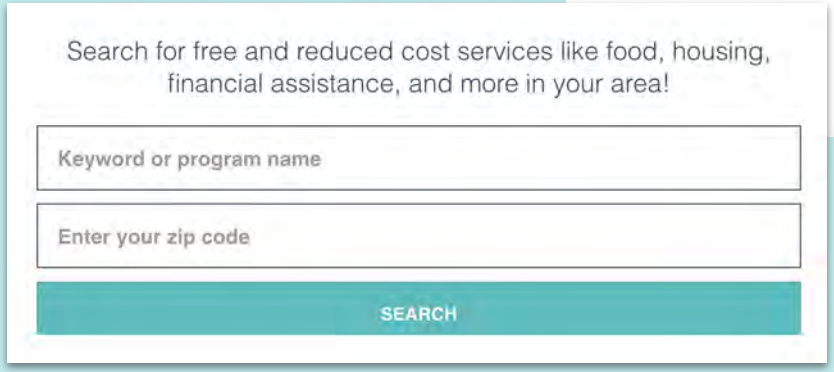
Search for free and reduced cost services like food, housing, financial assistance, and more in your area!

Keyword or program name

Enter your zip code

SEARCH

Powered by findhelp.org



SCAN ME

CGMs: What's new, Inspiration, & Panel

Heidi L. Diez, PharmD, BCACP

Program Co-Director and Lead Pharmacist, MCT2D

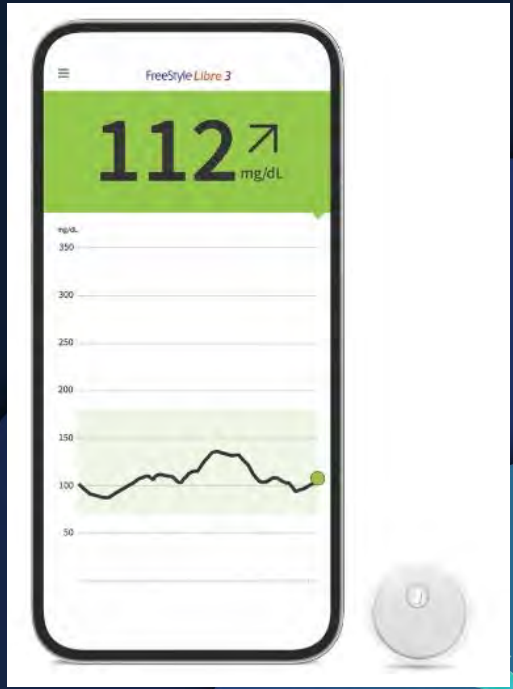
CGM Coverage

- 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*
  - *R*eader 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



https://www.freestyle.abbott/us-en/home.html Accessed June 9 2023
https://www.diabeteseducator.org/danatech/glucose-monitoring/continuous-glucose-monitors-(cgm)/cgm-selection-training/dexcom-g7-libre-3-comparison Accessed June 9 2023

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

https://www.dexcom.com/en-us/g7-cgm-system Accessed June 9 2023
https://www.diabeteseducator.org/danatech/glucose-monitoring/continuous-glucose-monitors-(cgm)/cgm-selection-training/dexcom-g7-libre-3-comparison Accessed June 9 2023

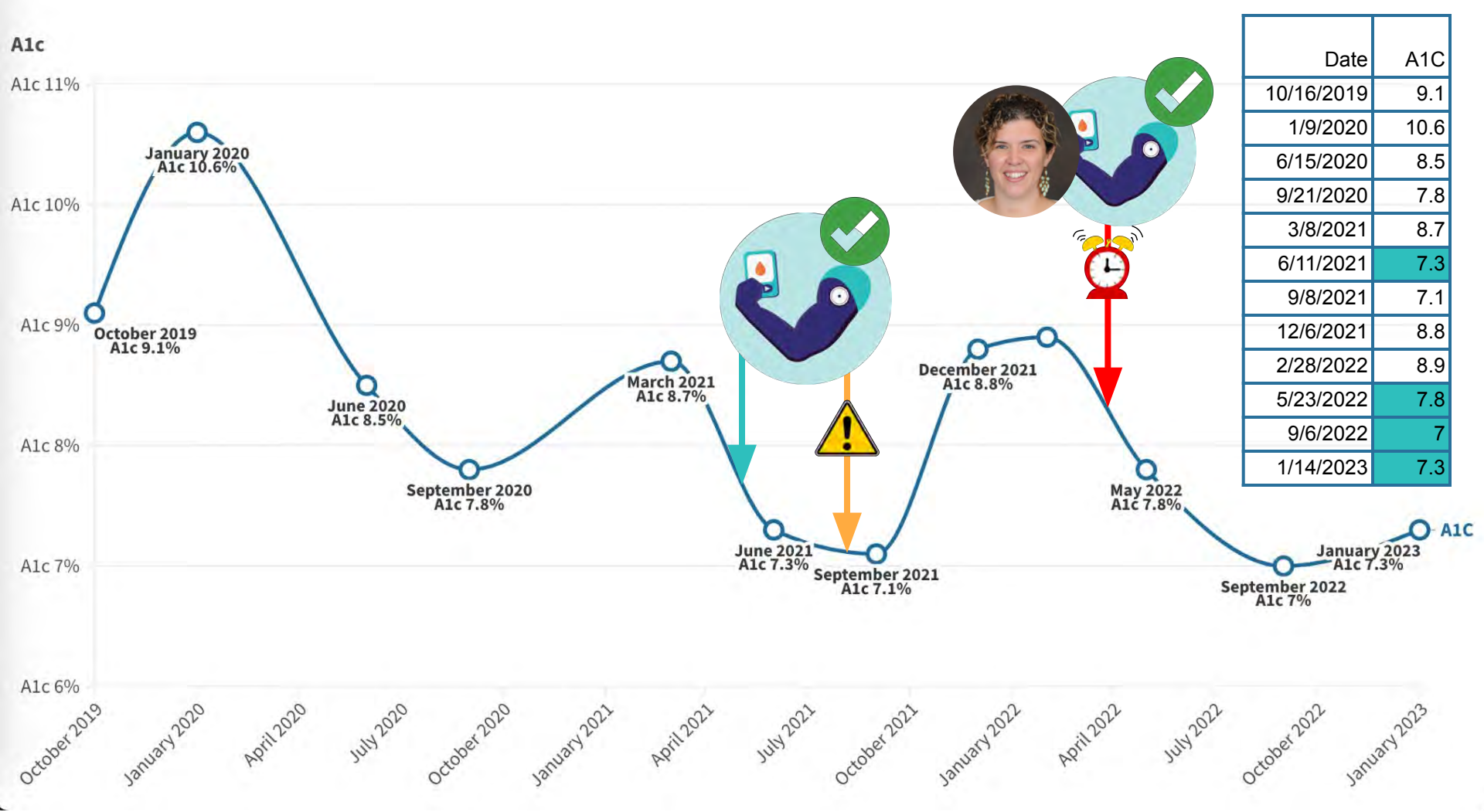
Questions

Abbott

Dexcom

Keith McIntyre

MCT2D Patient Advisory Board Member

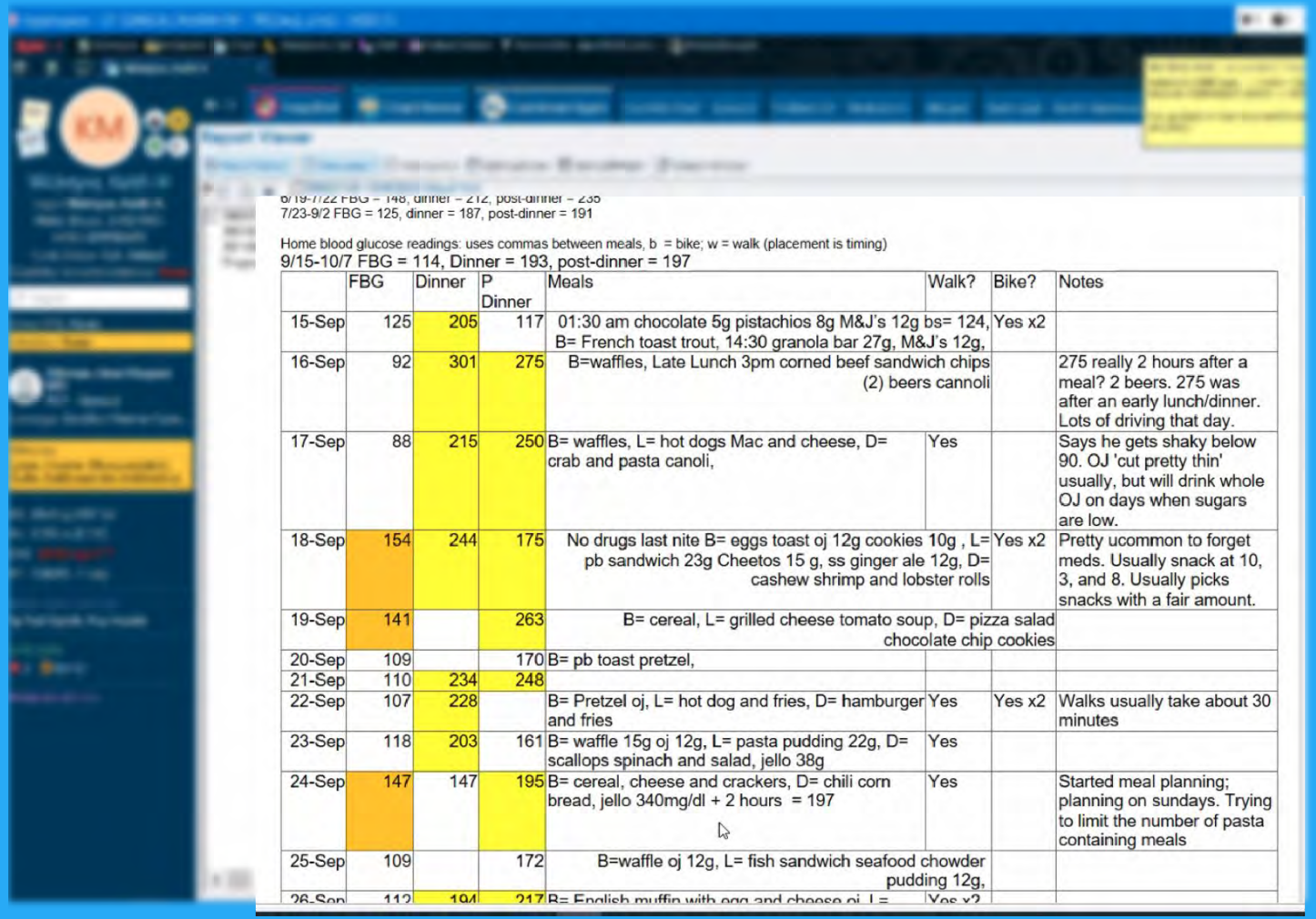


Date	A1C
10/16/2019	9.1
1/9/2020	10.6
6/15/2020	8.5
9/21/2020	7.8
3/8/2021	8.7
6/11/2021	7.3
9/8/2021	7.1
12/6/2021	8.8
2/28/2022	8.9
5/23/2022	7.8
9/6/2022	7
1/14/2023	7.3

Aug-Sept 2020

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

How?



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)

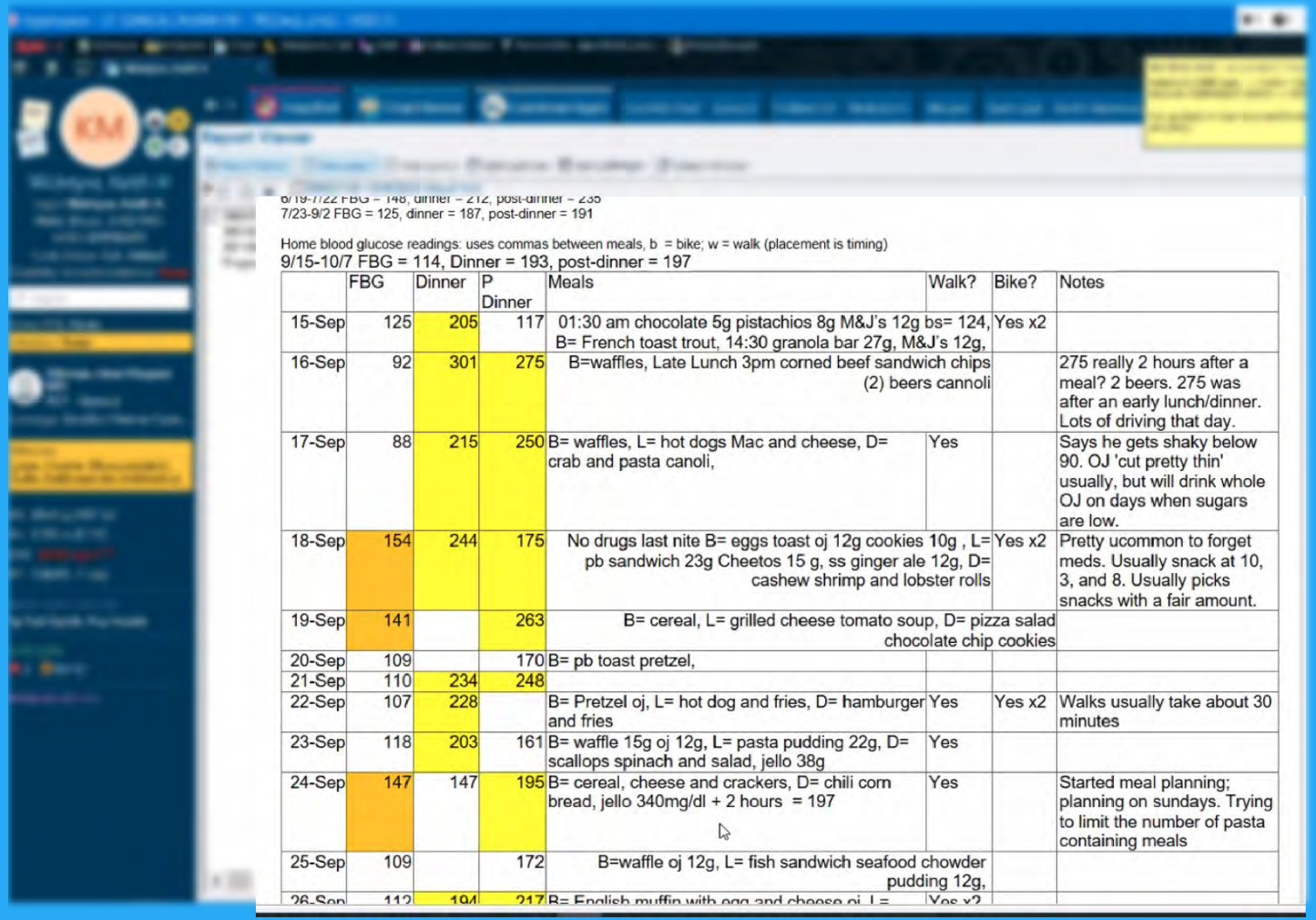
9/15-10/7 FBG = 114, Dinner = 193, post-dinner = 197

	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 ucommon 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	194	217	B= English muffin with egg and cheese oj, 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 = 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

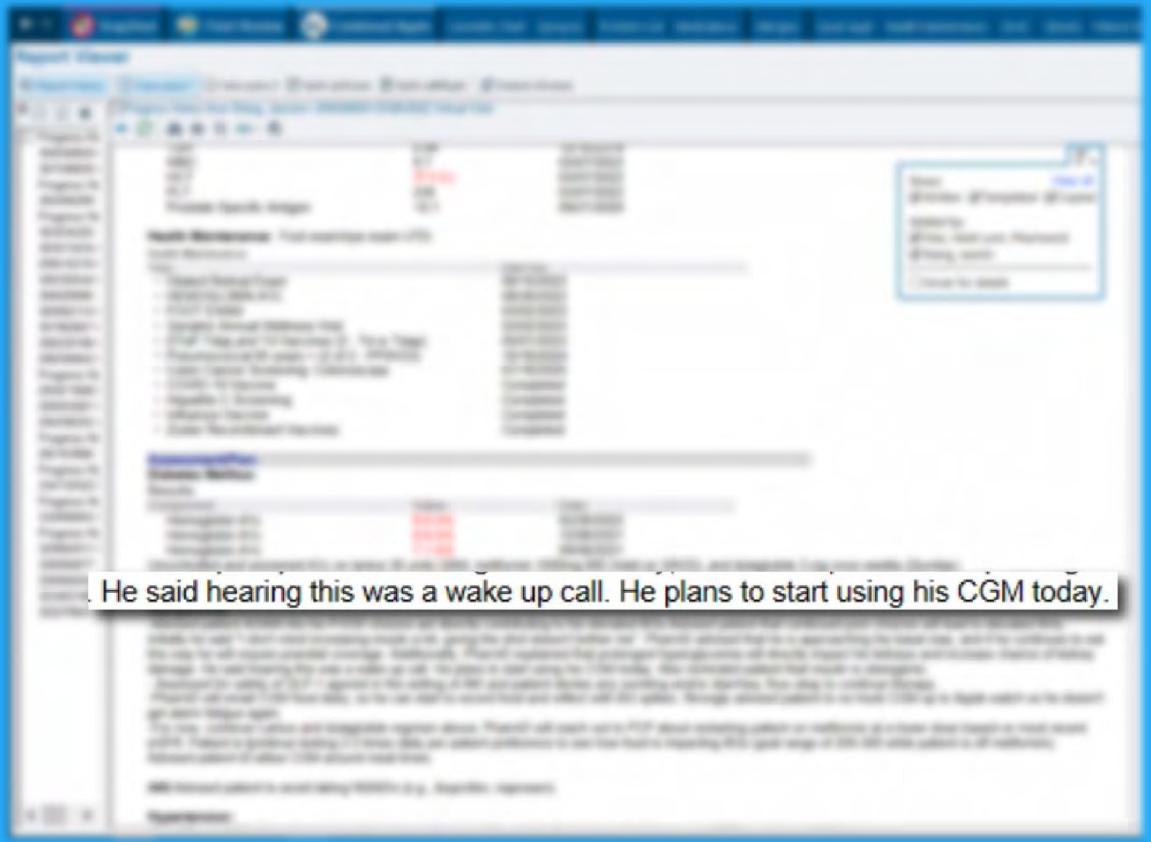
	FBG	Dinner	P Dinner	Meals	Walk?	Bike?	Notes
15-Sep	125	205	117	01:30 am chocolate 5g pistachios 8g M&J's 12g bs= 124, B= French toast trout, 14:30 granola bar 27g, M&J's 12g,	Yes x2		
16-Sep	92	301	275	B=waffles, Late Lunch 3pm corned beef sandwich chips (2) beers cannoli			275 really 2 hours after a 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 ucommon 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	194	217	B= English muffin with egg and cheese oj, L=	Yes x2		

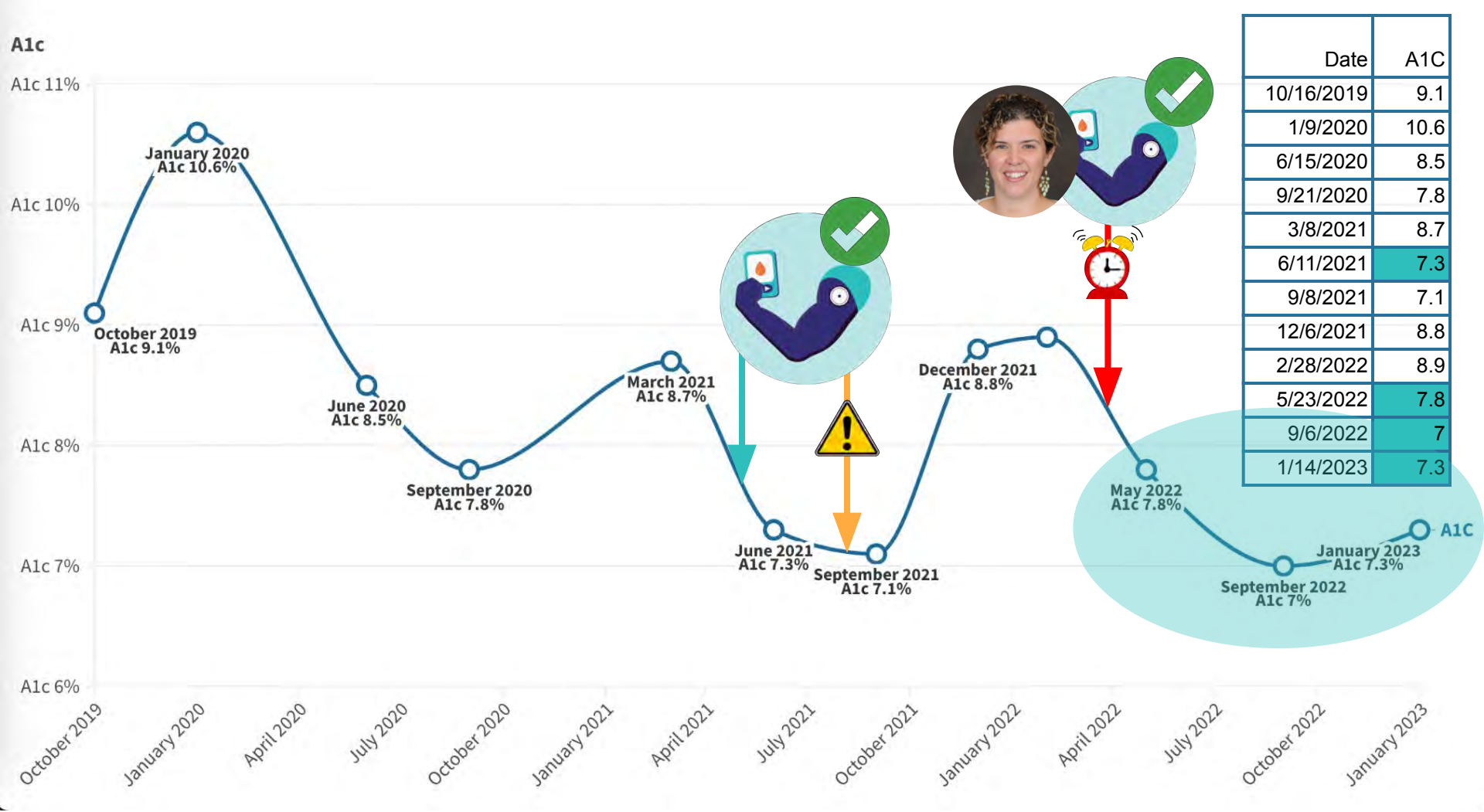

Average Glucose
140
Standard Deviation
38
GMI
6.6%
Time in Range
1% Very High
12% High
86% In Range
<1% Low
0% Very Low
Target Range:
70-180 mg/dL
Sensor Usage
Days with CGM data
93%
13/14
Avg. calibrations per day
0.0
Overlay
Mon
Tue
Wed
Thu
Fri
Sat
Sun
12am
3
6
9
12pm
3
6
9
12am

March 2022

A1C 7.1 to 8.8.

Considers resuming CGM in the new year.





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


NO SMOKING

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

MCT2D Collaborative Wide Meeting
June 16, 2023

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

Froedtert & Medical College of Wisconsin

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

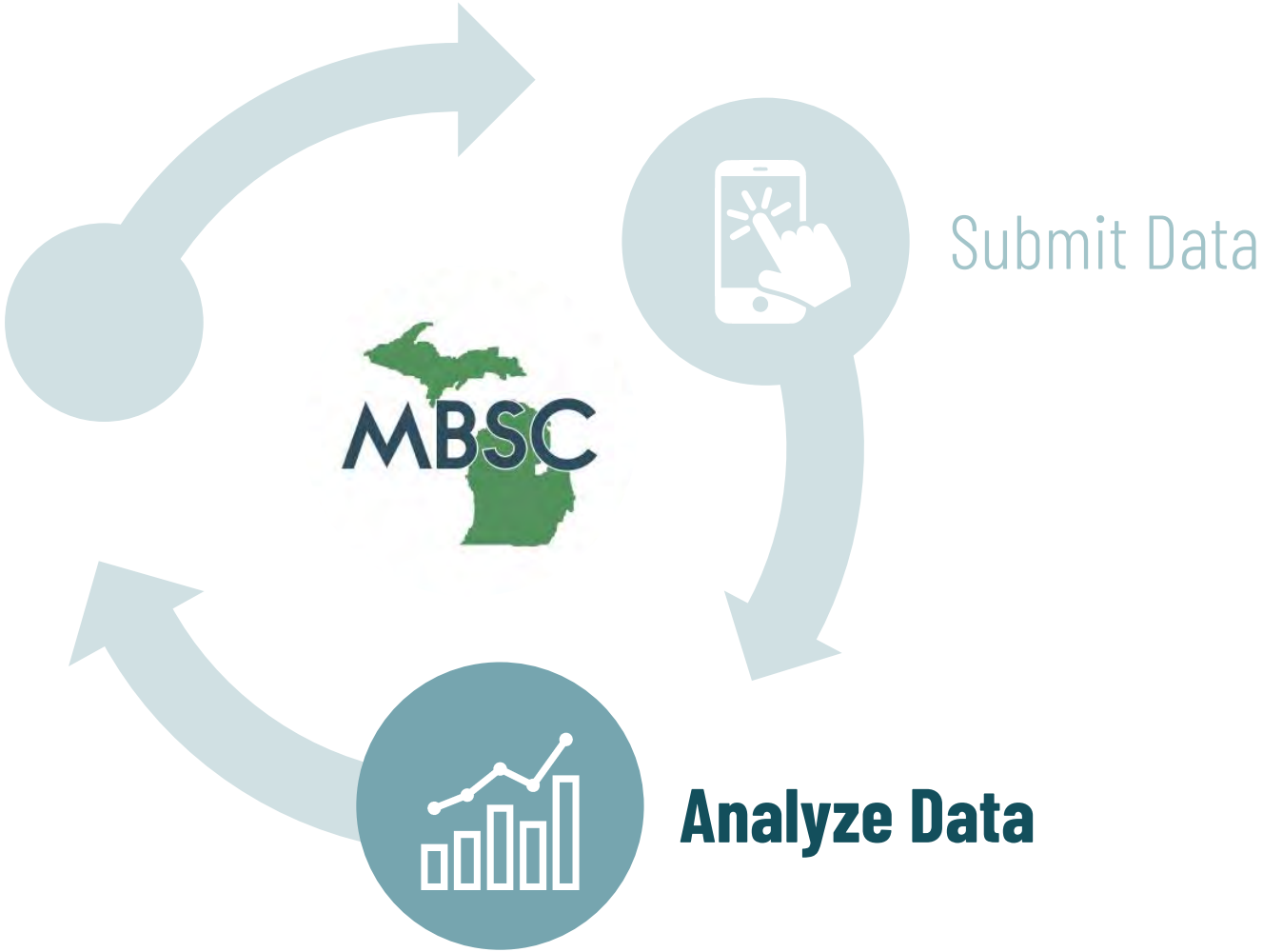
- Statewide quality improvement
- Research focus on organizational structure/dynamics
- Departmental clinical program building and operations
- Health system leadership and change management

Disclaimers/Experience

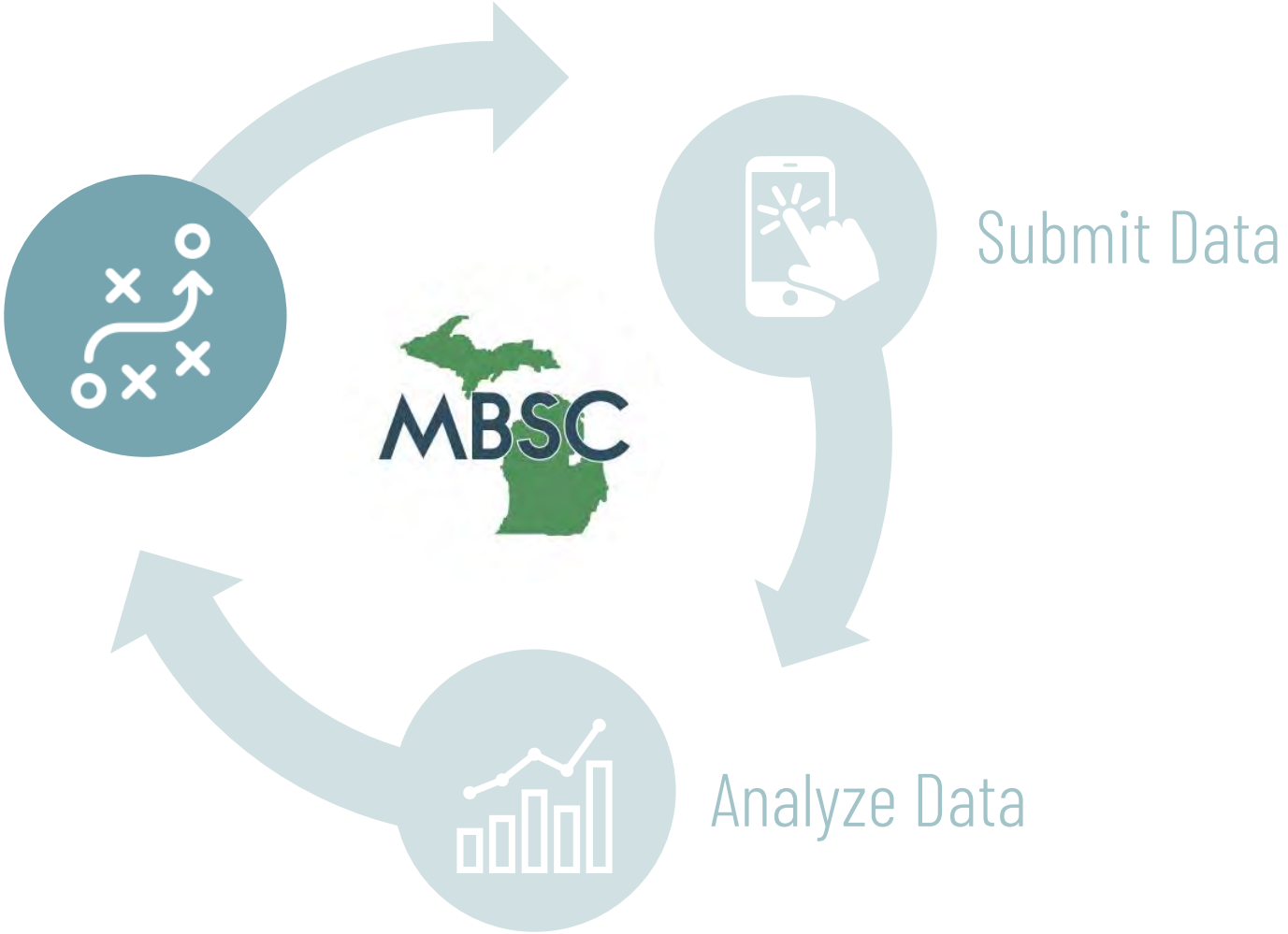
- **Statewide quality improvement**
- Research focus on organizational structure/dynamics
- Departmental clinical program building and operations
- **Health system leadership and change management**


MICHIGAN BARIATRIC SURGERY COLLABORATIVE
MBSC
15 YEARS
& counting

Submit Data


MBSC
Submit Data
Analyze Data

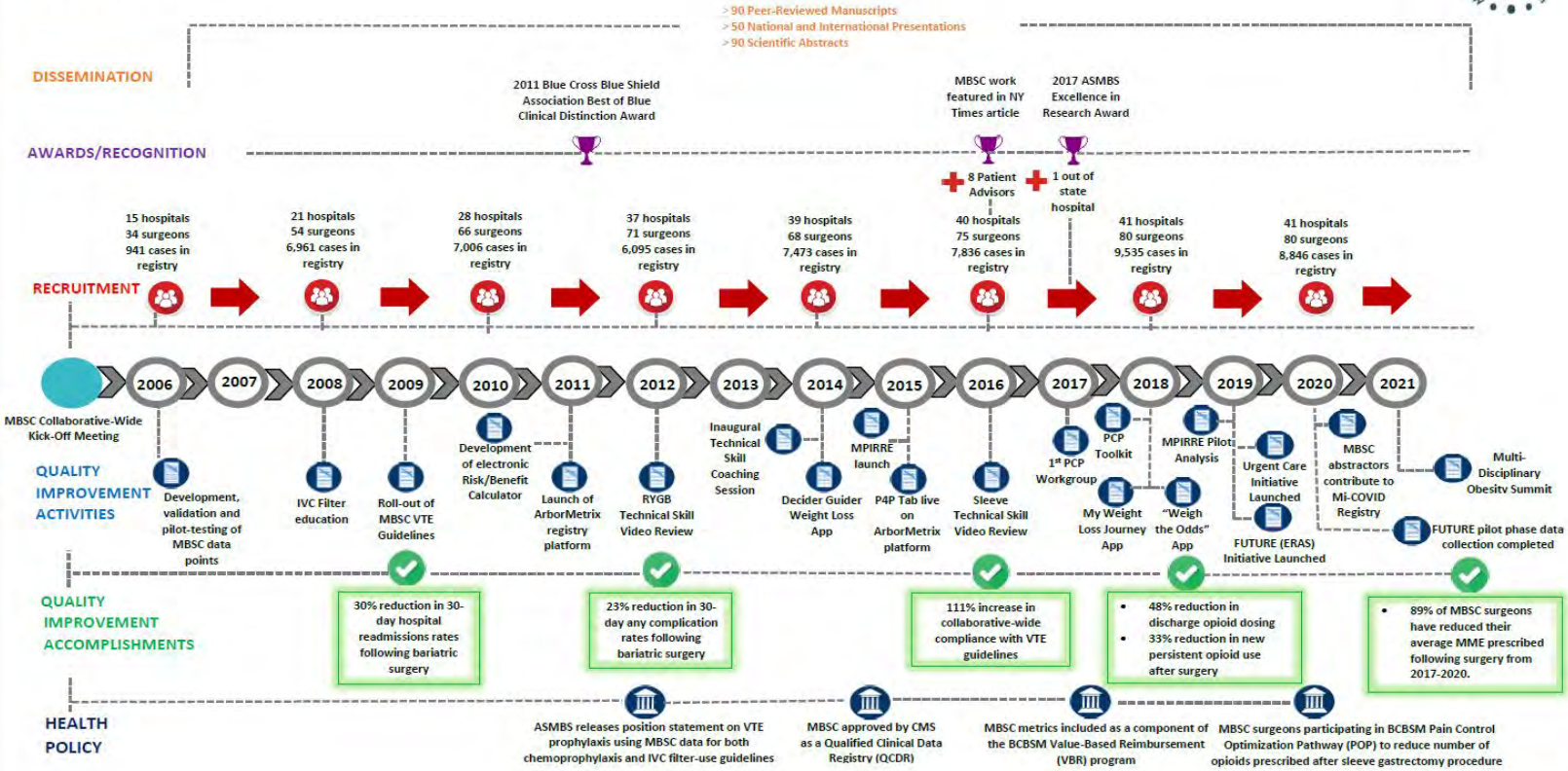
Design Strategy



Blue Cross Blue Shield Blue Care Network of Michigan

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

MBSC Timeline



Blue Cross Blue Shield Blue Care Network of Michigan

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

MBSC 5-Year Timeline

MICHIGAN BARIATRIC SURGERY COLLABORATIVE

DISSEMINATION

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

Future Plan

- CQI collaboration
- Health Disparities
- PCP Engagement
- Telehealth
- Expanding current initiatives

40 MI-Hospitals + 1 CA Hospital
80 surgeons
102,503 cases in registry

40+ MI-hospitals + 1 CA Hospital
80+ surgeons
140,000+ cases in registry

QUALITY IMPROVEMENT ACTIVITIES

2021
- Expand current initiatives
  - Complete enrollment for the MPIRRE
  - Develop dissemination plan for MWLI App
  - Continue voluntary enrollment for FUTURE
- Health Disparities
- CQI Collaboration
  - MVC COVID MARCQI
- PCP Engagement
  - Obesity Summit Fall 2021
  - PCP data feedback to participating hospitals

2022
- Complete FUTURE enrollment
- CQI Collaboration
  - M-OPEN Diabetes
- PCP Engagement
  - Telehealth
  - Obesity Summit Fall 2022

2023
- Opioid-free discharge prescribing
- PCP Engagement
  - Collaborate with Medical Weight Loss MDs through MBSC website
- CQI Collaboration
  - Health Disparities Kidney Failure

2024
- Get ready for surgery toolkit
- PCP Engagement
  - Patient Selection Collaboration

2025
- PCP Engagement
  - Impact of Weight Loss Medications Before/After Surgery
- Collaboration with plastic surgery regarding skin removal following bariatric surgery to improve patient satisfaction

QUALITY IMPROVEMENT ACCOMPLISHMENTS

- 30% reduction in 30-day hosp. readmissions rates following bariatric surgery
- 23% reduction in 30-day any complication rates following bariatric surgery
- 111% increase in collaborative-wide compliance with VTE guidelines
- 48% reduction in discharge opioid dosing
- 33% reduction in new persistent opioid use after surgery

2023
Complete ROI for MPIRRE and Decrease in Opioid Prescribing

2024
Complete ROI for FUTURE Initiative

2025
Health Disparities Evaluation/Telehealth

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

The “Black Box” of Surgery

Technique and Technical Skill

Image modified, original by Bruno Mangyoku

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

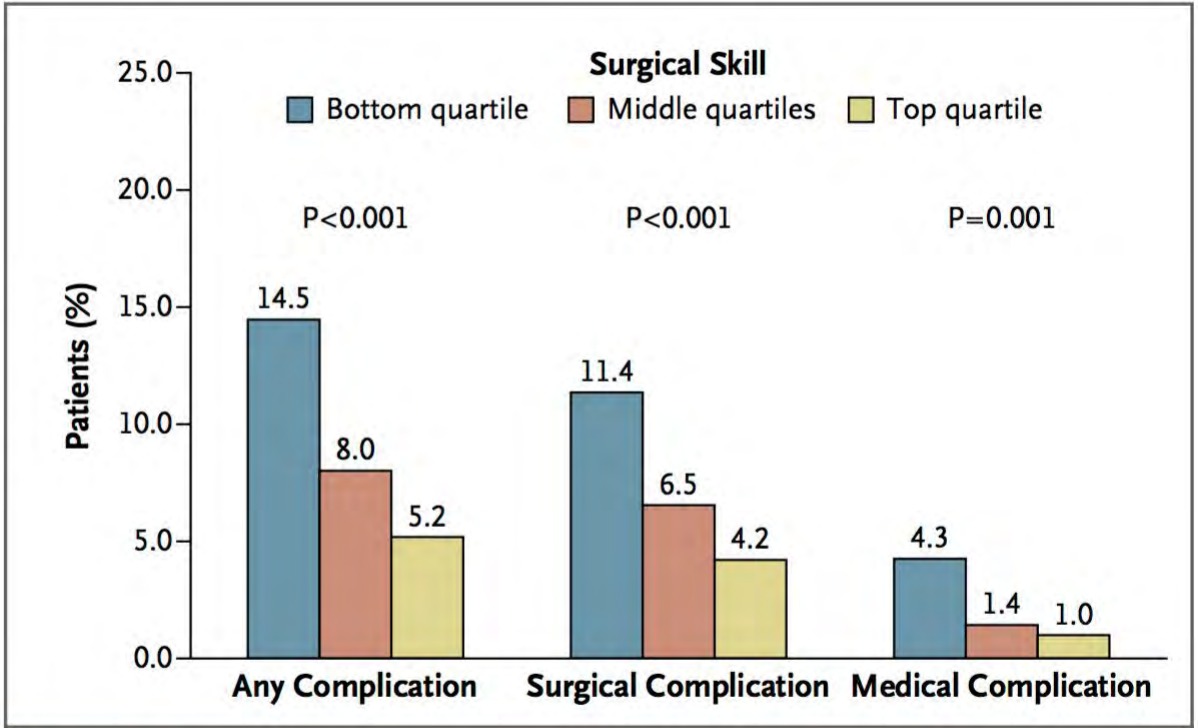


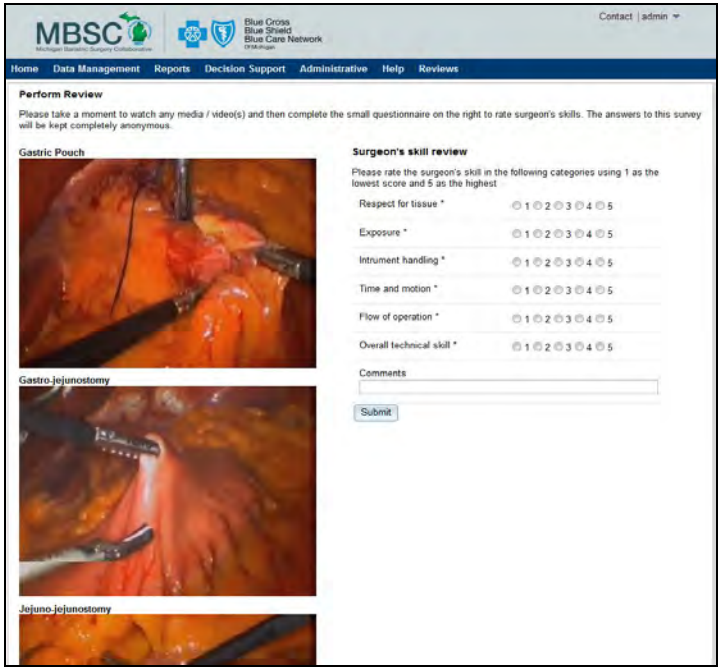
Figure 2. Risk-Adjusted Complication Rates with Laparoscopic Gastric Bypass, According to Quartile of Surgical Skill.

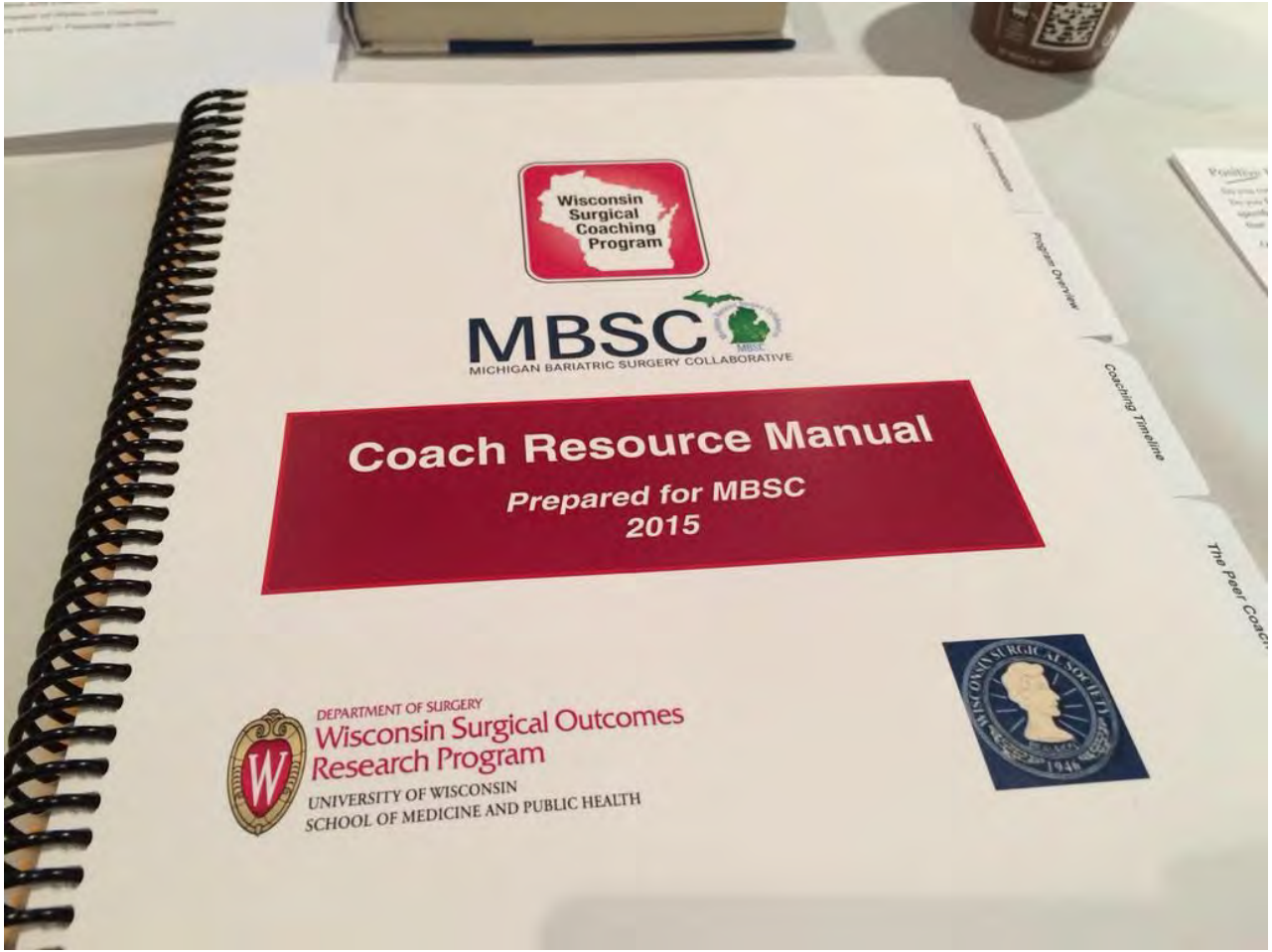
Value of using video to assess quality:

- 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




Wisconsin Surgical Coaching Program
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
Program Overview
Coaching Timeline

Leadership and Change Management

- Principled
- Data Driven
- Collaborative

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

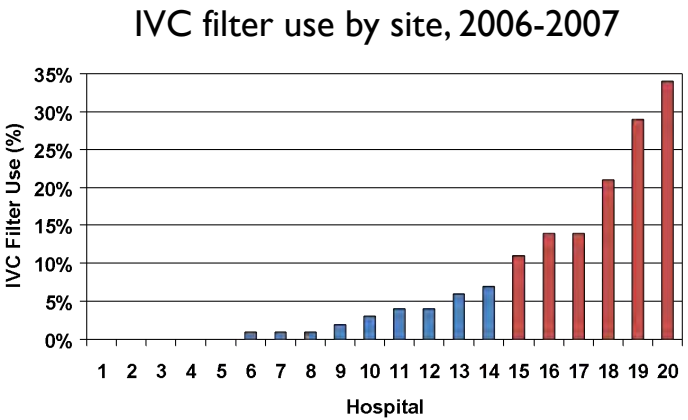
Yes, like all other collaborative quality initiative programs, MCT2D is an all-patient, all-payer initiative. When performance is measured, all patients that a practice sees will be part of the denominator, not just BCBSM patients. In regards to the data, the CQI Data Hub is working diligently to ensure 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.

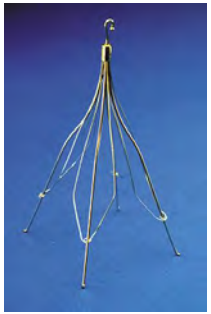
IVC Filter Utilization

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

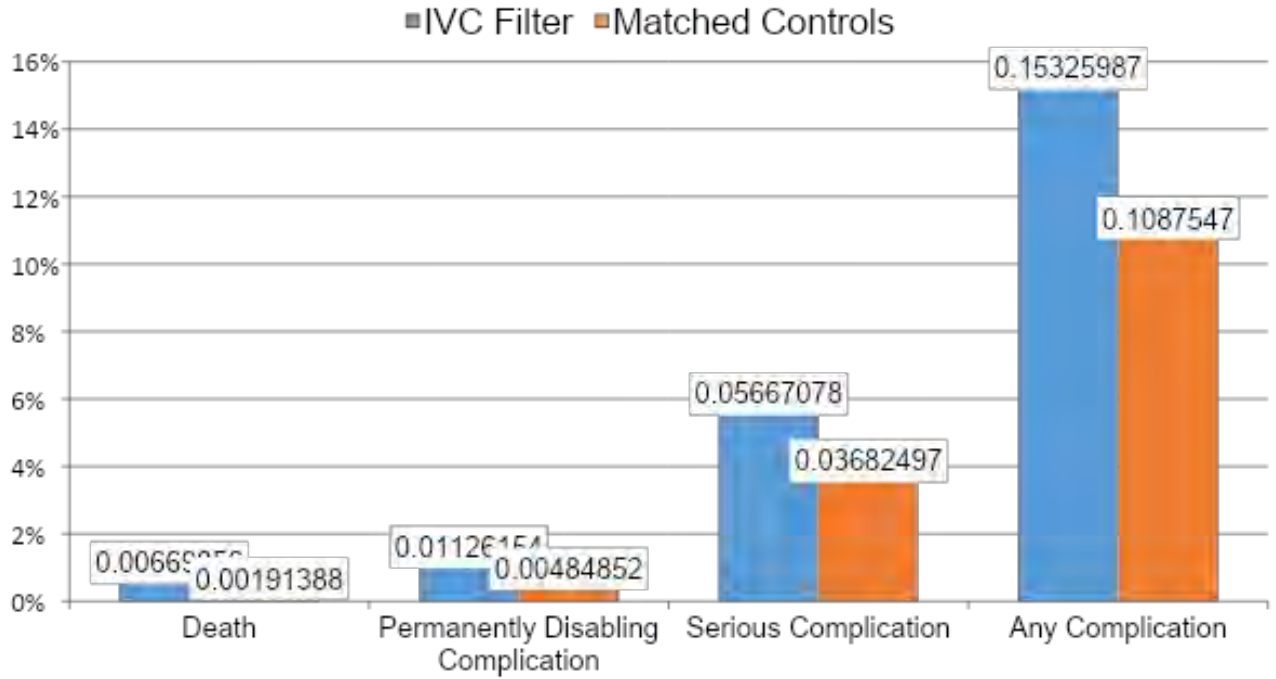
IVC Filter Utilization

- 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

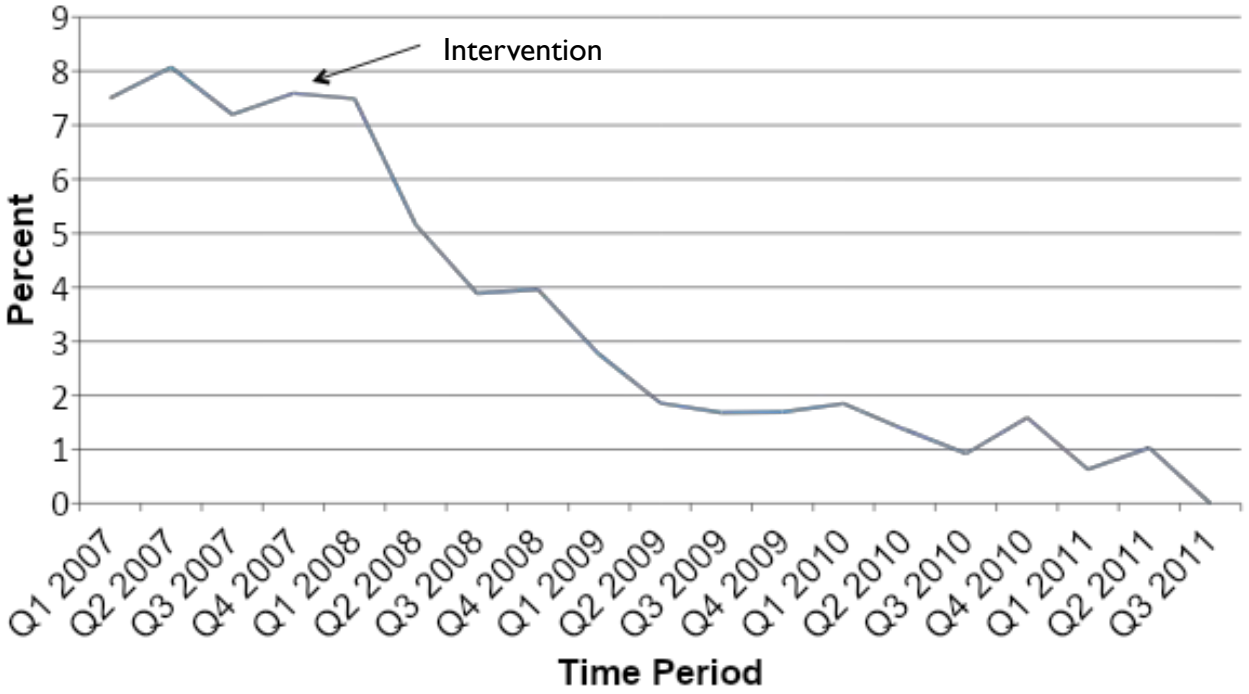
Half of the IVC filter patients with the most serious complications, had a PE or a complication specifically related to the IVC filter

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), death
ED (POD14) for PE, reintubated, cardiac arrest, death
ED/readmitted (POD 13) for excessive anticoagulation and intra-abdominal bleeding, PE/cardiac arrest (POD 16), death
ED (POD 15), readmitted (POD 16) IVC filter occlusion leading to vascular collapse, shock (POD 17), cardiac arrest (POD 17, 18), death

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

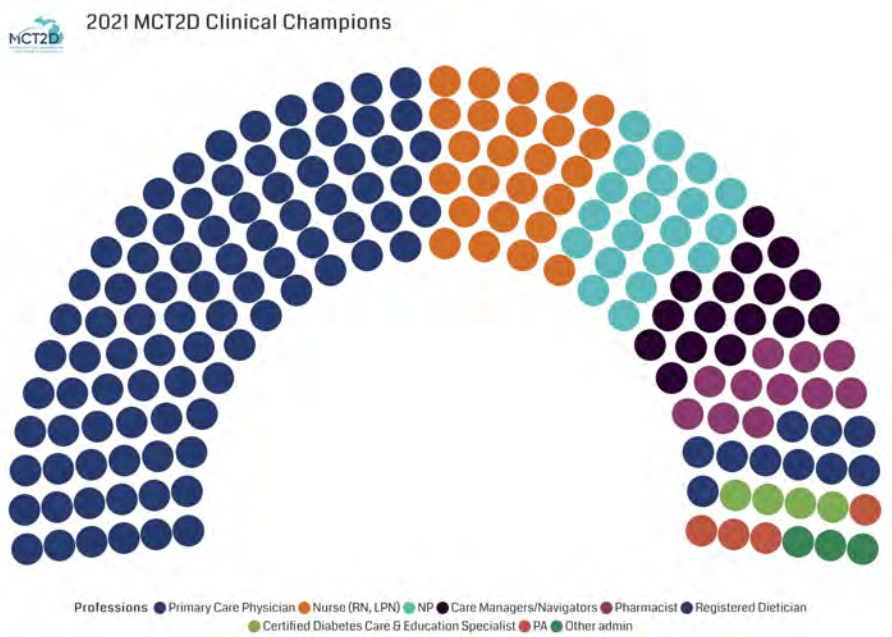
Description	Cost	Annual # Averted	Savings
Excess cost IVC filter placement	$13,500	456	$5.2 million
Excess cost serious complication	$12,000	22	$264,000
Total			$5.5 million

Leadership and Change Management

- Principled
- Data Driven
- Collaborative

MCT2D

MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

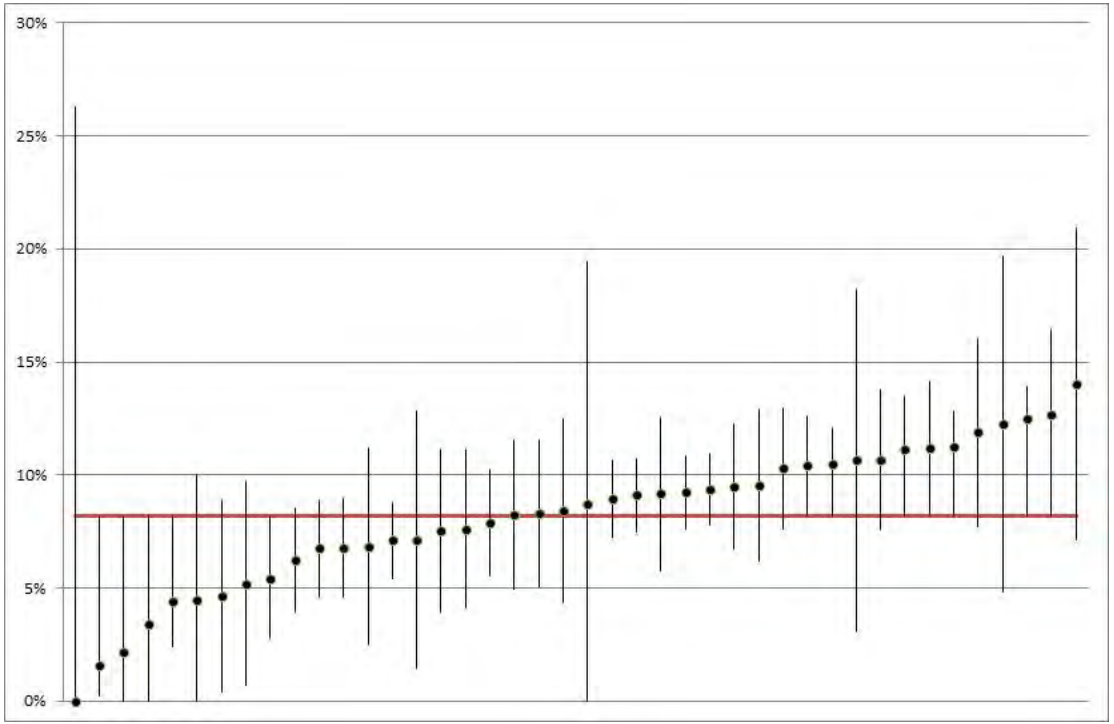


Emergency Department Visits

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


PRIVATE
PRIVATE
PRIVATE

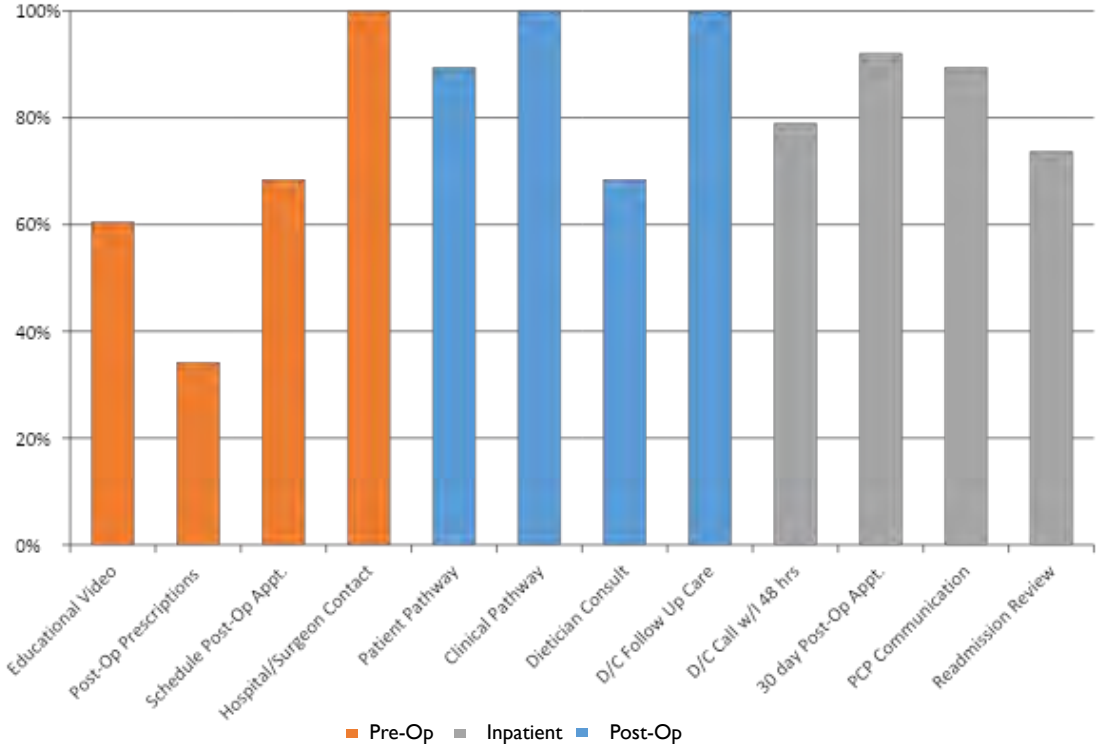
ER Visits Variation By Site



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

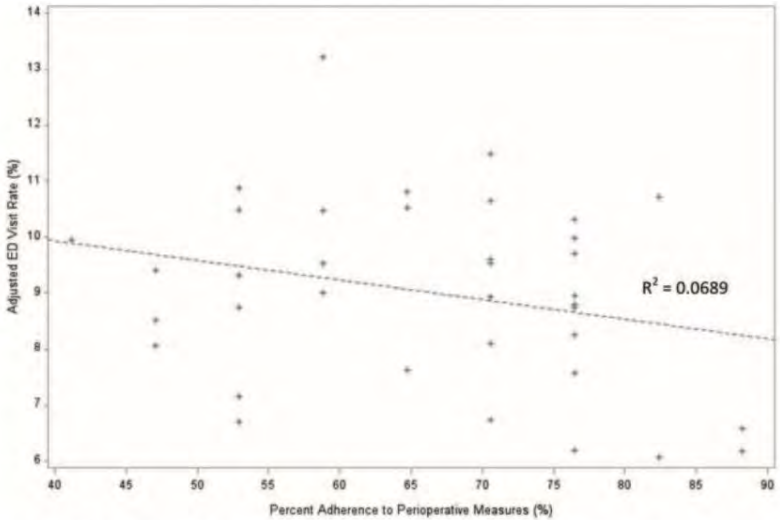
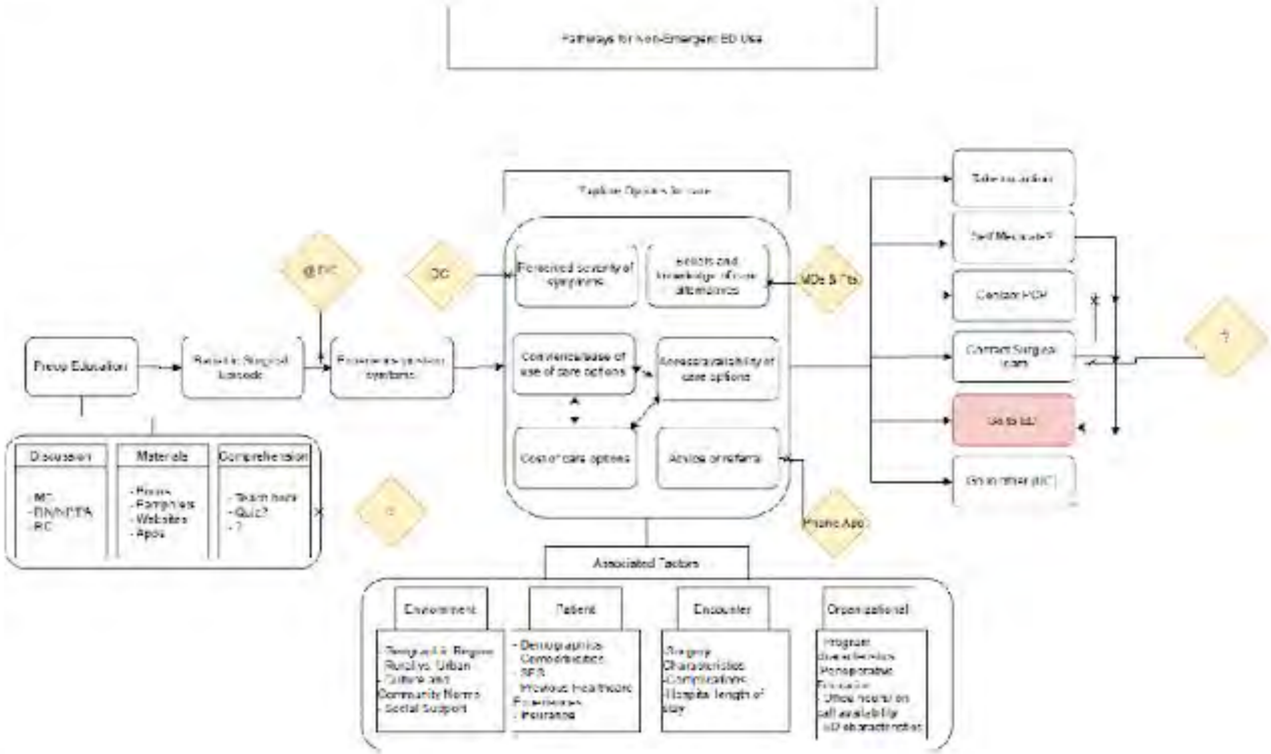


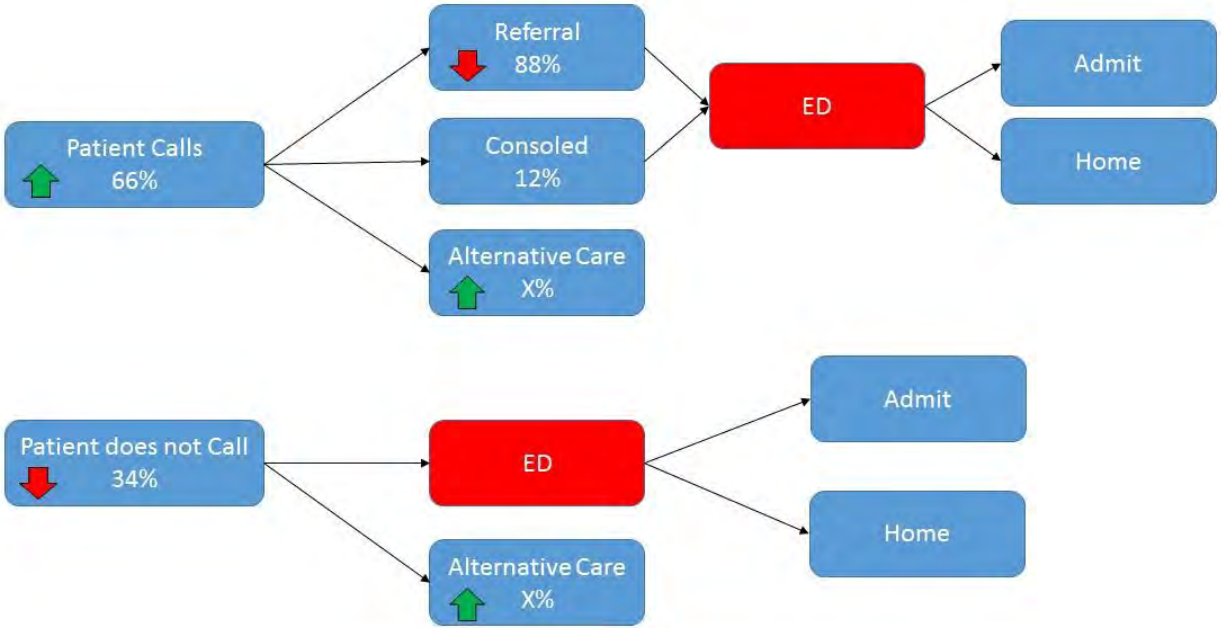
FIGURE 1. The relationship between a hospital's adherence to the perioperative measures surveyed for (Table 1) and ED visit rates.

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
Preop Education
Discussion
Materials
Comprehension
- Books
- Pamphlets
- Websites
- Apps
- Quiz?
Perceived severity of symptoms
Convenience/ease of use of care options
Cost of care options
Advice or referral
MDs & Pts
Phone App
Contact PCP
Contact Surgical team
Associated Factors
Environment
Patient
Encounter
Organizational
- Rural vs. Urban
- Culture and Community Norms
- Social Support
- Demographics
- Comorbidities
- Previous Healthcare Experiences
- Insurance
Surgery Characteristics
- Complications


Patient Calls
66%
Referral
88%
Consoled
12%
Alternative Care
X%
ED
Admit
Home
Patient does not Call
34%
ED
Alternative Care
X%
Admit
Home

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!

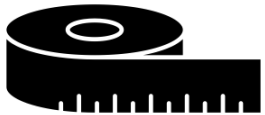
twitter @AmirGhaferi

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

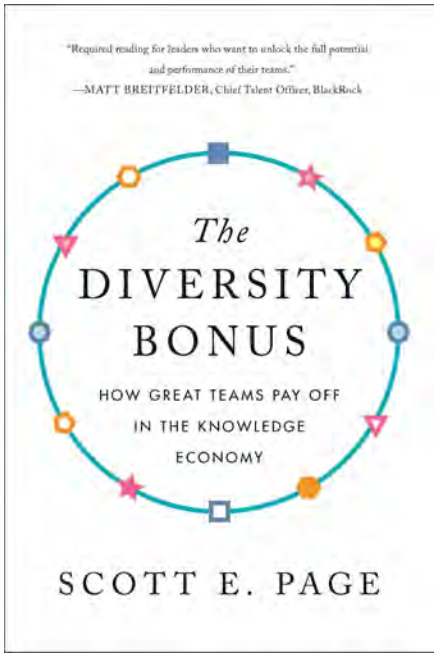
Problem

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

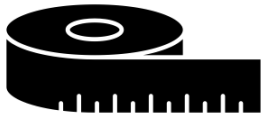
Partners

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?

5 ESSENTIALS OF A GREAT REDESIGN PITCH

Problem

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

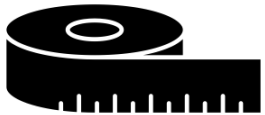
Partners

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?