



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

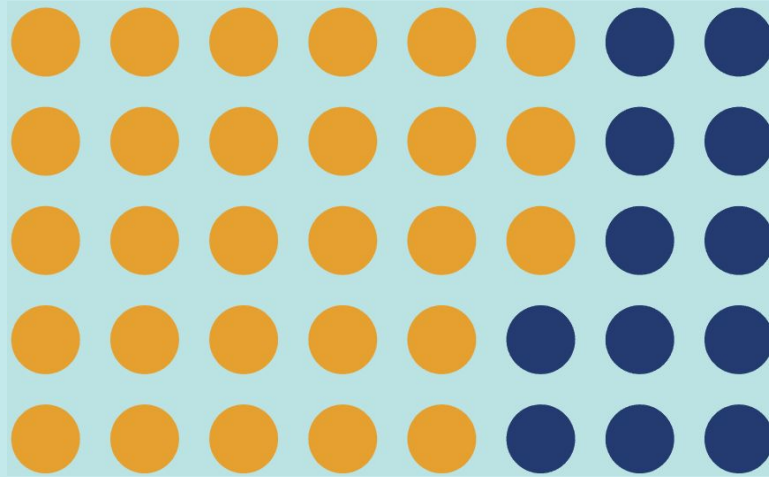


MCT2D: we're on a mission!

- **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



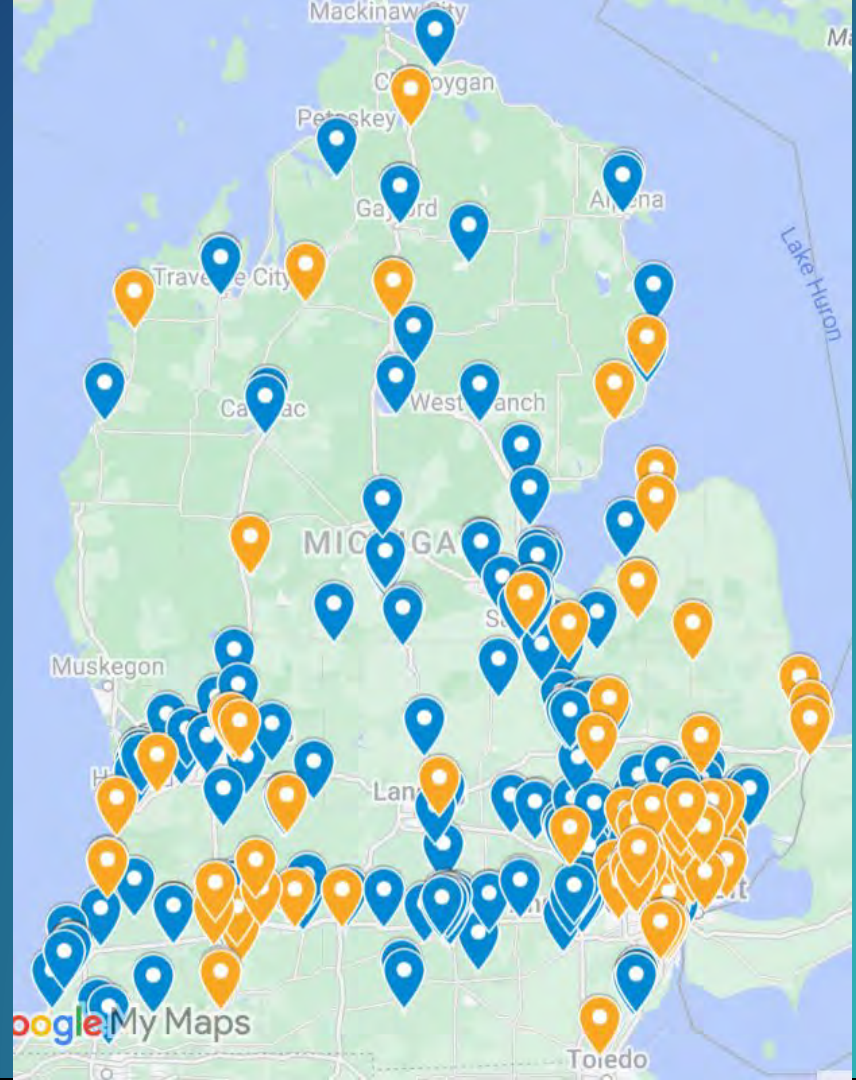
15

**nephrology
practices**

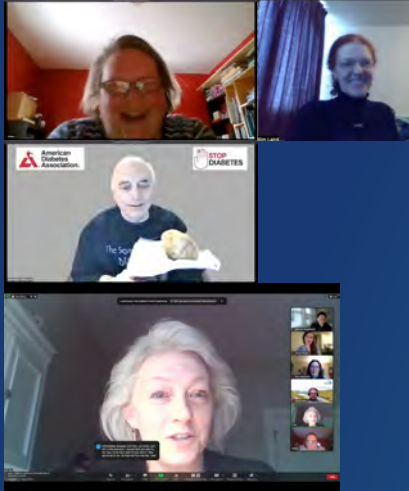
Added 6 practices in 2022

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

Diabetes in Michigan
MCT2D.org
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 to join 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 will help 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 household chores.

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 used for you and know how to recognize side effects.

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

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

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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?

- Eye Exams:** Lower carbohydrate diet and sugar in your diet can help improve your hearing, vision, and eye health.
- Get Moving:** An active lifestyle helps.
- Medication:** Take your medication as prescribed.
- Monitor Your Blood Sugar:** At home as often as directed by your provider.
- Diabetes:** 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 body with 30 minutes of movement.

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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.

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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?

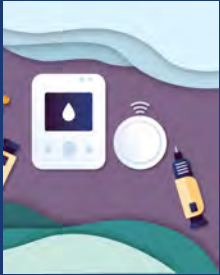


Want to learn more about a low carb lifestyle? Ask your doctor or care team!

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Designed by
Jannie 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.”

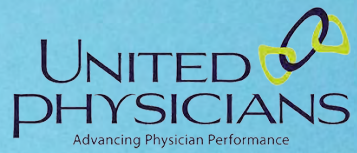




So I was really
really excited
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Jamie

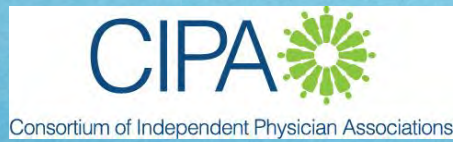


T H A N K

Y O U

JACKSON HEALTH NETWORK

Northern Michigan Care Partners



For helping make this program a success!

Launched since last June

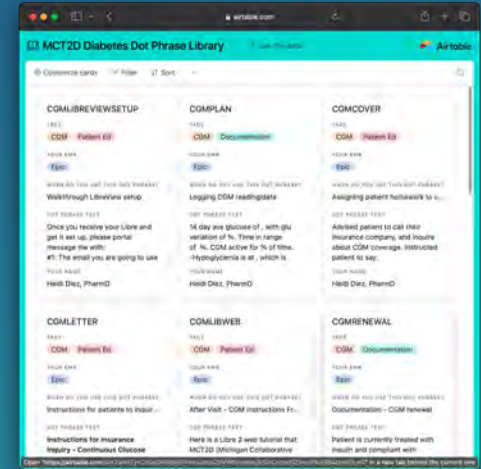


Dietitian and
Pharmacist 1on1
Consults

Coming Soon:
Cooking Demo and
Breadless
Collaboration



Best Practices
Database



Dot Phrase
Library



New tools since last June

Supporting Patients During GLP-1 Receptor Agonist Shortages

MCT2D
Member of the **AMERICAN DIABETES ASSOCIATION**

Due to the glycemic, weight loss, and cardiovascular benefits of GLP-1 receptor agonists, many of these medications are experiencing short-term shortages. Here are some tips for supporting patients during medication shortages.

Have patients do the homework

- Patients can ask their local pharmacies if their GLP-1 RA medication and dose is available to offset work from your staff.
- Patients can ask their health insurance company about alternate GLP-1 RAs are covered.
 - Ex: Semaglutide 3 mg is not available. Ask if two 1.5 mg injections weekly would be covered during the shortage. This may be approved.
- If you make a substitute, instruct patient to call their pharmacy to see if their original GLP-1 RA medication and dose is back in stock, prior to next visit.

Switch to a different oral or injectable GLP-1 RA or GLP-1/GIP RA

- When switching from a weekly to a daily medication, take the first dose of the daily medication seven days after the last dose of the weekly medication.
- When switching from a daily to a weekly medication, take the first dose of the weekly medication one day after the last dose of the daily medication.
- In general, consider the lowest therapeutic dose when switching to avoid GI side effects.
 - If a patient experienced severe issues starting a GLP-1 RA in the past, consider starting at the lowest remaining dose of the substitute GLP-1 RA and titrating up if well tolerated, and at shorter intervals.
 - Consider equivalency compares the relative strength of medications but does not predict severity of initial side effects.

Agent	Frequency	Titration Schedule	Equivalent Doses
Dulaglutide	Weekly	4 weeks	0.75 mg, 1.5 mg, 3 + 4.5 mg
Semaglutide	Weekly	4 weeks	0.25 mg, 0.5 mg, 1 mg, 2 mg
Liraglutide	Daily	1 week	0.6 mg, 1.2 mg, 1.8 mg
Oral Semaglutide	Daily	4 weeks	3 mg, 7 mg, 14 mg
Tirzepatide	Weekly	4 weeks	2.5 mg, 5 mg, 7.5-11.5 mg

Use a lower dose of medication

- Many pharmacies have shortages of higher-dose GLP-1 RA; lower doses are available.
- Monitor glycemic control carefully when using a lower dose of medication.

Switch to an alternative medication

- If the patient is a good candidate, an SGLT2 inhibitor may be a good alternative.

Use MCT2D Tools

- Check the MCT2D coverage by [PhysiGuide](#) and consult our [Dosing Information Guide](#).

Medication shortages are frustrating and hard to solve work for your teams. Many patients may tolerate a lower dose of medication short term until a shortage resolves.

[MCT2D Coverage by PhysiGuide](#)

Medication shortages are frustrating and hard to solve work for your teams. Many patients may tolerate a lower dose of medication short term until a shortage resolves.

Ref: AmJMed. JP. 2022; 143: 1223-1219-2022 MCT2D by American Diabetes Association

GUIDE FOR STARTING PATIENTS on a Low Carb Lifestyle

A low carbohydrate (carb) lifestyle consists of reducing one's carbohydrate intake to 50-130g of total carbohydrates per day. Patients with type 2 diabetes (T2DM) who are interested in adopting a low carbohydrate lifestyle should monitor their blood glucose carefully and work closely with their primary care team to adjust medications as needed. Risk of hypoglycemia is greatest among patients who are on insulin or sulfonylureas, particularly if they significantly reduce carbohydrate intake without adjusting their medications.

Patients with T2DM who are on these medications may need to have their medications proactively reduced (i.e., when their diet is initiated) to prevent hypoglycemia. View a detailed review on medication management for patients with T2DM who follow a low carbohydrate lifestyle by visiting medlineplus.gov/jmgp/ or scanning the QR code.

Low carbohydrate lifestyles are not "one-size-fits-all." Success may require fine-tuning and adjustments along the way to find a sustainable lifestyle range for a patient. Considerations such as patient characteristics, experience, cultural background, and commitment to work closely with their care team and to practice in self-management skills are necessary tools for success.

MONITORING BLOOD PRESSURE

- Monitor BP for all patients.
- For patients with controlled BP or edema.
 - Consider stopping/decreasing diuretics during the first 2-4 weeks of dietary change.
 - If BP is elevated, recheck in 90 days.
- T2DM hypoglycemia advice patient to monitor for fatigue and dizziness, use appropriate permission to stop a medication in this setting (OCDL medication and call office).
- Monitor for hypotension.

SETTING CARB GOALS & ADJUSTING MEDICATIONS

GREEN CATEGORY: CONTINUE

Patients will need minimal medication adjustment.

Signatures: GLP-1 RA, DPP-4 Inhibitors

Medication adjustments: If patients are on BP-lowering medications, close monitoring and adjustments may be necessary to prevent hypotension.

Blood glucose range and monitoring: Most patients should achieve a fasting glucose level of 75-130 mg/dL and a two-hour postprandial level of <180 mg/dL. Work with your patient to determine blood sugar monitoring goals.

The Benefits of Newer Diabetes Medications (GLP-1 RA)

MCT2D
Member of the **AMERICAN DIABETES ASSOCIATION**

How do newer prescriptions (as opposed to older medications) differ?

Older medications (Glucagon-like peptide-1 (GLP-1) agonists) include: Exenatide (Byetta), Exenatide ER (Bydureon BCAA)

Newer medications (GLP-1 receptor agonists) include: Dulaglutide (Trulance), Semaglutide (Ozempic), Liraglutide (Victoza), Tirzepatide (Zepbound), and Semaglutide (Oral) (Rybelsus).

Did you know that newer medications can also help lower your blood sugar? Check out the benefits of newer medications:

- All GLP-1 RAs lower blood sugar levels.
- Many GLP-1 RAs lower risk of heart attack and stroke.
- Bydureon does not reduce these risks.

Side effects are usually mild and may improve or go away over time. These include:

- Stomach or intestinal side effects are the most common and improve or go away in a few weeks.
- Nausea or vomiting.
- Diarrhea or constipation.
- Stomach discomfort or bloating.
- Skin reactions at site of injection.

When should I call my health care team?

- If you experience:
 - Diarrhea or constipation.
 - Stomach discomfort or bloating.
 - Skin reactions at site of injection.

How do the medications differ?

How are newer (weekly or daily) used the skin on your stomach - for some you do NOT wear the needle!

See our New To Video Series to learn GLP-1 RA injection:

Rybelsus is an oral medication that must be taken with a meal 30 minutes before eating that day. The dose must be taken prior to other medications including thyroid medications.

How can I lose or prevent side effects?

- Look for your best bet for signs of being but (you might surprise you!).
- Eat smaller meals.
- Avoiding walking 1-2 hours of going to bed.
- Avoid fatty, greasy or spicy foods.
- Drink plenty of water daily.
- Monitor your blood sugar to find an effective, tolerable, or appropriate dose.
- Your health care team may adjust these medications if your blood sugar is too low.

Medication Dose Savings Card (Patient Reference Guide)

[medlineplus.gov/glp1a](#)

Patient Assistance Program (PAP) Guide

[medlineplus.gov/glp1a](#)

***NOTE:** These are the most common side effects. This list does not include all possible side effects. You may not experience these side effects. Please talk to your health care team if you have other concerns about side effects. This handout should not be used as a substitute for medical advice from your health care team. It is your responsibility to know information provided by your primary care provider, your doctor or health care team, and to ask your doctor questions about these medications with any questions about your medication.

CONTINUOUS GLUCOSE MONITOR (CGM) Use Case Guide for Type 2 Diabetes

MCT2D
Member of the **AMERICAN DIABETES ASSOCIATION**

If a patient has received a Continuous Glucose Monitor (CGM) or you are suggesting a CGM, use the criteria below to determine if a CGM is appropriate for the patient, and if so, likely to be covered by the patient's insurance.

Section 1: Scenario

Do any of these scenarios apply to the patient?

Scenario #1
Patient is on multiple daily insulin injections and CGM will reduce multiple finger sticks per day for glycemic monitoring.

Scenario #2
Patient with T2DM is experiencing hypoglycemic and one use of a CGM will alert the patient to hypoglycemic episodes.

Scenario #3
Patient with T2DM who is overweight has obesity related to CGM to drive lifestyle changes for glycemic control and weight loss.

Scenario #4
Patient with T2DM who is overweight has obesity related to CGM to drive lifestyle changes for glycemic control and weight loss.

If none of the scenarios above apply, CGM may not be an appropriate choice for the patient.

Section 2: Phone / Internet Considerations

Use the Decision Tree to determine if a CGM is right for the patient based on their ability to access the internet and/or use a standalone reader.

Does the Patient have a compatible smart phone?

NO → Move on to the next section.

YES → Does the patient have a computer and internet at home to upload their data? YES → YES. NO → NO.

NO → Does the patient have a computer and internet at home to upload their data? YES → YES. NO → NO.

NO → Is spending only at the office at work sufficient? (if a patient without internet access) YES → YES. NO → NO.

NO → Does the patient have the ability/access to transport for office visits? YES → YES. NO → NO.

STUDY - CGM is not right for this patient.

GLP-1 Receptor Agonist Shortages

Guide for Starting Patients on a Low Carb Lifestyle

GLP-1 RA & SGLT2 Patient Handout

CGM Use Case Guide

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 onset 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 "never touch 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 (plan)/smartphrase or go all-in 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** handout 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 30-15 BA as a starting point and send it to the pharmacy. Advise the patient to ask the pharmacist about the cost of the copay before they pick up the prescription, and to consider if this copay will be affordable for them 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 for a new prescription.
- 4. Get a head start**
 - **Leveraging samples:** (if you have access to them):
 - Use medication samples to bridge the 90-day/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

0 CARB FOODS (per serving)
Meats, Poultry, Fish/Shellfish, Eggs, Beef, Lamb, Pork, Chicken, Turkey, Duck, Fish, Seafood, Salmon, Tuna, Shrimp, Scallops, Crab, Shrimp, Lobster, Oyster, Shellfish, Turkey, Chicken, Turkey, Duck, Fish, Seafood, Eggs, White or whole (8 eggs)

1-5 CARB FOODS
Lentils, Lima Beans, Green Beans, Spinach, Broccoli, Cauliflower, Cabbage, Bell Peppers, Zucchini, Pumpkin, Squash, Eggplant, Tomatoes, Cucumbers, Onions, Celery, Carrots, Parsnips, Turnips, Shrimps, Avocado, Olive Oil, Coconut Oil, Butter, Margarine, Shortening, Mayonnaise, Salad Dressing, Cream, Sour Cream, Whipped Cream, Ice Cream, Gelatin, Jell-O, Sugar, Honey, Maple Syrup, Molasses, Syrup, Stevia, Sweetener, Vanilla, Baking Soda, Baking Powder, Yeast, Flour, Cornstarch, Tapioca, Xanthan Gum, Guar Gum, Psyllium Husk, Arrowroot, Potato Starch, Tapioca Starch, Coconut Flour, Almond Flour, Cashew Flour, Hazelnut Flour, Pistachio Flour, Walnut Flour, Pecan Flour, Macadamia Flour, Coconut Oil, Butter, Margarine, Shortening, Mayonnaise, Salad Dressing, Cream, Sour Cream, Whipped Cream, Ice Cream, Gelatin, Jell-O, Sugar, Honey, Maple Syrup, Molasses, Syrup, Stevia, Sweetener, Vanilla, Baking Soda, Baking Powder, Yeast, Flour, Cornstarch, Tapioca, Xanthan Gum, Guar Gum, Psyllium Husk, Arrowroot, Potato Starch, Tapioca Starch, Coconut Flour, Almond Flour, Cashew Flour, Hazelnut Flour, Pistachio Flour, Walnut Flour, Pecan Flour, Macadamia Flour

5-10 CARB FOODS
Bacon, Ham, Sausage, Salami, Pepperoni, Hot Sauce, Mustard, Ketchup, Mayo, Dressing, Pickles, Olives, Capers, Anchovies, Pickled Onions, Pickled Peppers, Pickled Cucumbers, Pickled Carrots, Pickled Radishes, Pickled Beets, Pickled Turnips, Pickled Apples, Pickled Lemons, Pickled Limes, Pickled Oranges, Pickled Grapefruit, Pickled Pineapples, Pickled Mangoes, Pickled Tomatoes, Pickled Onions, Pickled Peppers, Pickled Cucumbers, Pickled Carrots, Pickled Radishes, Pickled Beets, Pickled Turnips, Pickled Apples, Pickled Lemons, Pickled Limes, Pickled Oranges, Pickled Grapefruit, Pickled Pineapples, Pickled Mangoes, Pickled Tomatoes

10-20 CARB FOODS
Cottage Cheese, Ricotta Cheese, Cream Cheese, Mascarpone, Sour Cream, Whipped Cream, Ice Cream, Gelatin, Jell-O, Sugar, Honey, Maple Syrup, Molasses, Syrup, Stevia, Sweetener, Vanilla, Baking Soda, Baking Powder, Yeast, Flour, Cornstarch, Tapioca, Xanthan Gum, Guar Gum, Psyllium Husk, Arrowroot, Potato Starch, Tapioca Starch, Coconut Flour, Almond Flour, Cashew Flour, Hazelnut Flour, Pistachio Flour, Walnut Flour, Pecan Flour, Macadamia Flour

Low Carb Cheatsheet and tracker

SGLT2i & GLP-1 RA PATIENT ASSISTANCE PROGRAMS

BYDUREON BXiSE & BYETTA, EXENATIDE XR (AstraZeneca) **AZ & ME**
AZ & ME PRESCRIPTION SAVINGS PROGRAM
 1-800-292-8383
 Must have no prescription coverage for needed medication. This application must be completed online. Application can be completed online by mailed to home.

FARXIGA, DAPAGLIFLOZIN (AstraZeneca) **AZ & ME**
AZ & ME PRESCRIPTION SAVINGS PROGRAM
 1-800-292-8383
 Must have no prescription coverage for needed medication. This application must be completed online. Application can be completed online by mailed to home.

INVOKANA, CANAGLIFLOZIN (Johnson & Johnson) **AZ & ME**
AZ & ME PRESCRIPTION SAVINGS PROGRAM
 1-800-612-8227
 No insurance coverage (as of Jan 2023). This application must be completed online.

JARDANCE, EMPAGLIFLOZIN (Boehringer Ingelheim & Eli Lilly) **AZ & ME**
LOW CARB PATIENT ASSISTANCE PROGRAM
 1-800-554-8317
 Must be uninsured or underinsured. This application must be completed online. Application can be completed online by mailed to home.

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

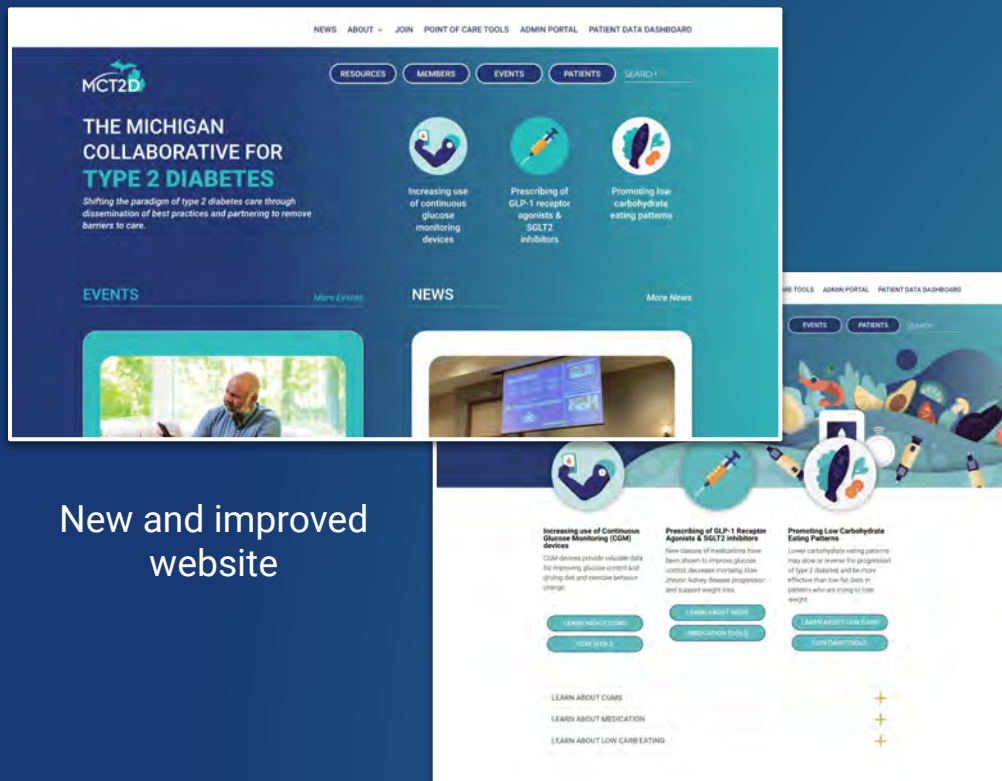
PRIVATE & PBM Coverage for GLP-1 RA & GIP

Insurance Plan	TRULICITY (Dulaglutide)	OZEMPIC (Semaglutide)	RYBELSUS (Semaglutide)	VICTOZA (Liraglutide)	MOUNARIO (Tirzepatide)	EVIONON BXiSE (Exenatide)
AETNA	Preferred (PA)	Preferred (PA)	Preferred (PA)	Preferred (PA)	No info.	Not Covered (NC)
BCBSM	Preferred (PA)	Preferred (PA)	Preferred (PA)	Preferred (PA)	Preferred (PA)	Not Covered (NC)
EXPRESS SCRIPTS	Preferred (PA)	Preferred (PA)	Preferred (PA)	Not Covered (NC)	Preferred (PA)	Preferred (PA)
HAP	Preferred (PA)	Preferred (PA)	Not Covered (NC)	Preferred (PA)	Not Covered (NC)	Not Covered (NC)
PRIORITY	Preferred (PA)	Preferred (PA)	Not Covered (NC)	Preferred (PA)	Preferred (PA)	Not Covered (NC)
PRIORITY (OPTIMIZED)	Preferred (PA)	Preferred (PA)	Not Covered (NC)	Preferred (PA)	Preferred (PA)	Not Covered (NC)
UNITED	Preferred (PA)	Preferred (PA)	Not Covered (NC)	Preferred (PA)	Preferred (PA)	Preferred (PA)

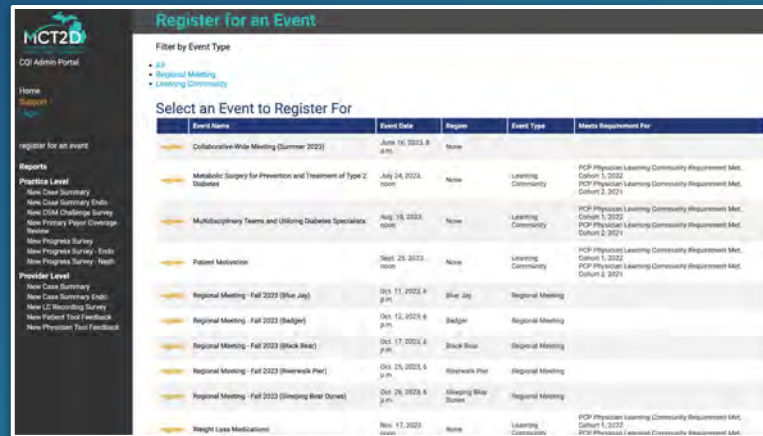
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES (m2d.org) (MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES)

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

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

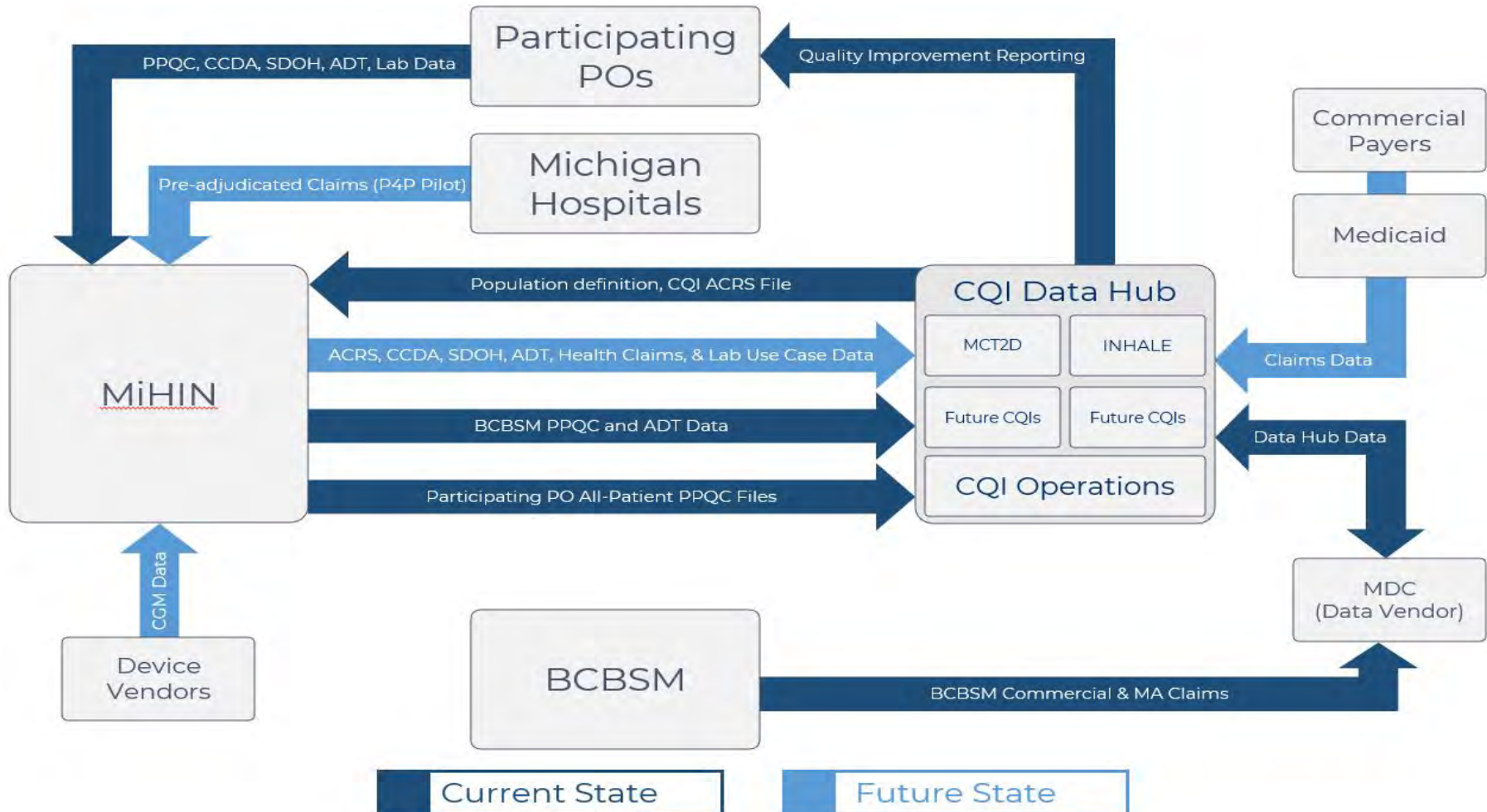
Methods

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

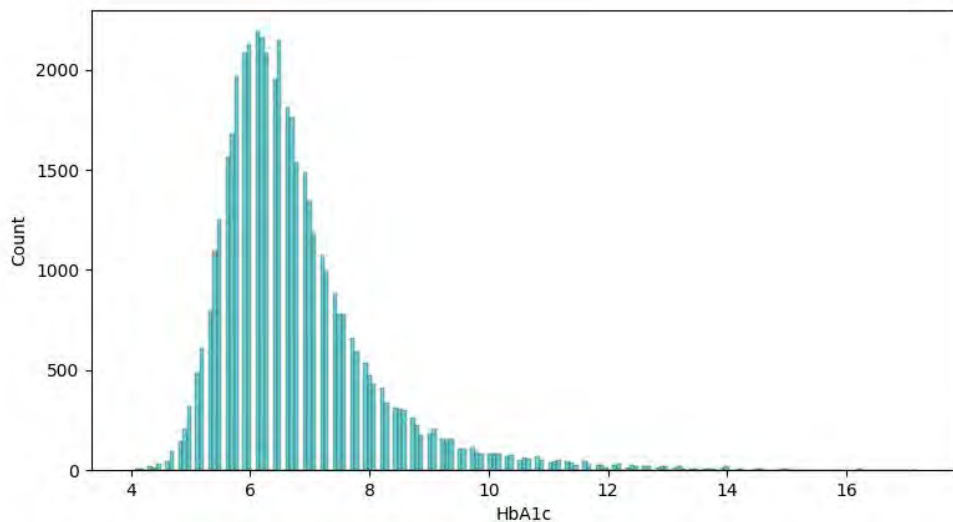
- 70,936 patients

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%

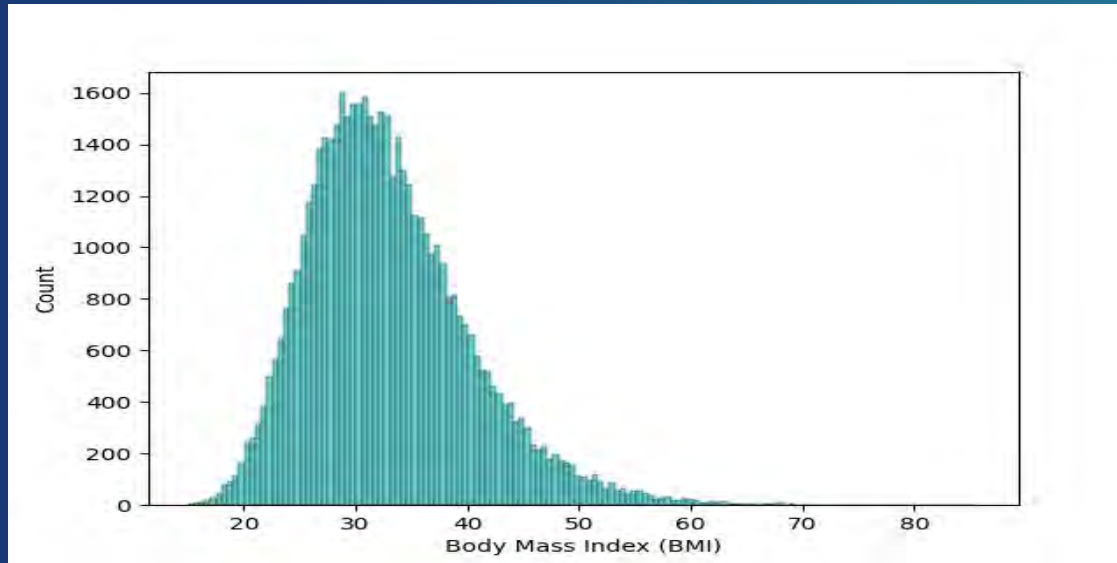
HbA1c

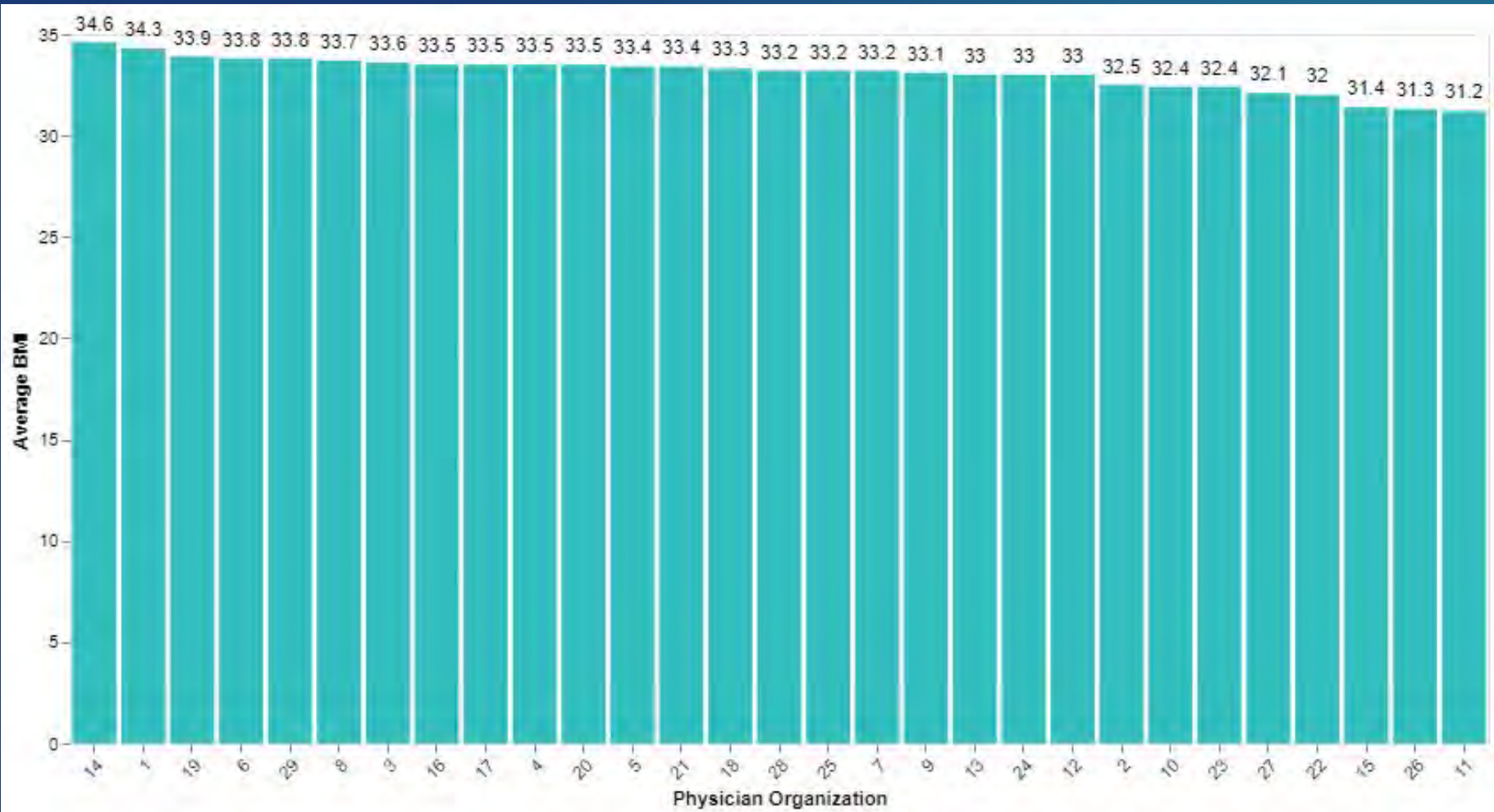
HbA1c	N	Mean	Median	Mode	Minimum	Maximum
	46621	6.75	6.50	6.10	4.0	17.2



BMI

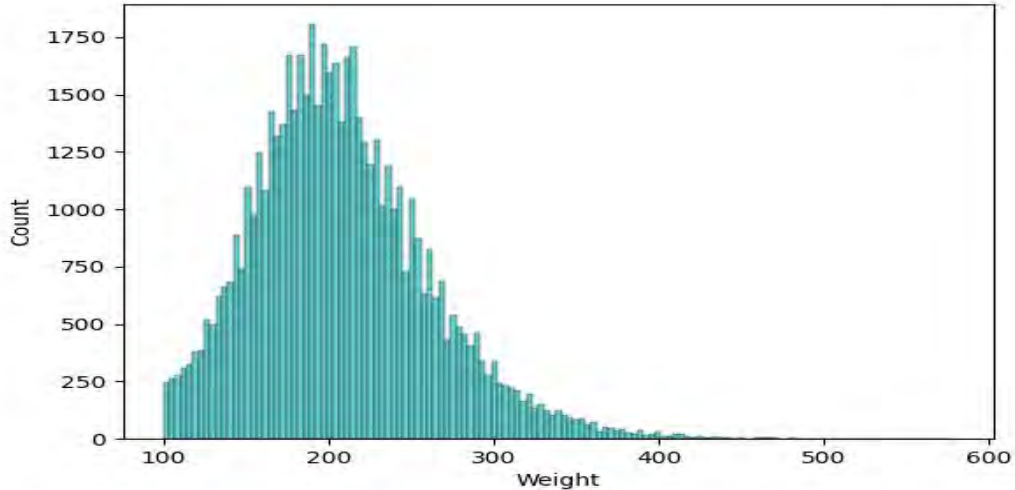
BMI	N	Mean	Median	Mode	Minimum	Maximum
	51400	32.96	31.98	31.00	15.00	85.82

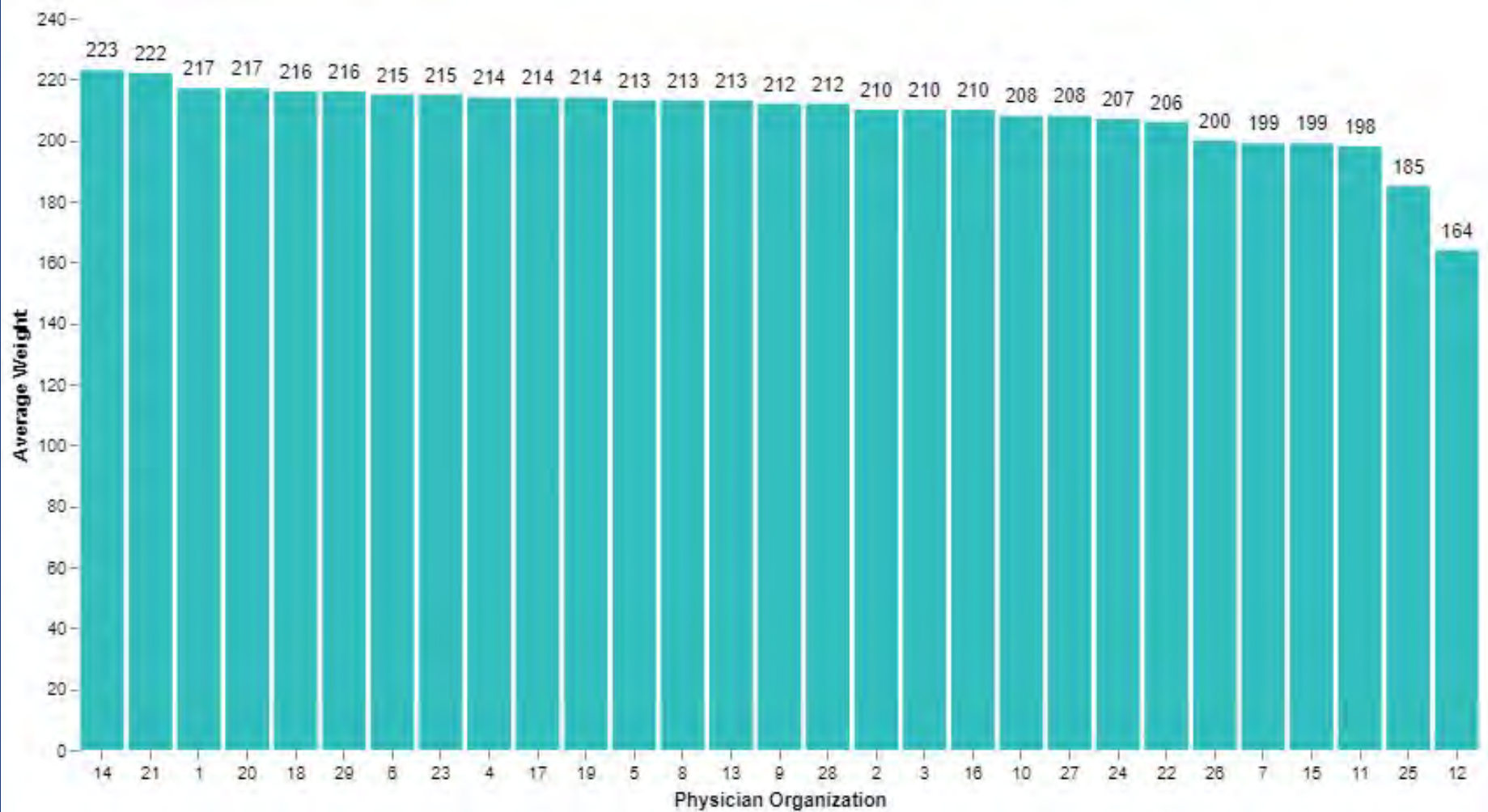




Weight

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

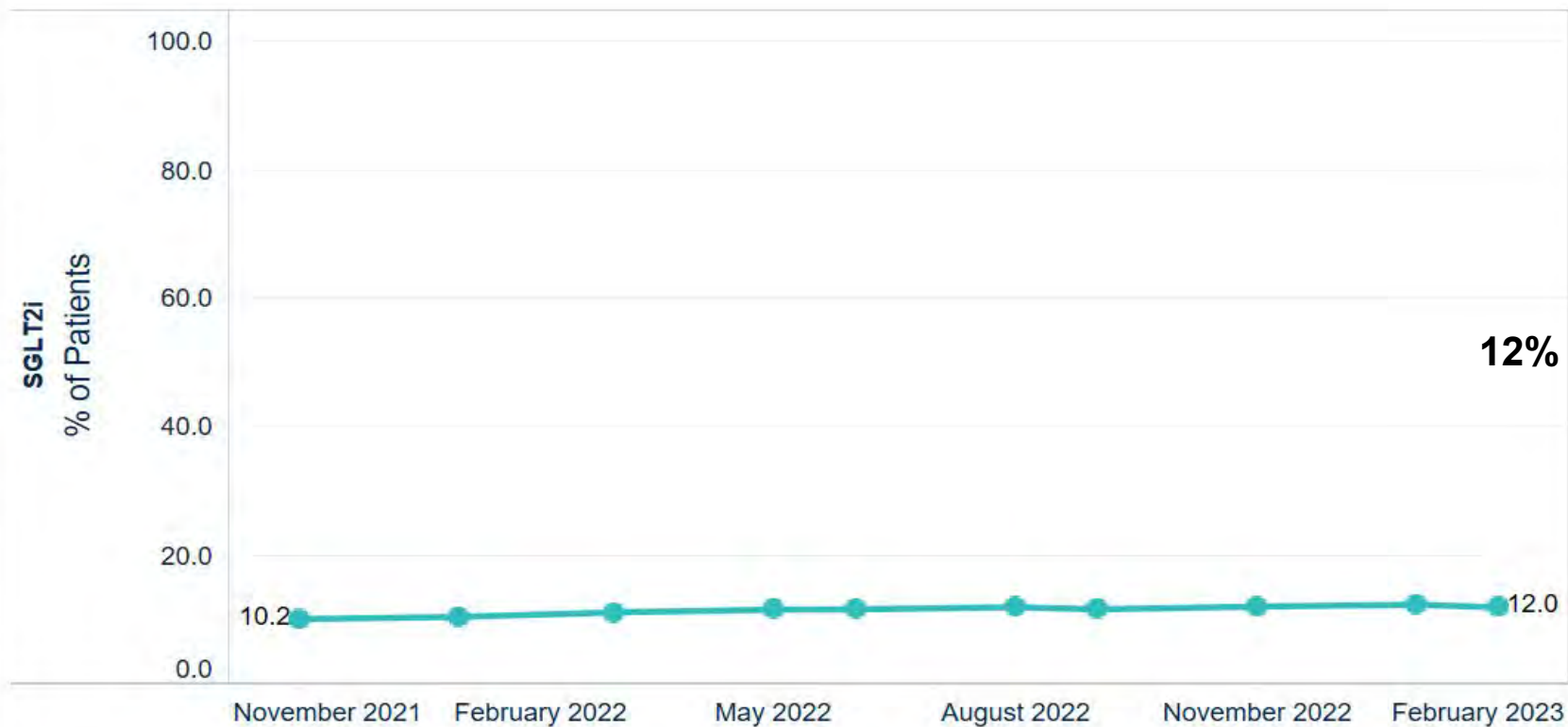
June 1, 2021 - February 28, 2023



Rx - All (Rx Fill in Last 6 Months)

Collaborative

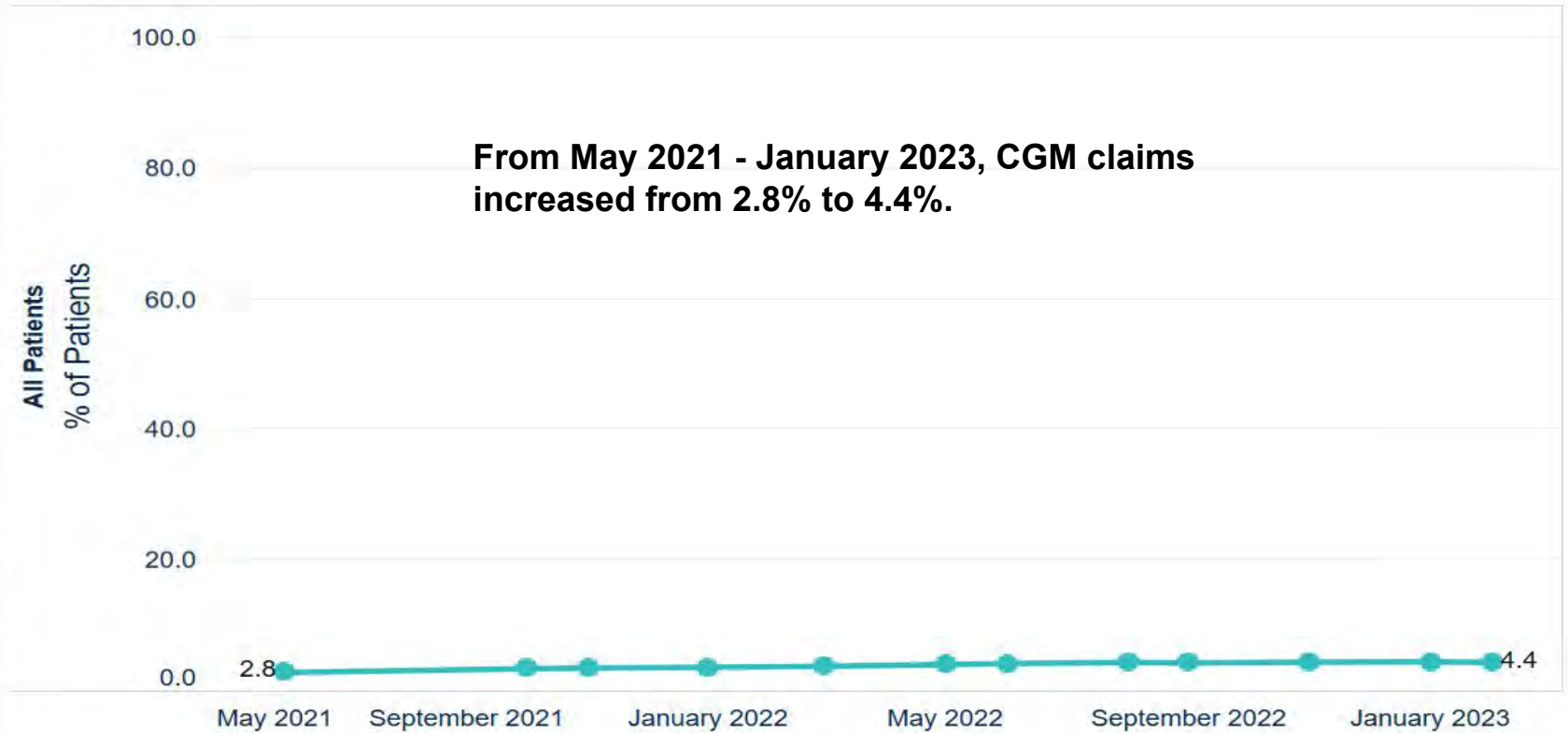
June 1, 2021 - February 28, 2023



CGM (Last 12 Months)

Collaborative

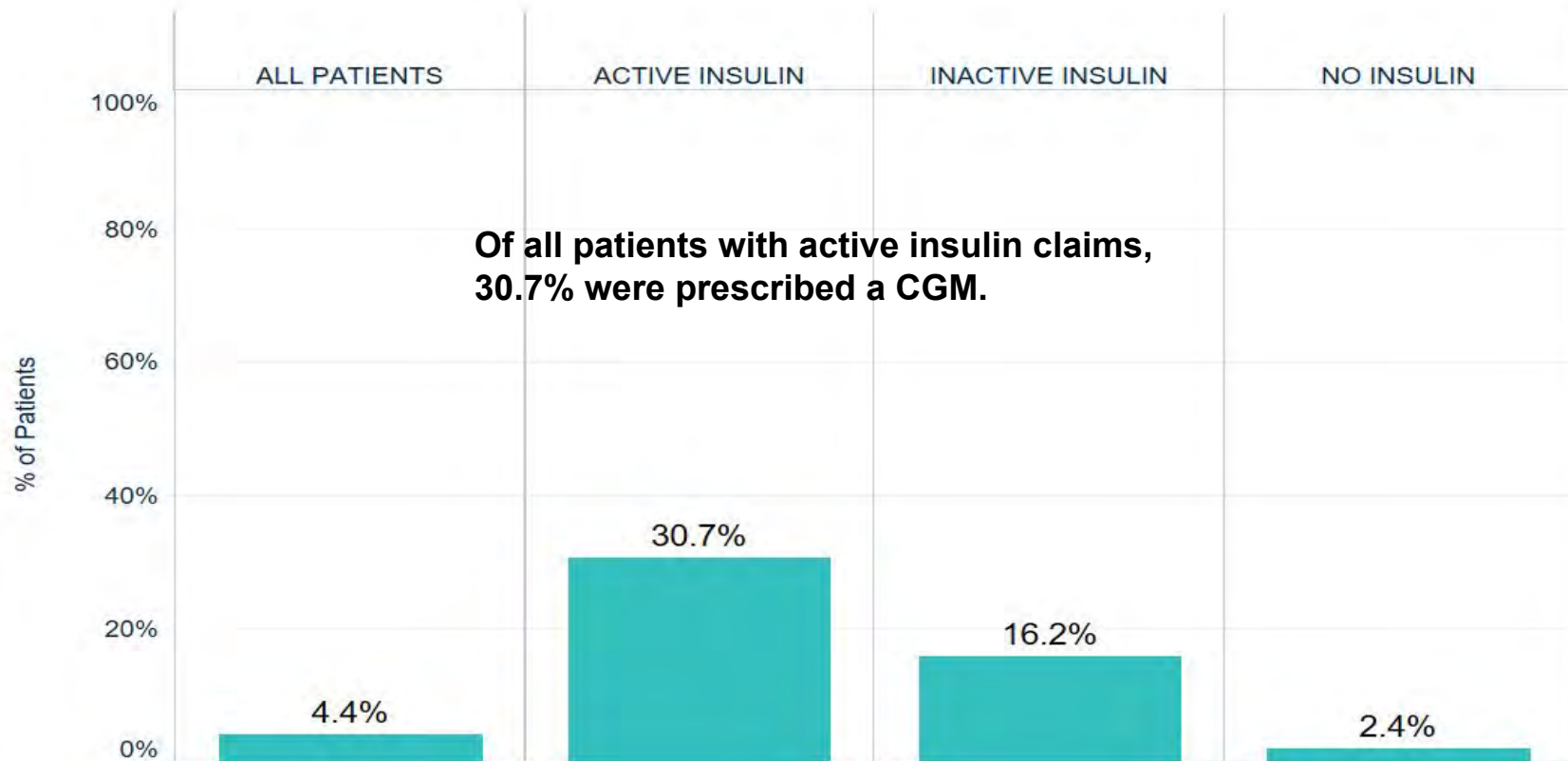
July 1, 2020 - February 28, 2023



CGM (Last 12 Months)

Collaborative

March 1, 2022 - February 28, 2023





Larrea Young



Noa Kim (they/them)



Julian Weisensel (He/Him)



Jacqueline Rau



Katherine Lisa Khosrovaneh



Lypha Yang



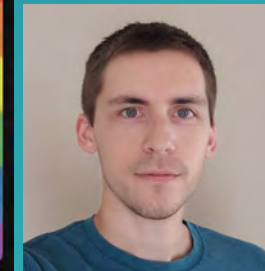
Neha Bhomia



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 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
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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

Our Team



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

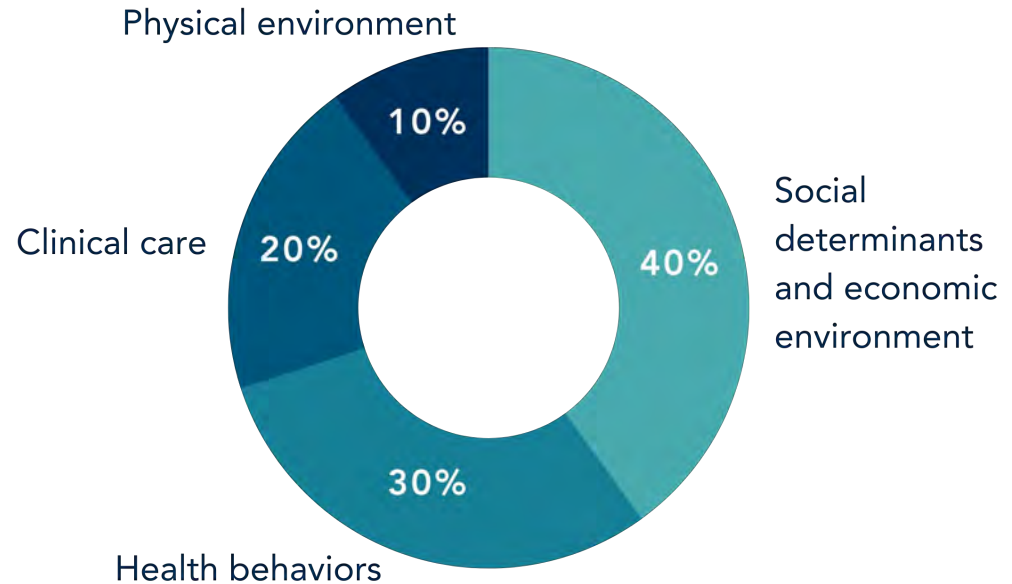
- Neighborhood revitalization instead of gentrification
- The unhindered ability to engage in political processes
- Access to homeownership
- Access to various food options
- Access to educational opportunities that allow for advancement

Health Care Equity

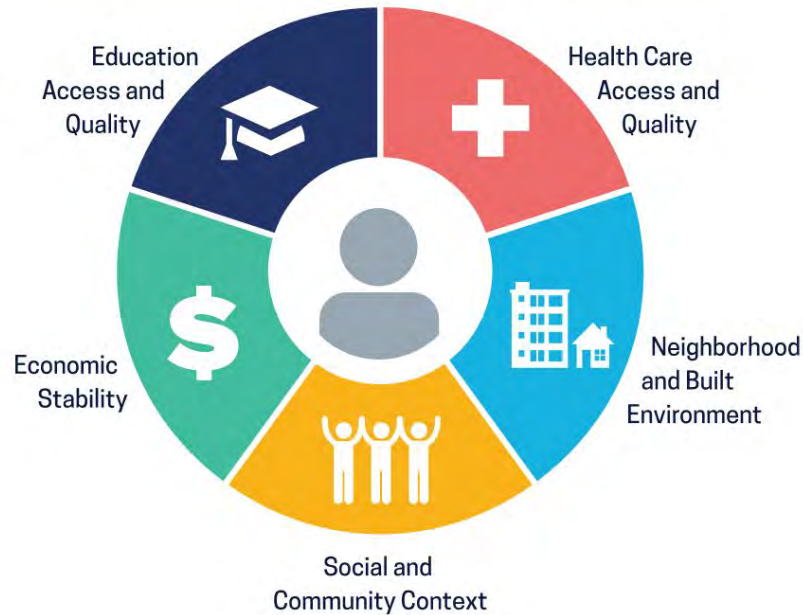
- Providing low-cost, basic health care services to low-income neighborhoods.
- Mobile health screenings to provide treatment to those without transportation.
- Offering free health seminars targeted toward the health issues of historically marginalized populations.
- Providing health appointments after 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, walkable areas,
fast food outlets, etc. and more. For
BIPoC there are a number of T2D
risks among the food insecure
population have a 2x higher T2D
rate than college educated adults

County Health Rankings Model | Accessed June 8, 2023
Minnesota State | 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

Multiple studies show relationships between SDCH, 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^{1,2}, Kai McKeever Bullard¹, Karen R Siegel², Jean M Lawrence³

By the Correspondence: Sarah S Casagrande, MD, MPH, Division of General Internal Medicine, University of Michigan, 1600 Hill Street, Ann Arbor, MI 48106-0610, USA. Email: scasagr@umich.edu

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Check for updates

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BMJ Open 2022;16:e025000. doi:10.1136/bmjopen-2021-025000

ABSTRACT
Objective A healthy diet is recommended to support diabetes management, including HbA1c, blood pressure, and cardiovascular (CVD) control, but food insecurity is a barrier to consuming a healthy diet. We determined the prevalence of food insecurity and diet quality among US adults with diabetes and the associations with A1C management.

Research design and methods Cross-sectional analyses were conducted among 2073 adults ≥20 years with diagnosed diabetes who participated in the 2013–2014 National Health and Nutrition Examination Survey. Food insecurity was assessed using a standard questionnaire and diet quality was assessed using quartiles of the 2014 Healthy Eating Index. Adjusted ORs, 95% CIs were calculated from logistic regression models to determine the association between household food insecurity/diet quality and the A1C while controlling for sociodemographic characteristics, healthcare utilization, smoking, medication for diabetes, blood pressure, or cholesterol, and body mass index.

Results Overall, 17.6% of adults had food insecurity; diet quality was 14.7% below the recommended diet quality. 33.1% had food insecurity and diet quality, and 35.2% had food insecurity and diet quality. Compared with adults with food security and diet quality, those with food insecurity and diet quality were significantly more likely to have HbA1c ≥9.0% (OR 1.5, 95% CI 1.2 to 1.9) and HbA1c ≥8.0% (OR 1.7, 95% CI 1.4 to 2.1) but diet quality was significantly associated with elevated HbA1c and food insecurity/diet quality with elevated A1C.

Conclusions Food insecurity, regardless of diet quality, was significantly associated with elevated A1c, for people with food insecurity, providing resources to reduce food insecurity could improve the overall approach to optimal diabetes management.

INTRODUCTION
The American Diabetes Association (ADA) recommends that individuals with diabetes eat a healthy diet that includes a variety of non-starchy foods such as fruits, vegetables, and whole grains in appropriate portions and is limited in added sugars and fats.¹ A report based on the 1999–2002 National Health and Nutrition Examination Survey (NHANES) demonstrated that diabetes prevalence was higher among people with severe food insecurity than people without food

WHAT IS ALREADY KNOWN ON THIS TOPIC

While a healthy diet is important for people with diabetes to manage their disease, food insecurity may negatively impact healthy eating. Few national studies have assessed the contribution of food insecurity and diet quality on the management of diabetes.

WHAT THIS STUDY ADDS
Among a national sample of adults with diabetes, food insecurity, regardless of diet quality, was significantly associated with elevated A1c.
Low diet quality, even in the presence of food insecurity, was significantly associated with elevated A1c.
There were no statistically significant associations between food insecurity and low diet quality, high blood pressure, or elevated low-density lipoprotein cholesterol.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

Identifying persons with food insecurity in health-care settings and referring them to interventions and resources to reduce food insecurity could strengthen the overall approach to optimal diabetes management.

body weight; achieve individualised HbA1c, blood pressure (BP), and cholesterol (C) targets; and delay or prevent cardiovascular and diabetes-related complications.² However, there are barriers to consuming a healthy diet, including adequate disposable income to purchase food, access to healthy food, education on preparing and cooking healthy meals, and healthy eating support from friends and family.^{3,4}

Food security, a state of having reliable access to sufficient quantities of affordable and nutritious food, is one factor that may affect eating a healthy diet among people with diabetes.⁵ A report based on the 1999–2002 National Health and Nutrition Examination Survey (NHANES) demonstrated that diabetes prevalence was higher among people with severe food insecurity than people without food

THE IMPACT OF SOCIAL DETERMINANTS ON TYPE 2 DIABETES

An analytical study



INTRODUCTION

A whole-person analytical analysis was conducted and revealed novel and actionable insights to reduce the burden of diabetes for our members. Integrated social determinants of health (SDOH), clinical, behavioral and financial data were analyzed to understand the impact of social determinants on Type 2 diabetes (T2D) incidence, severity, and progression. Findings from this study support the need to address social determinant interventions, to reduce the incidence and severity of diabetes across all lines of business—including commercial markets—contrary to some opinions. While the amount of members without any SDCH factors diminished in the advanced stages of the disease, unique clinical and non-clinical factors emerged for each line of business as it relates to the progression of diabetes. Findings from this analysis have informed our enterprise diabetes strategy and provided a data driven path towards advancing health equity and reducing the social and economic burden of diabetes.

Over the past two decades, the rate of diabetes has doubled in the U.S., now ranking as the seventh leading cause of death.¹ The burden of this disease is not shared equally, however.



¹ Wang J. Diabetes. *StatPearls*. October 25, 2021. | <https://www.ncbi.nlm.nih.gov/books/NBK537028/>
² Healthy Heart Rankings Model. Accessed October 18, 2022.

218

Diabetes Care Volume 44, January 2021



Social Determinants of Health and Diabetes: A Scientific Review

Diabetes Care 2021;44:258–279 | <https://doi.org/10.2337/DC200303>



Felicia H. Briggs,^{1,2} Nancy E. Adler,³ Seth A. Berkowitz,⁴ Marshall H. Chin,⁵ Jeffrey L. Gary, Heidi A. Jonsson-Aker, Pamela L. Thornton,⁶ and Debra Heem-Joshi⁷

Decades of research have demonstrated that diabetes affects racial and ethnic minority and low-income adult populations in the U.S. disproportionately, with relatively intractable patterns seen in these populations: higher risk of diabetes and rates of diabetes complications and mortality (1). With a health care shift toward greater emphasis on population health outcomes and value-based care, social determinants of health (SDOH) have risen to the forefront as essential interventions targets to achieve health equity (2–4). Most recently, the COVID-19 pandemic has highlighted unequal vulnerabilities borne by racial and ethnic minority groups and by disadvantaged communities. In the wake of concurrent pandemic and racial justice events in the U.S., the American College of Physicians, American Academy of Pediatrics, Society of General Internal Medicine, National Academy of Medicine, and other professional organizations have published statements on SDOH (5–8), and calls to action focus on amelioration of these determinants as individual, organizational, and policy levels (9–11). In diabetes, understanding and mitigating the impact of SDOH are priorities due to disease prevention, economic costs, and disproportionate population burden (12–14). In 2013, the American Diabetes Association (ADA) published a scientific statement on sociological determinants of prediabetes and type 2 diabetes (15). Toward the goal of understanding and advancing opportunities for health improvement among the population with diabetes through addressing SDOH, ADA convened the current SDCH and diabetes writing committee, preeminent, to review the literature on 1) associations of SDOH with diabetes risk and outcomes and 2) impact of interventions to targeting amelioration of SDOH on diabetes outcomes. This article begins with an overview of key definitions and SDOH frameworks. The literature review focuses primarily on U.S. based studies of adults with diabetes and on five SDOH: socioeconomic status (education, income, occupation), neighborhood and physical environment (housing, built environment, toxic environmental exposures), food environment (food insecurity, food access), health care (access, affordability, quality), and social context (social cohesion, social capital, social support). This review concludes with recommendations for linkages across health care and community sectors from national advisory committees, recommendations for diabetes research, and recommendations for research to inform practice.

DEFINITIONS OF HEALTH DISPARITIES, HEALTH EQUITY, AND SDOH

Table 1 displays definitions of key terms. Differences in diabetes risk and outcomes can result from multiple contributors, including biological, clinical, and sociocultural factors (1). A substantial body of scientific literature demonstrates the adverse impact of a particular type of difference, health disparities (16) in diabetes (17,18). A preponderance of health disparities research in the U.S. has examined disparities by race and ethnicity (3,19). Internationally, the term health equity has traditionally been used to encompass the range of population inequalities resulting from demographic and economic characteristics, and this term is used increasingly in the U.S. (20–24). Addressing healthy equity necessitates an understanding of social and environmental factors that combined account for 30% to 40% of health outcomes (22,25). These social and environmental factors collectively are known as SDOH (23,27).

SDOH NOMENCLATURES AND CONTEXTUAL FACTORS

The writing committee reviewed the following commonly referenced SDOH frameworks for classifications and terminology: the World Health Organization (WHO) Commission on Social Determinants of Health (26), Healthy People 2020 (29,30), the

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Received 21 September 2020 and accepted 25 November 2020

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See accompanying articles, pp. 1, 8, 11, and 188.





Measuring Health Equity

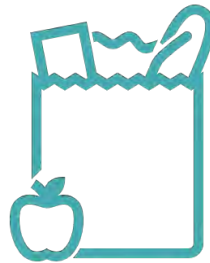
Exploring available data

- 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?

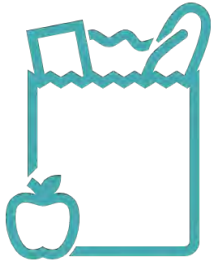
Are you worried that in the next 2 months, you may not have (stable) housing?

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

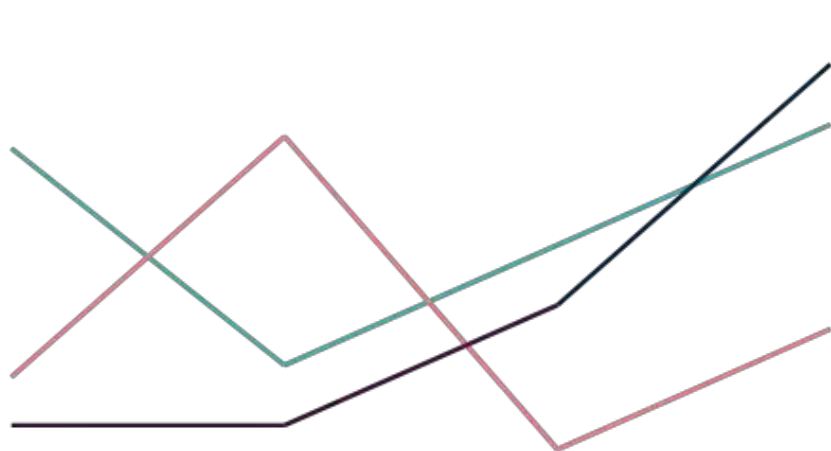
Can you match the need to a
program?
What information is needed to
provide help today?

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.

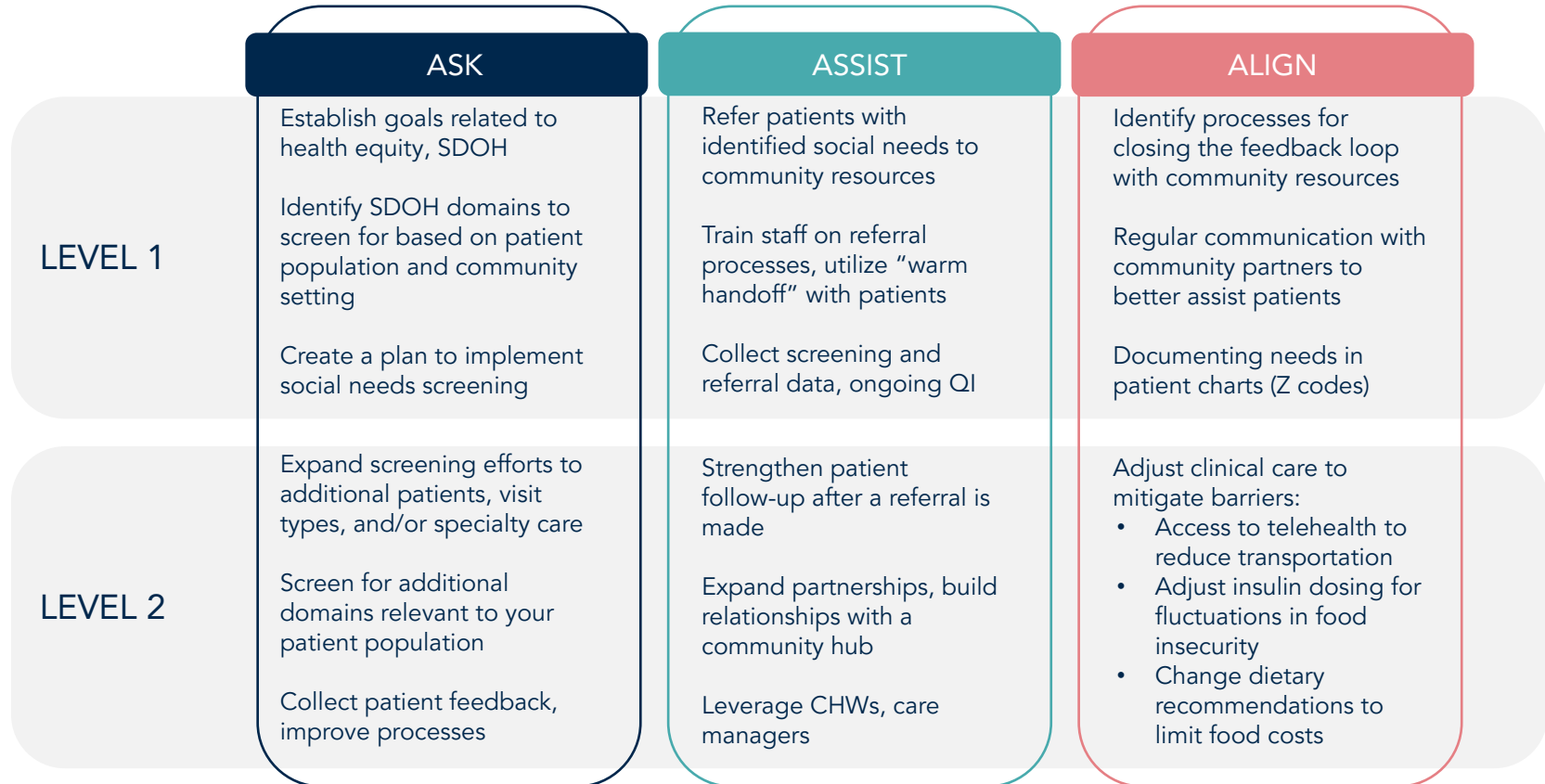
ASSIST

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

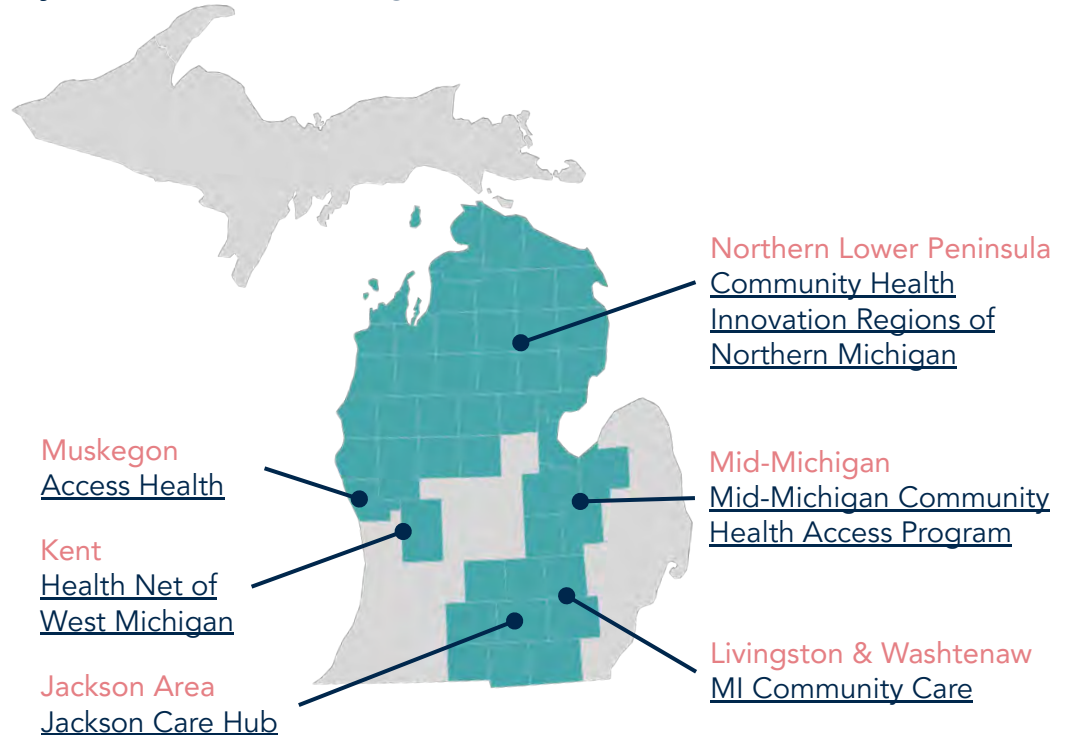
We work with transformative community hubs across Michigan:

- 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

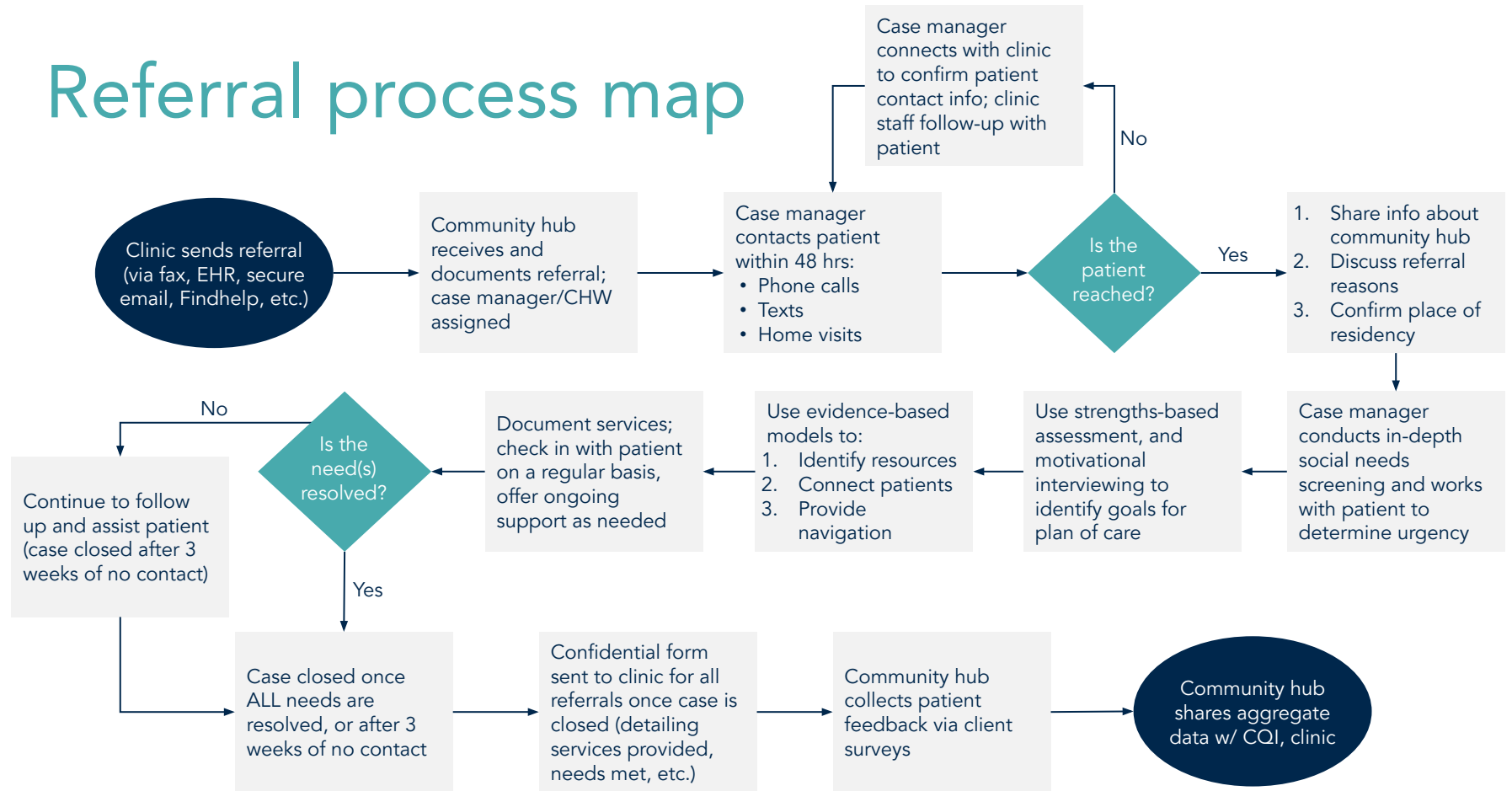
To learn more about our partners, visit:



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!

Contact Us:

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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



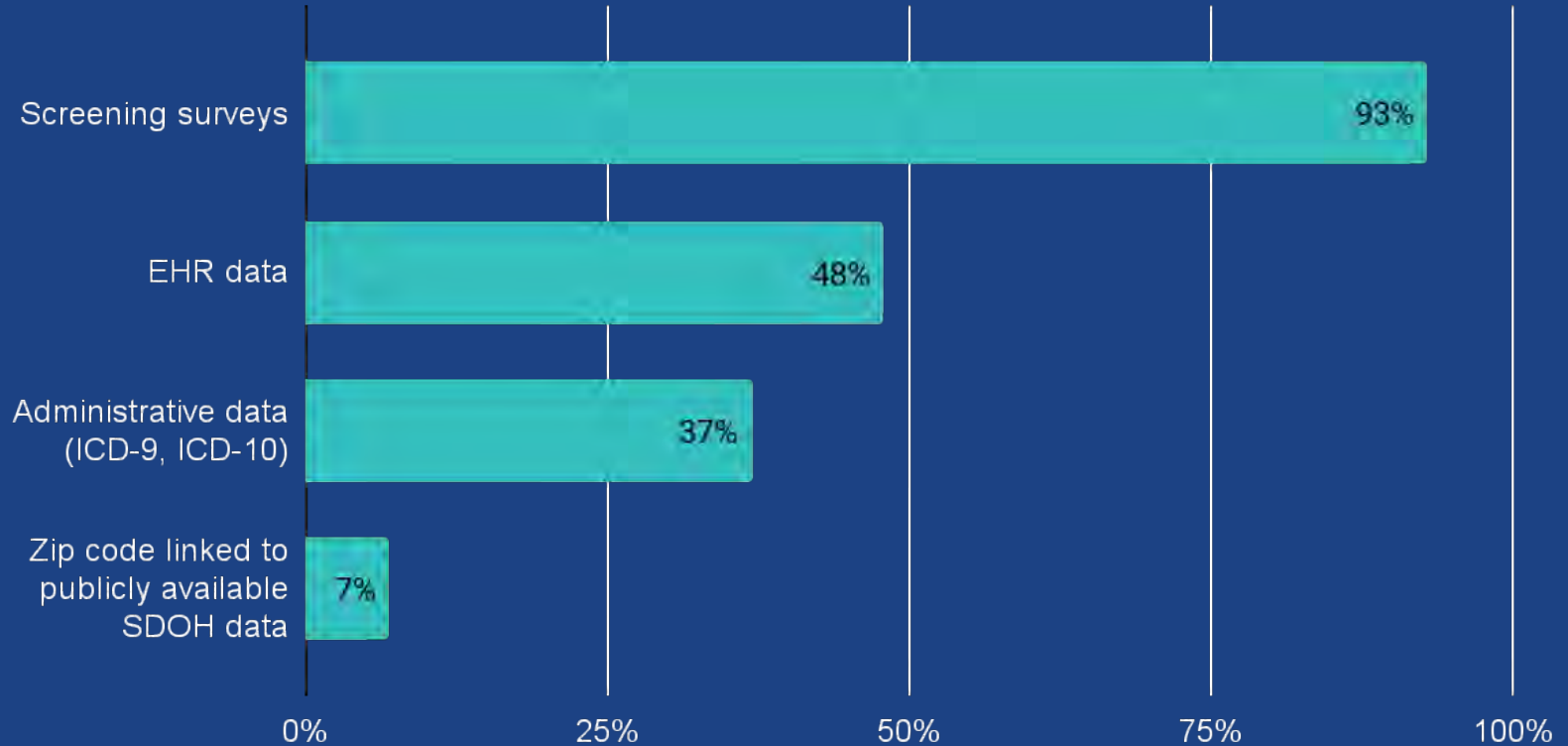
1. "Within the past 12 months we worried whether our food would run out before we got money to buy more."
 Often true Sometimes true Never true
2. "Within the past 12 months the food we bought just didn't last and we didn't have money to get more."
 Often true Sometimes true Never true
3. What is your 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, 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?		
Gender	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 mentally causing you harm?		

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? Yes No

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

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? 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 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, tablet/PCs) 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

PRAPA: Protocol for Responding to and

Date Completed/Updated: 08/17/2020

Patient Name: Ducky Feet

Address: 4788 Address-Rescheduler

Race: Declined to Specify

Ethnicity: Declined to Specify

Insurance: DEHS of Michigan

Insurance Class: Unknown

Income Level: Unknown

ED: Unknown

Sign-out: Unknown

Sexual-act: Unknown

Violence: Unknown

Money & Resources

What is your current housing situation?

Rent apartment

Do not have housing (staying with others, in a hotel, in a shelter, being evicted from the street, etc. in a past)

I choose not to answer this question

Are you worried about losing your housing?

Yes

I choose not to answer this question

What is the highest level of school that you have finished?

Less than a high school degree

High school diploma or GED

More than high school

I choose not to answer this question

What is your current work situation?

Unemployed and seeking work

Part time or temporary work

Full time work

Otherwise unemployed but not seeking work (see: disabled, retired, disabled, unpaid primary care giver)

I choose not to answer this question

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? Check all that apply

Food

Clothing

Utilities

Other care

Medicine or any health care (preventive, acute, mental health or vision)

Other (please write in notes)

I do not have problems meeting my needs

I choose not to answer this question

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

Yes, it has kept me from medical appointments or from getting my medications

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: _____

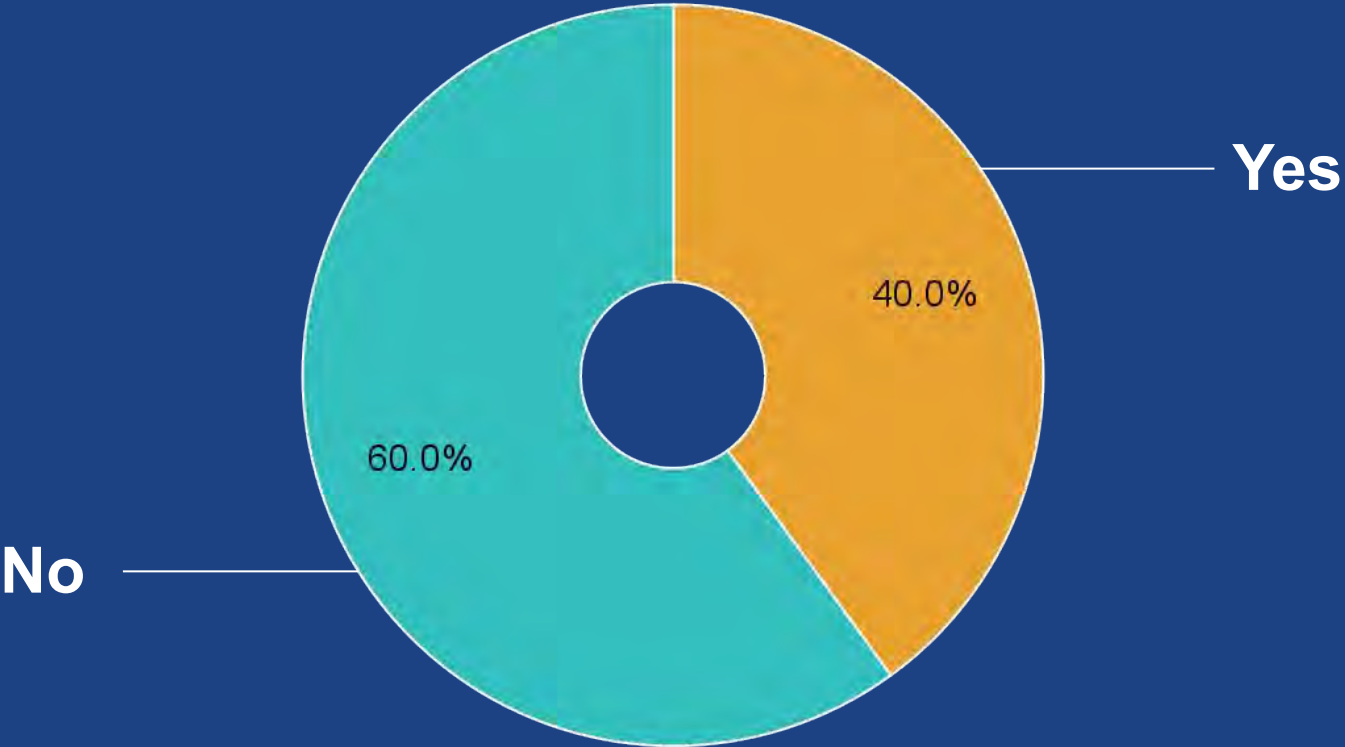
Please check Yes or No to the following questions:

	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 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?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
02: In the past year, was the utility company shut off your services for not paying your bills?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
04: In the last 12 months, do you skip medications to save money?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
05: In the last 6 months, have you ever had to go without health care because you didn't have a way to get there?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
06: Do problems getting child care or elderly care make it difficult to work or study?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
07: Do you need any assistance with finding a local career center or job training?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
08: Have trouble understanding my doctor's written instructions.	<input type="checkbox"/> No	<input type="checkbox"/> Yes
09: How often do you feel lonely?	<input type="checkbox"/> Often	<input type="checkbox"/> Some of the time
	<input type="checkbox"/> Fairly often	<input type="checkbox"/> Never
10: Do you ever feel unsafe in your home or neighborhood?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
11: For these needs identified, which would you like help with?	<input type="checkbox"/> Access to Child Care	<input type="checkbox"/> Access to Elderly Care
	<input type="checkbox"/> Financial Resources	<input type="checkbox"/> Food Insecurity
	<input type="checkbox"/> Housing Instability	<input type="checkbox"/> Laundry
	<input type="checkbox"/> Social Isolation	<input type="checkbox"/> Social Transportation Difficulty
	<input type="checkbox"/> Utility Needs	<input type="checkbox"/> 10 Employment
	<input type="checkbox"/> 11 Other	<input type="checkbox"/> 11 Chronic
	<input type="checkbox"/> 12 No help needed	<input type="checkbox"/> 14 Behavioral Health
	<input type="checkbox"/> 18 Sexual Assault	<input type="checkbox"/> 18 Support Care
	<input type="checkbox"/> 19 Chronic Conditions	<input type="checkbox"/> 18 SUD Treatment
	<input type="checkbox"/> 19 PT & OT	<input type="checkbox"/> 20 Diabetes Programs
12: Can we share this information with organizations to whom we make referrals to address these needs?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

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

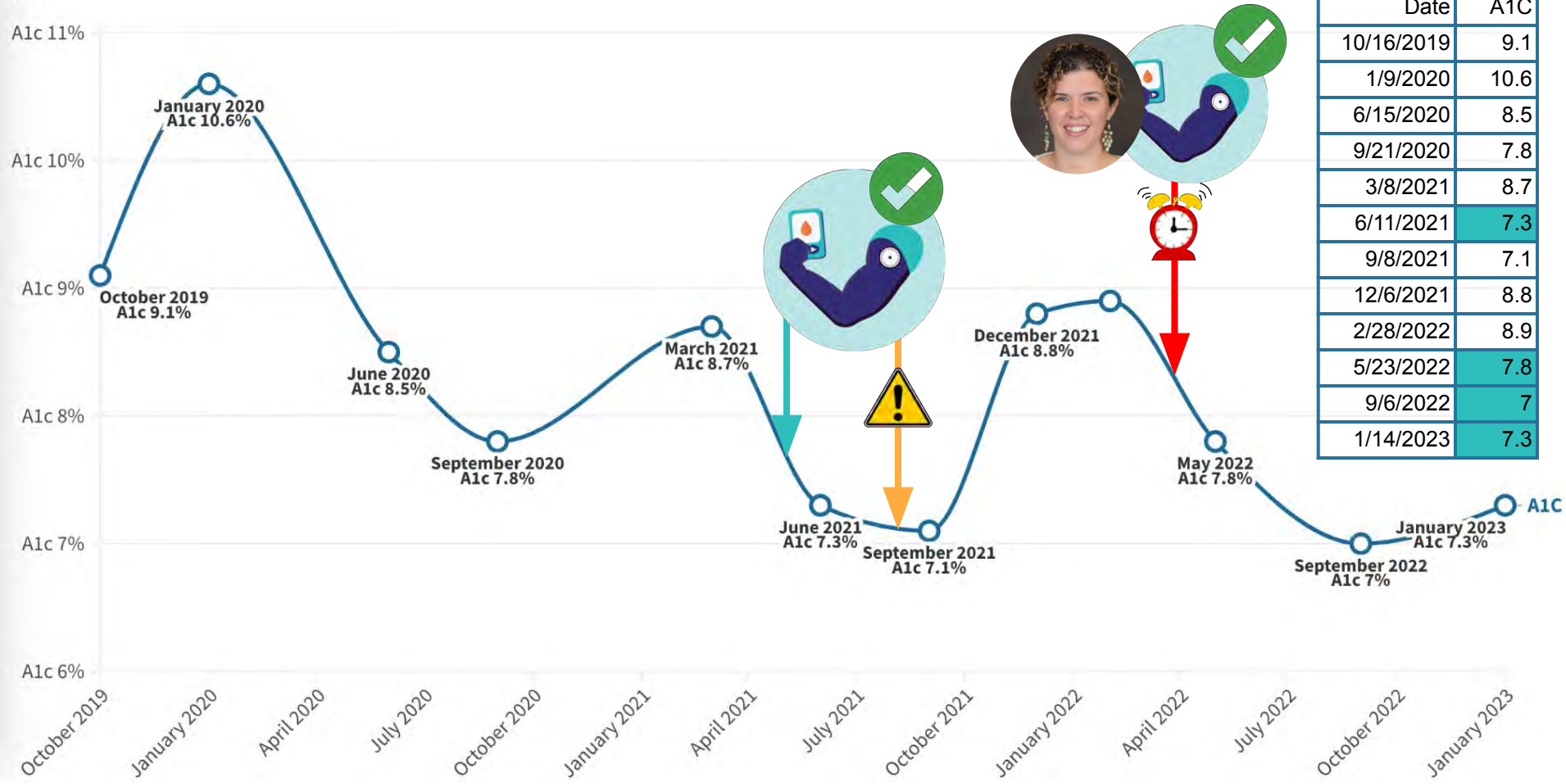
Keith McIntyre

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	R= 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
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26-Sep	112	104	217	R= English muffin with egg and cheese oj, L=	Yes x2		



WARNING
CAUTION: Do not use this device if you are pregnant or breastfeeding. Do not use this device if you are taking insulin. Do not use this device if you are taking any other medication that may affect your blood sugar levels.

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

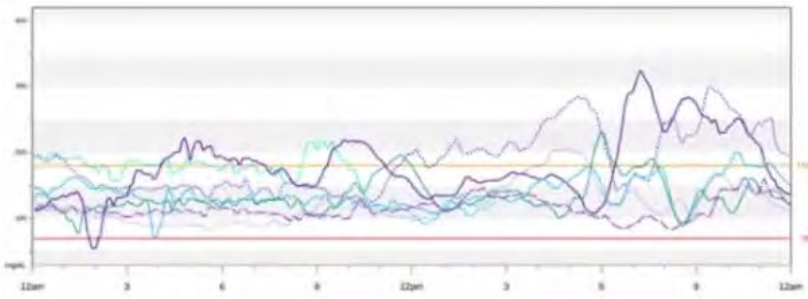
Avg. calibrations per day
2.0

Overlay

14 days | Fri May 2, 2023 | Thu May 10, 2023
Week 1 | Fri May 2, 2023 | Thu May 10, 2023

Glucose
Kath Moninger

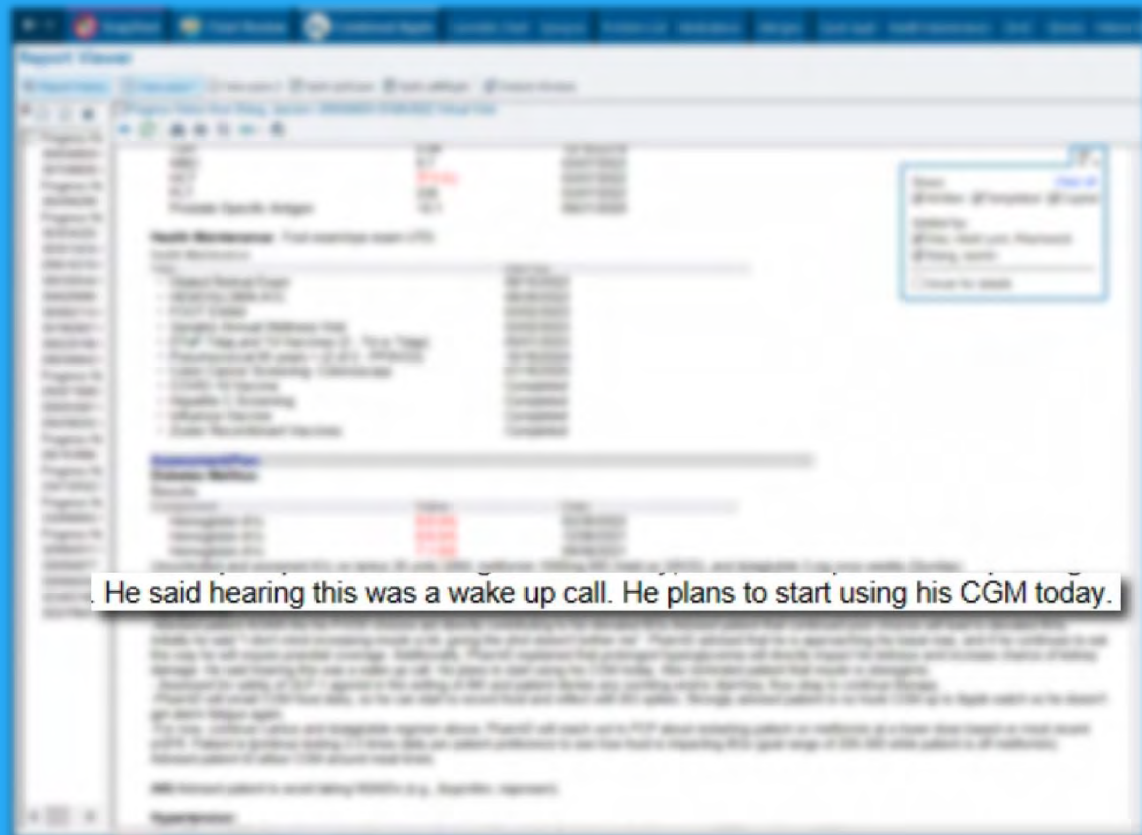
Mon Tue Wed Thu Fri Sat Sun



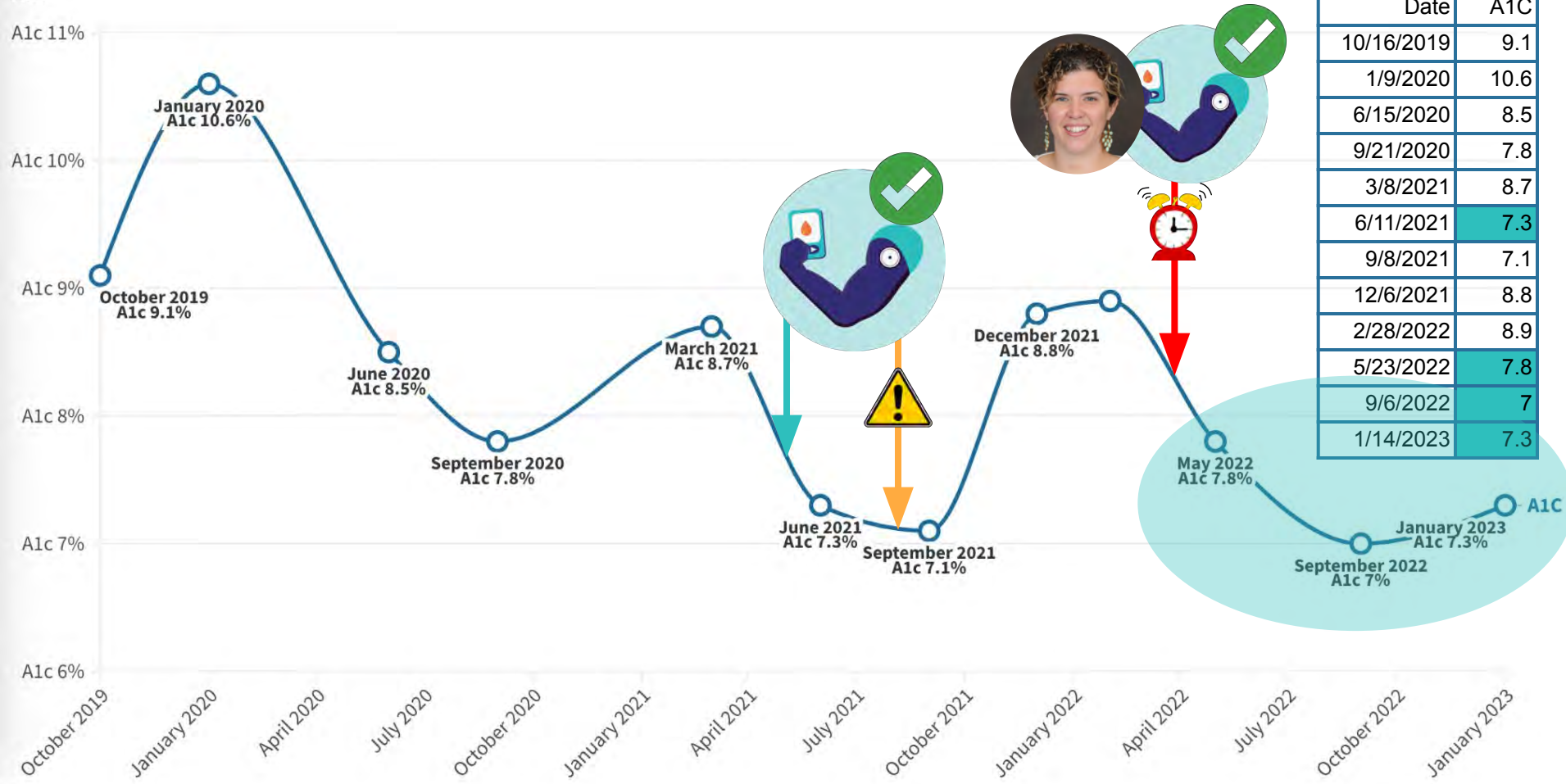
March 2022

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**
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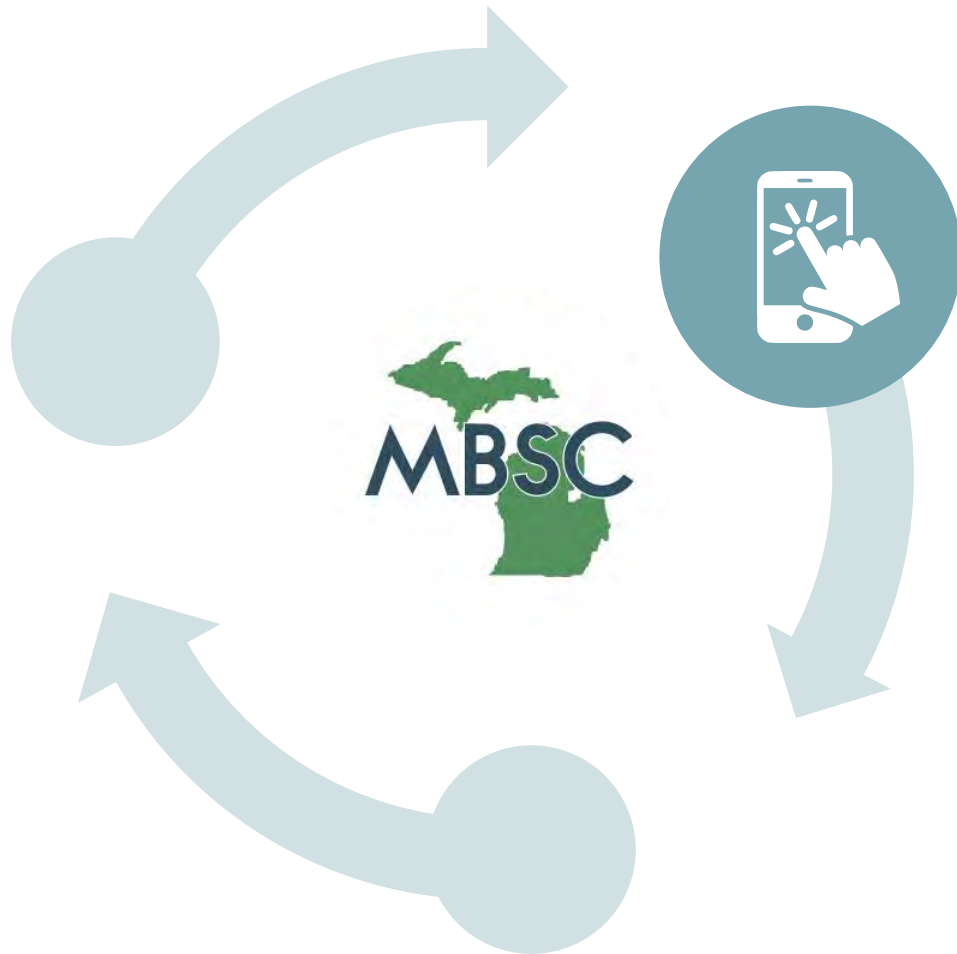
MICHIGAN BARIATRIC SURGERY COLLABORATIVE



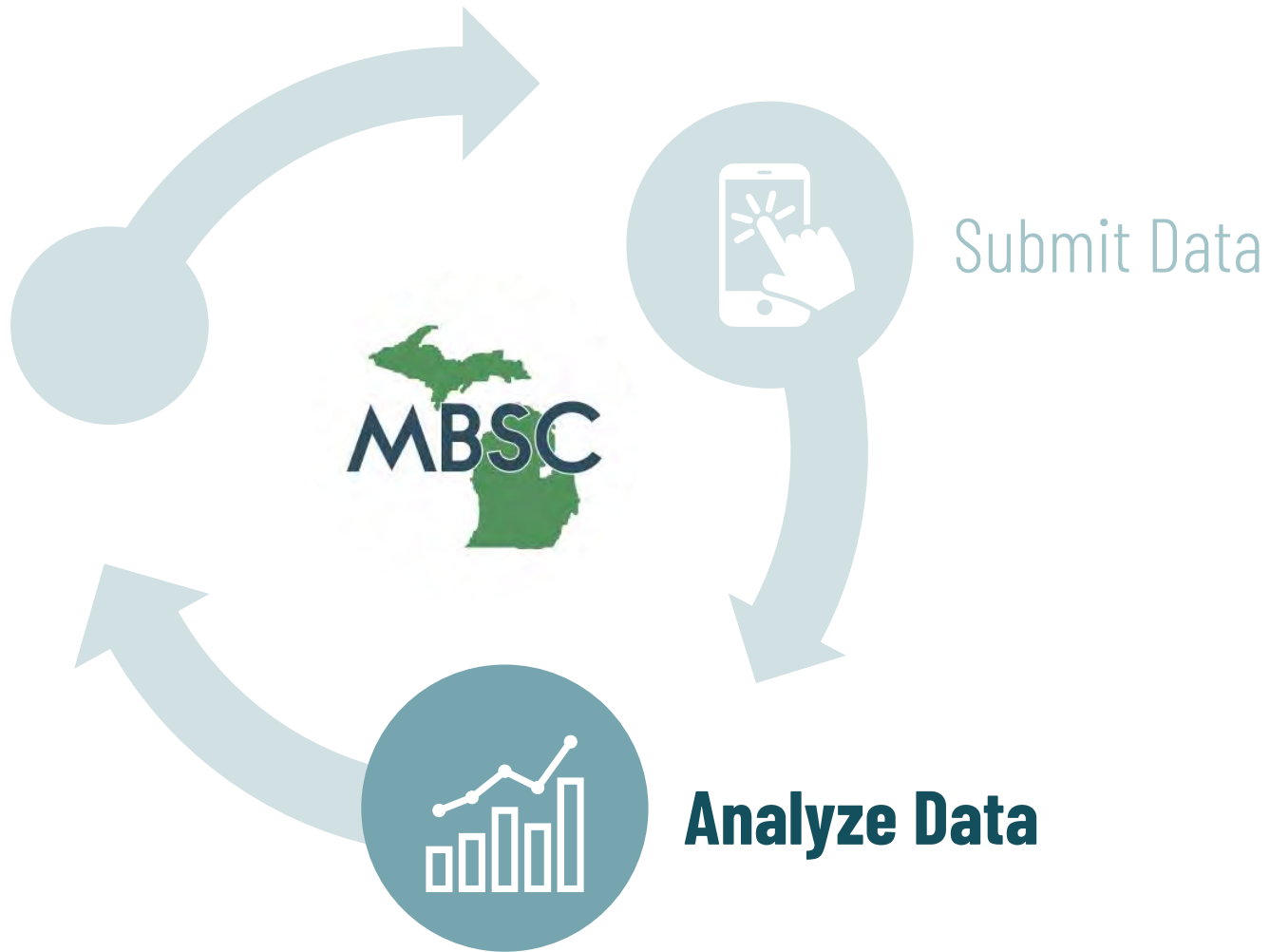
MBSC

15 YEARS
& counting





Submit Data



**Design
Strategy**



Submit Data



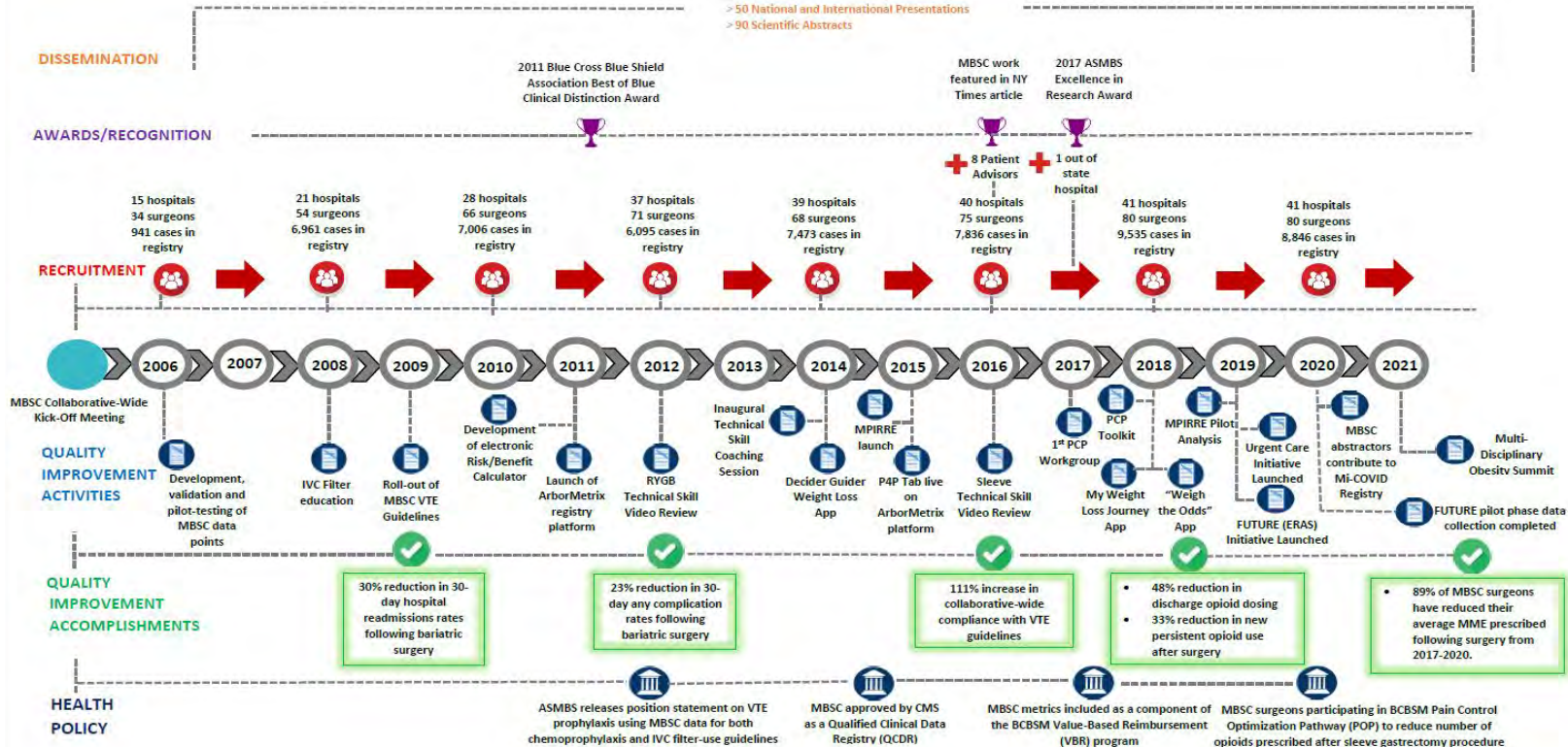
Analyze Data



MBSC Timeline



> 90 Peer-Reviewed Manuscripts
 > 50 National and International Presentations
 > 90 Scientific Abstracts

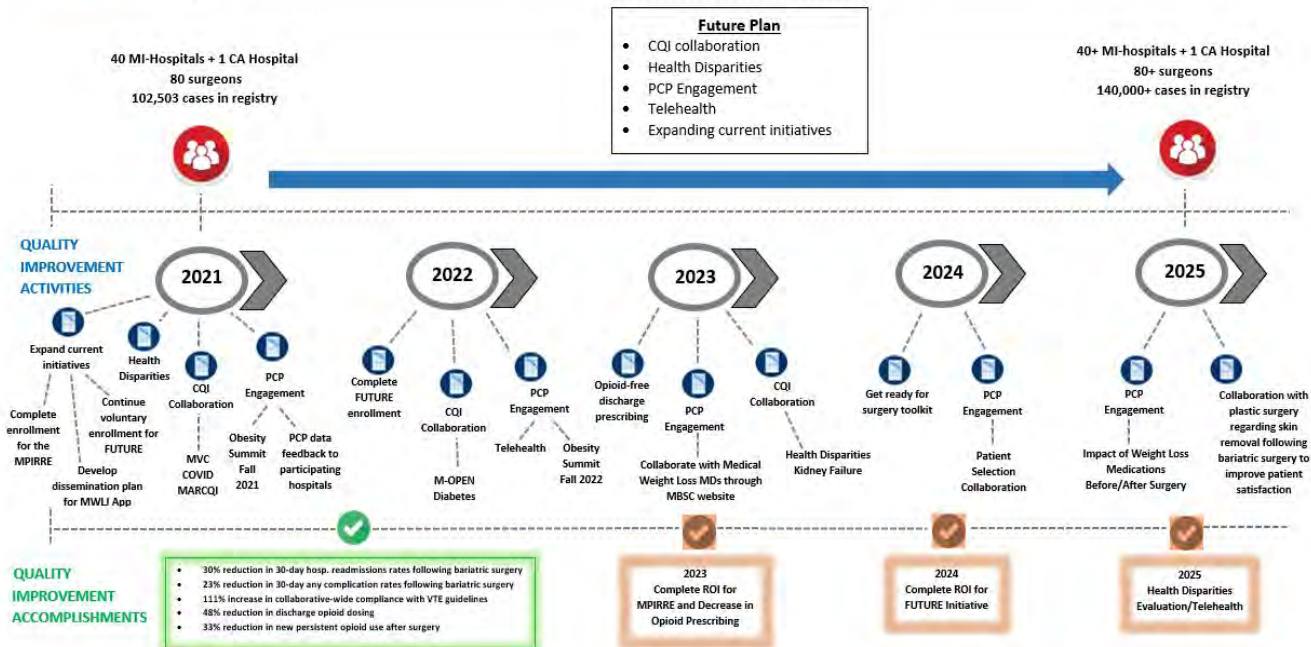


MBSC 5-Year Timeline



- > Manuscripts, Presentations, Scientific Abstracts
- > CQI 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

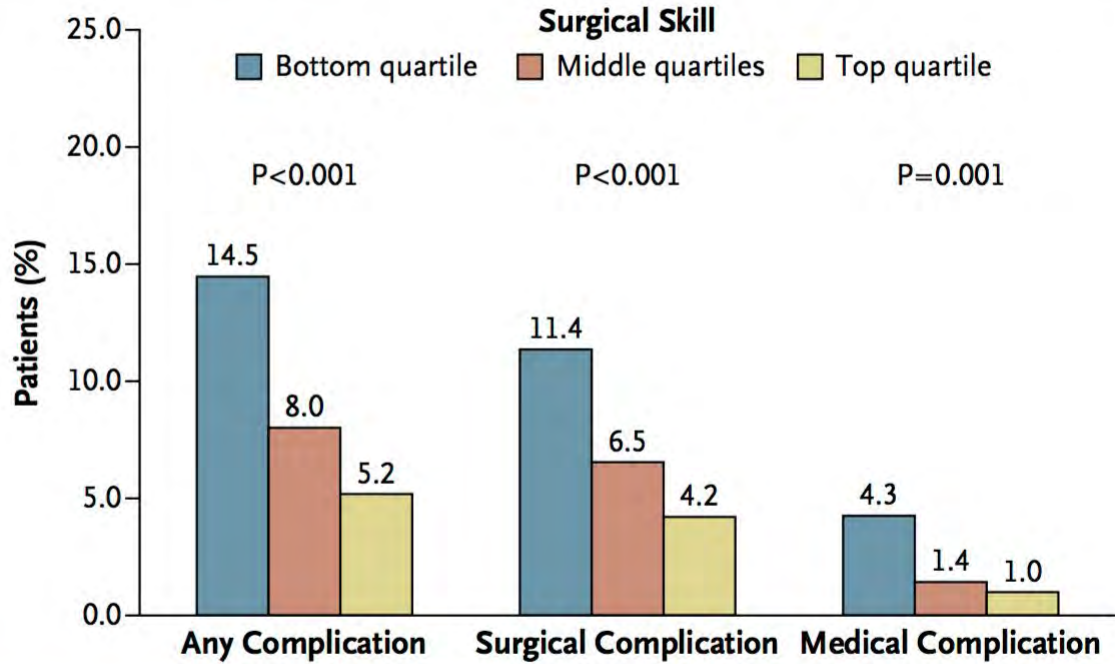


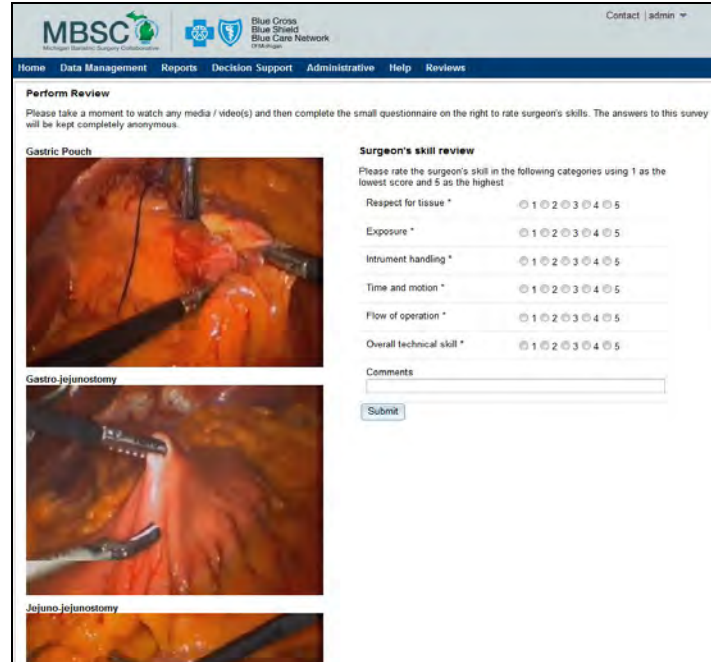
Figure 2. Risk-Adjusted Complication Rates with Laparoscopic Gastric Bypass, According to Quartile of Surgical Skill.

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 Bariatric 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

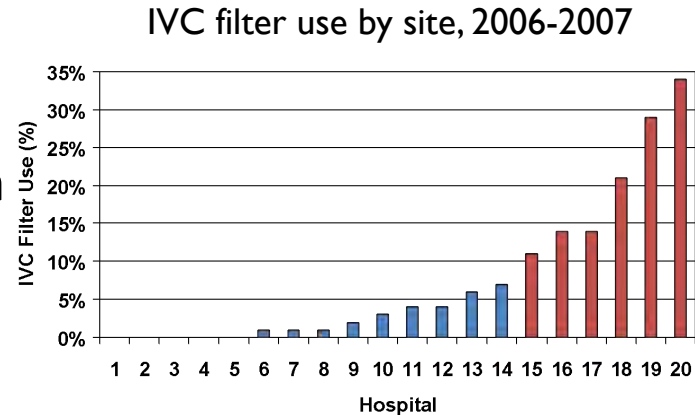
- Challenging to see the data
- Need trust and to share openly
- Rapid practice change can come about with strong data



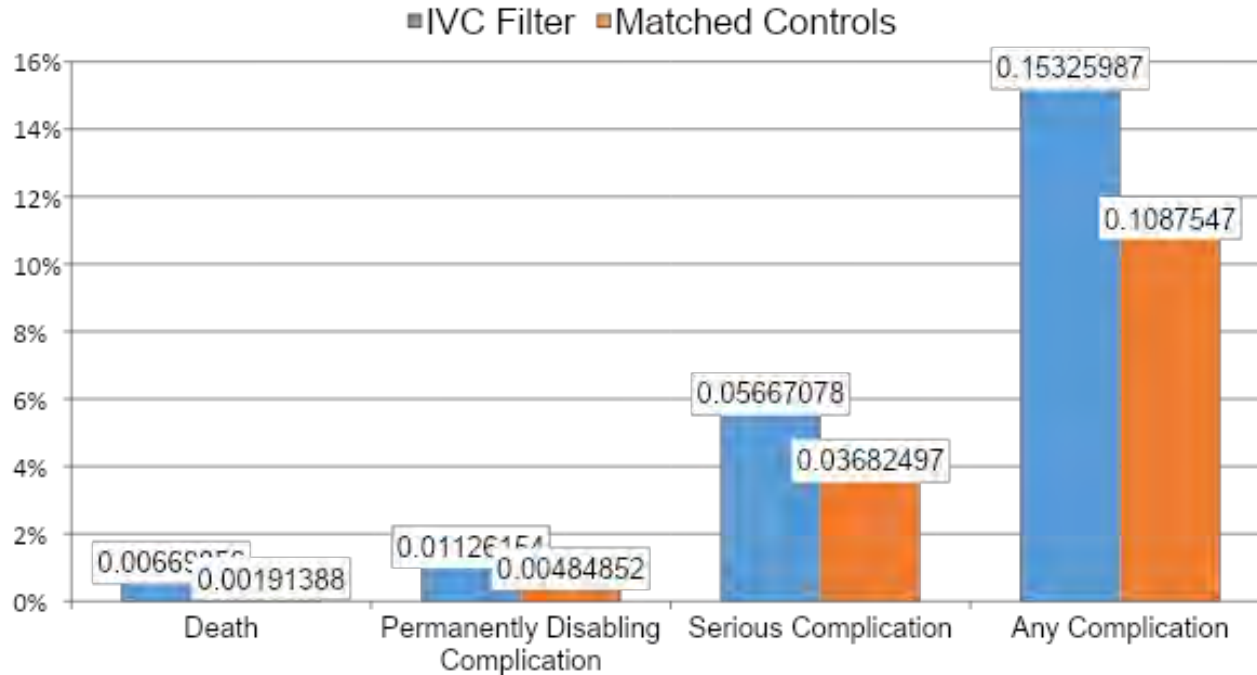
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of the Blue Cross and Blue Shield Association

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

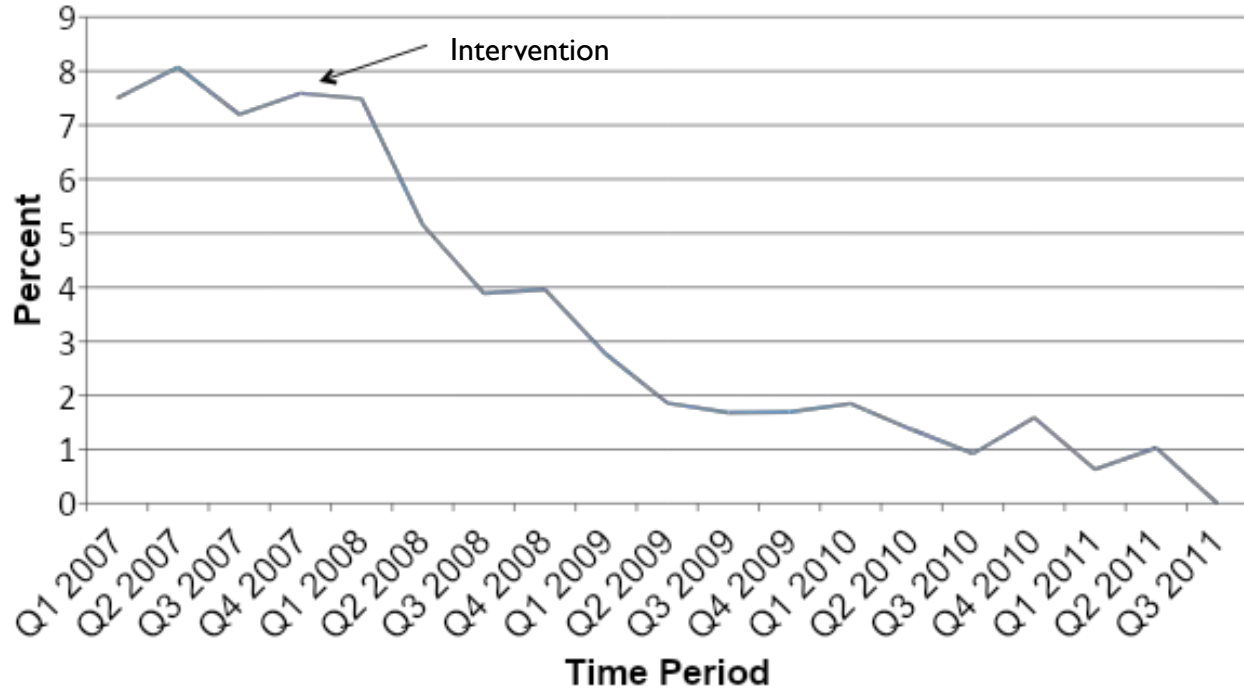
Specific Examples:
Filter migrated to R heart (POD #3), open heart surgery for removal
Bilateral lower extremity thrombosis, vena cava filter thrombosis (POD 4,5), reintubated (POD 5), <u>death</u>
ED (POD 14) for PE, reintubated, cardiac arrest, <u>death</u>
ED/readmitted (POD 13) for excessive anticoagulation 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

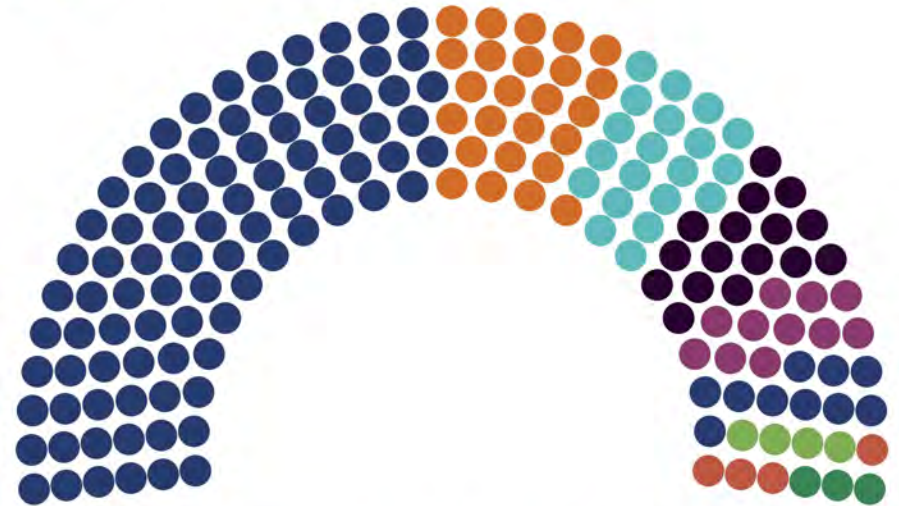
Leadership and Change Management

- 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

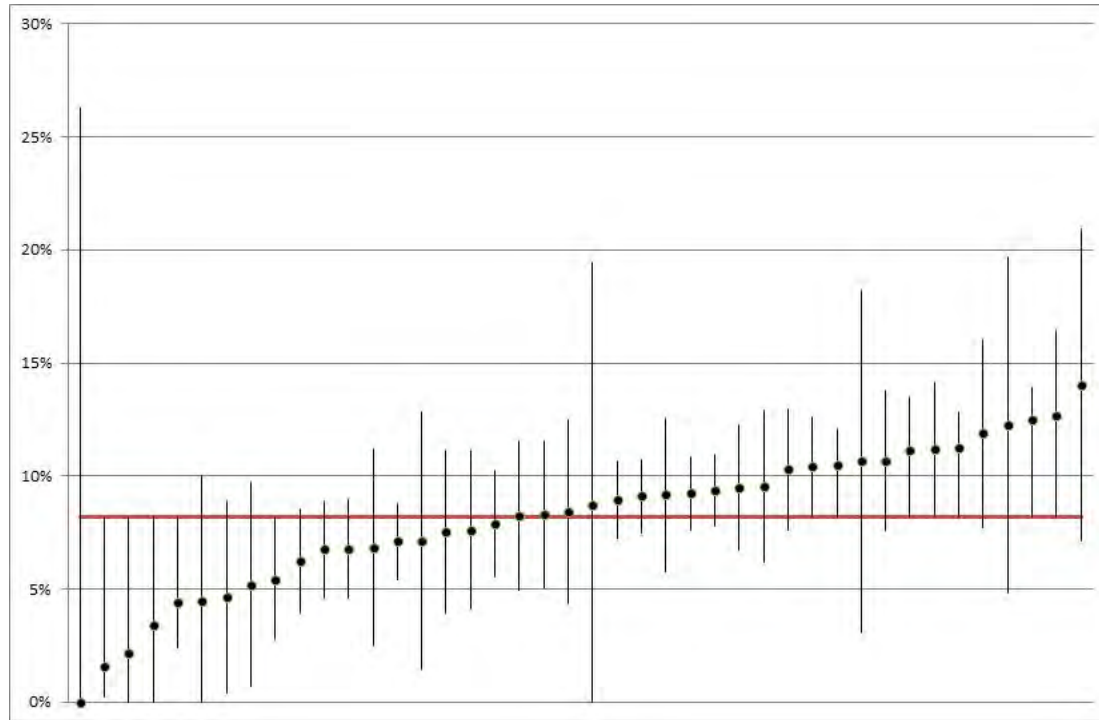
Emergency Department Visits

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





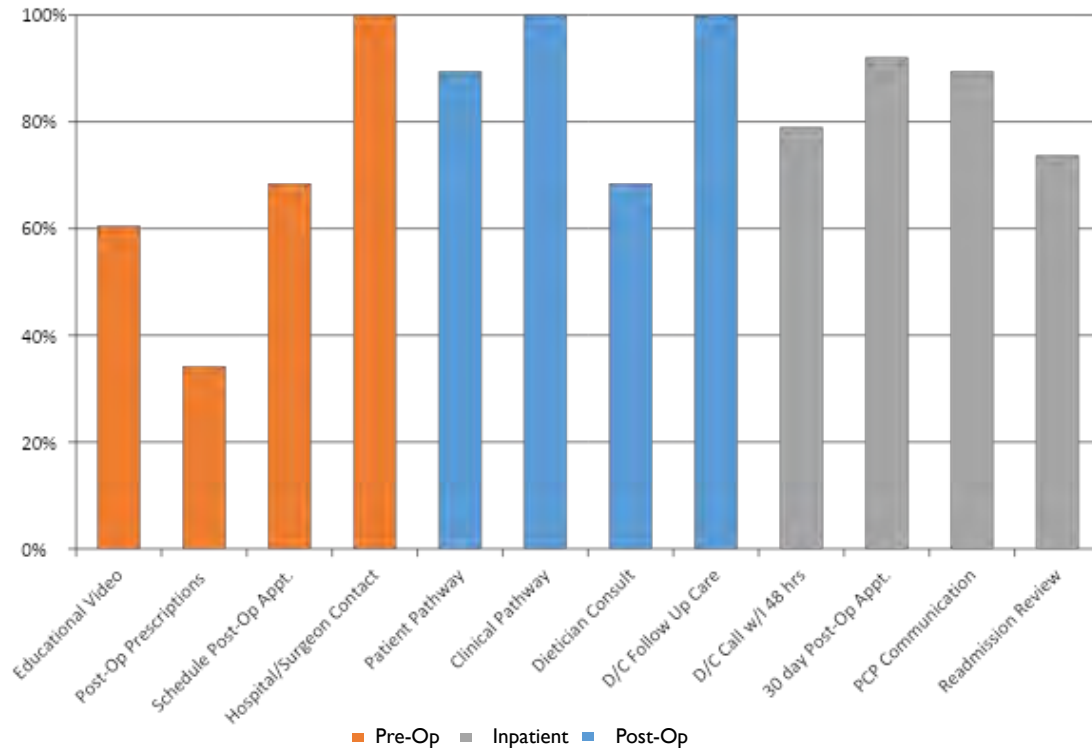
ER Visits Variation By Site



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

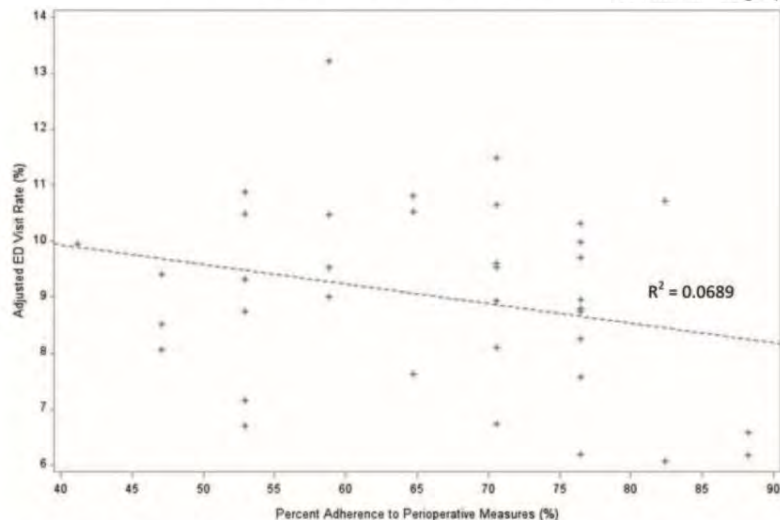


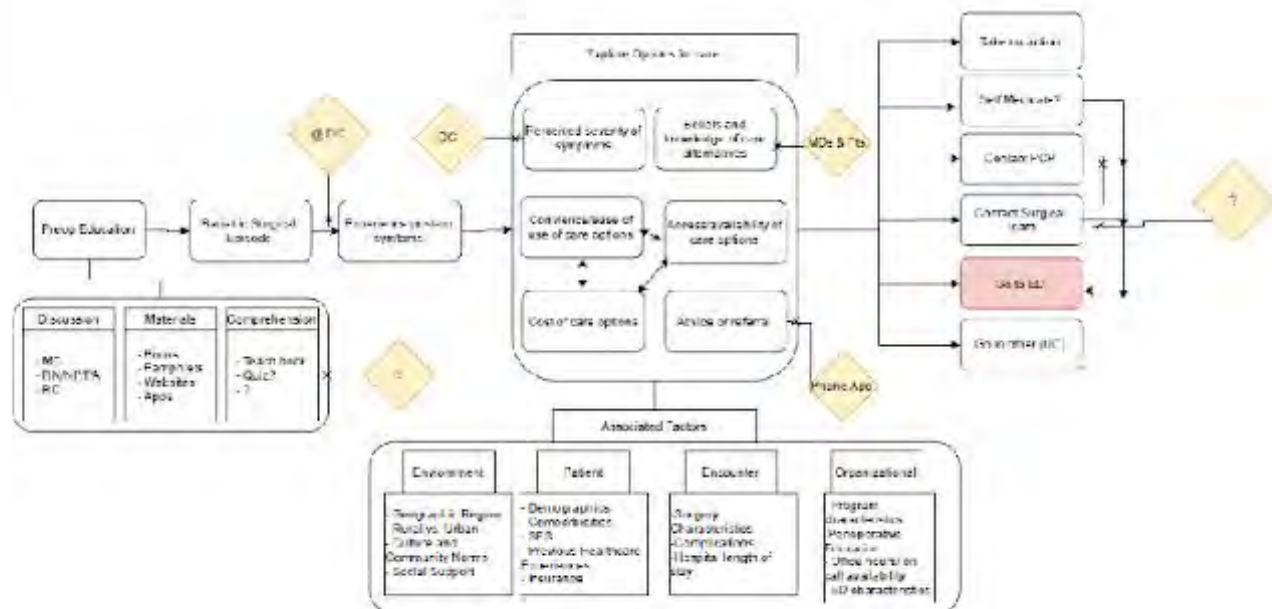
FIGURE 1. The relationship between a hospital's adherence to the perioperative measures surveyed for (Table 1) and ED visit rates.

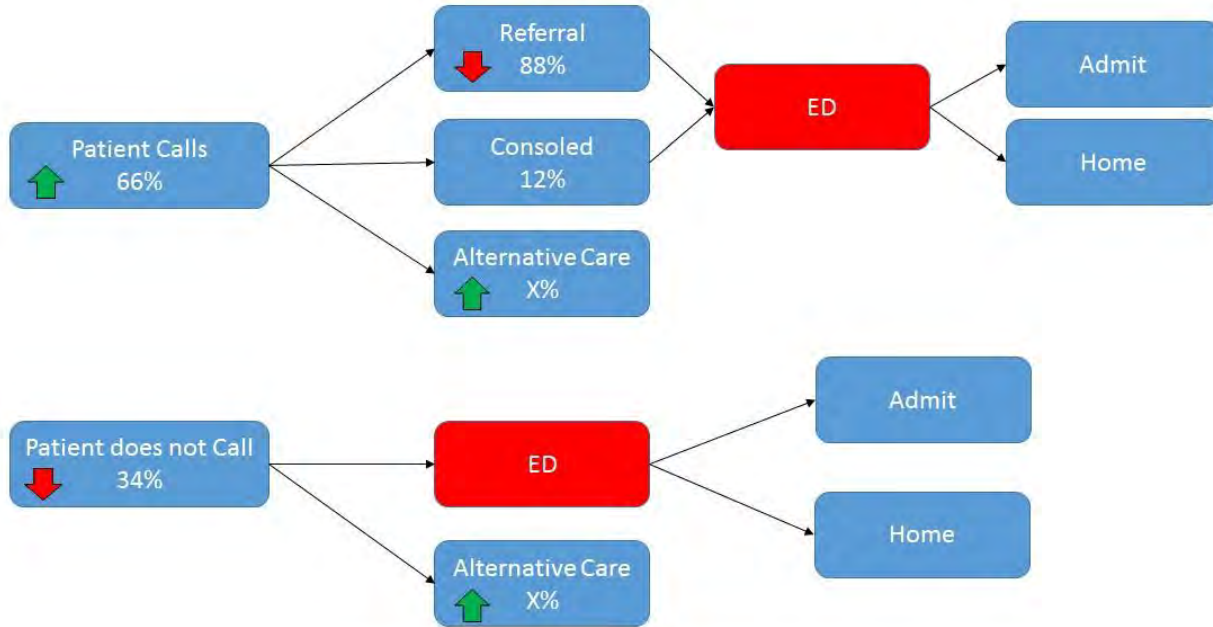
How to improve?

- 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 USA





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!

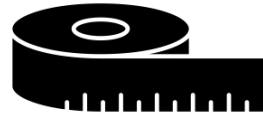
 **twitter** @AmirGhaferi

MichiganBSC.org



Appendix

5 ESSENTIALS OF A GREAT REDESIGN PITCH



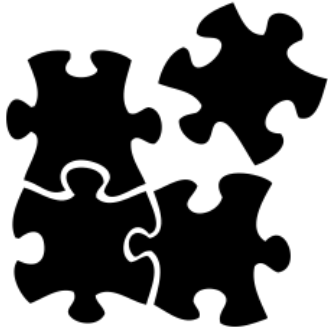
5 ESSENTIALS OF A GREAT REDESIGN PITCH

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



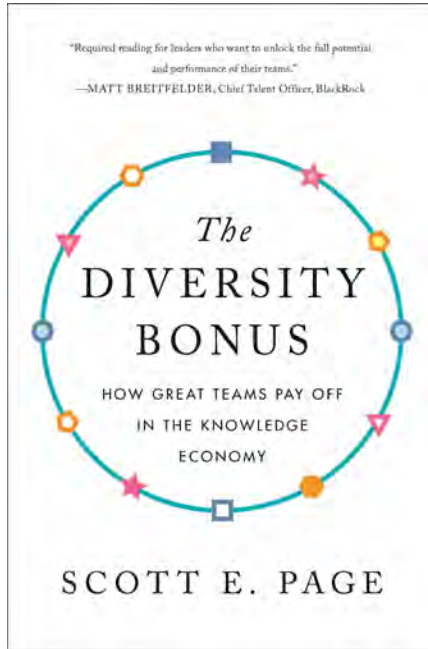
Can You Clearly Define It? It may be a moving target

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



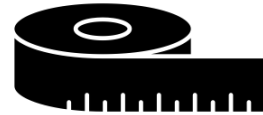
Who Are They? Who are the Critics? Can you align them?

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



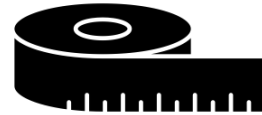
Who Are They? Who are the Critics? Can you align them?

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?