MCT2D
MICHIGAN COLLABORATIVE
FOR TYPE 2 DIABETES

Getting to Know MCT2D

Support for the Michigan Collaborative on Type 2 Diabetes is provided by Blue Cross Blue Shield of Michigan and Blue Care Network as part of the BCBSM Value Partnerships program. BCBSM's Value Partnerships program provides clinical and executive support for all CQI programs. To learn more about Value Partnerships, visit valuepartnerships.com. The opinions, beliefs, and viewpoints expressed by MCT2D do not necessarily reflect the opinions, beliefs, and viewpoints of BCBSM or any of its employees.

Michigan Collaborative for TYPE 2 DIABETES

BACKGROUND

Type 2 diabetes (T2D) is one of the most prevalent, costly, and disabling diseases in the United States. In Michigan alone, diagnosed and undiagnosed type 2 diabetes cases total close to 1 million adults. There have been dramatic advances in our understanding of T2D over the past 20 years. Many new and effective strategies for prevention and treatment have been developed, but dissemination has been challenging. MCT2D is a Blue Cross Blue Shield supported collaborative quality initiative that aims to facilitate the implementation of these new and effective treatment strategies.

MISSION

MCT2D strives to prevent type 2 diabetes and its complications by fostering a collaborative community of clinicians and patients to accelerate the equitable implementation of evidence-based diabetes care for all patients in Michigan.

PARTICIPATION

Physician Organizations (POs): POs will be the primary partners in MCT2D & will facilitate practice participation in the program.

Practices: Primary care practices, endocrinology practices, and nephrology practices will do the work to implement the quality initiatives into their patient care.

Patients: Patients are an vital component of MCT2D, playing an important role as our Patient Advisory Board, giving input on collaborative goals and reviewing patient focused tools.

INITIAL QUALITY INITIATIVES

RATIONAL BEHIND INITIATIVES

Expanding use of continuous glucose monitoring (CGM) devices	CGM devices are low cost and user friendly, they provide real time feedback on food and exercise choices, and detect nighttime hypoglycemia.
Supporting lower-carbohydrate diet interventions	Lower carb diets decrease glucose variability, decrease insulin requirements, support weight loss, and decrease cravings for sugar and fast carbs.
Aligning medication prescribing with guideline directed care	Guideline directed prescribing involves deprescribing of insulin, which can lead to weight gain, and appropriate prescribing of medications such as SGLT2is and GLP-1 RAs for patients with comorbities including chronic kidney disease and heart failure.

2024 TIMELINE

FEBRUARY
Recruitment opens for new POs and existing POs to add new primary care practices to MCT2D.

APRIL
Regional meetings with participating practices

MAY
Recruitment for PCP practices closes

JUNE
Collaborative wide meeting for POs on June 7

SEPTEMBER
Newly enrolled sites begin participation in MCT2D

OCTOBER
Regional meetings with participating practices

DECEMBER
September - December: New site clinical champions complete MCT2D virtual training

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Benefits of Participation:

CLINICIANS

HOW WILL PROVIDERS BENEFIT?

MISSION

MCT2D strives to prevent type 2 diabetes and its complications by fostering a collaborative community of clinicians and patients to accelerate the equitable implementation of evidence-based diabetes care for all patients in Michigan.

PATIENT DATA

Access to dashboards and reporting on patients with type 2 diabetes, with the goal of including all payer data

PATIENT FLAGGING

Patient-specific flagging that identifies patients who may be good candidates for interventions aimed at improving their health

EXPANDED COVERAGE

Participants are able to prescribe CGMs to patients with United Healthcare insurance with only a diagnosis of type 2 diabetes. Physicians will also be able to prescribe the BCBSM Patient Empowerment Toolkit, which includes 6 CGM sensors, and a wireless enabled blood pressure monitor and weight scale.

IMPROVED OUTCOMES

Improved patient outcomes through the implementation of quality initiative measures

TRAINING

Free training that introduces providers to the use of continuous glucose monitors, newer antihyperglycemic medications, and lower-carbohydrate diets

CGM SUPPORT

Individual practice support on implementing and accessing patient CGM data as well as access to the MCT2D CGM User Experience Program where clinicians are able to wear CGM themselves

LEARNING COMMUNITY

Participation in a Learning Community that facilitates eduction, support and engagement between primary care clinicians, patients, and specialists

ACCESS TO SUPPORT

Opportunities to have one-on-one consultations with the MCT2D pharmacist or dietitian on a specific patient case or general issues

COVERAGE SUPPORT

Support and advocacy surrounding insurance coverage for CGMs, SGLT2 inhibitors and GLP-1 receptor agonists

COLLABORATION

Learn from and collaborate with other primary care practices, endocrinologists, and nephrologists on type 2 diabetes care

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Benefits of Participation:

PATIENTS

The Michigan Collaborative for Type 2 Diabetes (MCT2D) represents a paradigm shift in how we care for patients. Instead of focusing on minimizing complications, we are aiming to prevent and reverse type 2 diabetes. The initiatives that MCT2D has initially targeted, result in benefits to the overall health of patients, in addition to putting them on the path to reversing their diabetes.

Guideline Directed Medications

- SGLT1i and GLP-1 RAs result in significant weight loss
- Deprescribing of insulin and sulfonylureas, will decrease weight gain and lower risk of hypoglycemia
- Focus prescribing of SGLT2i/GLP-1 RAs in patients with co-morbidities of chronic kidney disease, heart failure and cardiovascular disease, if covered by patient's insurance
- SGLT2i/GLP-1 RAs provide kidney protection benefits
- Potential to decrease injection burden by addition of SGLT2i and/or GLP-1 RAs
- SGLT2 inhibitors may also promote modest improvements in blood pressure

Continuous Glucose Monitoring

- Enhances patient understanding of how diet, exercise, stress, and daily routine impact blood glucose
- Can result in a statistically significant A1c reduction with no medication adjustment
- Identifies glycemic variability (peaks and valleys) to adjust diet and tailor medication regimen
- Decreases or removes need to test via finger pokes
- Lowers risk of hypoglycemia, identifies hypoglycemia unawareness, and glucose variability, especially in patients who are on insulin

Low Carbohydrate Diets

- Reduces post-prandial glucose spikes
- Reduces insulin requirements
- Reduces natural insulin, leading to reduced insulin resistance
- Results in weight loss without excessive hunger
- Reduces blood pressure
- Reduces triglycerides
- Increases HDL cholesterol
- Favorable changes in self-reported measures of energy level, hunger and food cravings

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PREMIERE ACCESS: CGM

Bypass Prior Authorization for Some Plans

Simplified CGM Prescribing

United Healthcare in-network providers participating in MCT2D can bypass prior authorization requirements for new prescriptions for preferred CGMs through the UHC pharmacy benefit managed by OptumRx. This means less time navigating administrative requirements and more time to focus on your patients and on improving the quality of care.

MCT2D continues to work with payers and plans to improve the CGM prescribing process.

CGM, BP Monitor, Scale for BCBSM PPO Patients

Patient Empowerment Toolkit

Blue Cross Blue Shield of Michigan is offering a type 2 diabetes device toolkit at $0 copay for patients with BCBSM Commercial PPO insurance. This partnership with MCT2D gives patients access to:

- An Abbott Freestyle Libre 3 CGM with six sensors
- A digital wireless blood pressure monitor
- A wireless enabled weight scale

At $0 copay regardless of the BCBSM Commercial PPO patient's pharmacy coverage.

A Trial CGM for Clinicians

CGM User Experience Program

Prescribing clinicians (including NPs, PAs, MDs, DOs, and PharmDs) at MCT2D practices are eligibile to try a free CGM, with the goal of building primary care clinicians' familiarity with using a CGM and ultimately, increasing understanding of the patient experience through off-label provider trial, administered by MCT2D.

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Benefits to Clinicians

PREMIERE ACCESS: Point-of-Care Tools

Nearly 100 free clinician and patient tools and resources, developed and curated by the MCT2D team.

Guides to coverage for CGM, GLP-1 RA and SGLT2i, patient education on low carb lifestyle, videos, interactive websites, one-page handouts, and more.

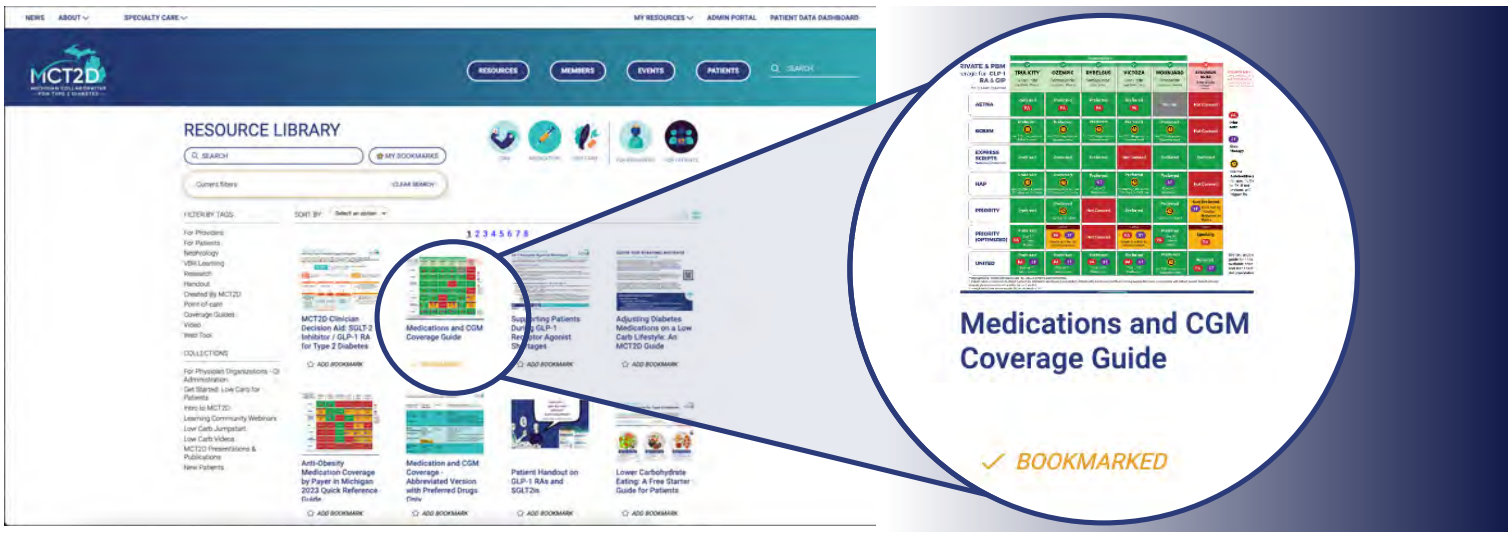
Insurance coverage checker for diabetes medications and CGMs

Dietitian, pharmacist, and physician-created patient educational resources to download, watch, and reuse

Medication and CGM algorithms to simplify your day

One-on-one support from a design team to make your multimedia idea come to life

Download from our resource library. Save your bookmarks. Share easily with patients.



MCT2D REPORTING & DASHBOARDS

Episodic care based CQIs set the standard for data collection and reporting. Due to the proportionately small number of cases, these CQIs were able to leverage on-site data abstraction. The creation of new CQIs focused on chronic disease, social determinants of health, and improving health behaviors necessitated a radically different way for CQIs to source, manage, analyze, and report data due to the large patient population and longitudinal follow up required. This new model uses automated data flows that are shared with the existing health information exchange in Michigan. Collectively, this partnership is called ***The Population Health Registry.***

THE POPULATION HEALTH REGISTRY PARTNERS

The Michigan Health Information Network (MiHIN) receives clinical data from physician organizations (POs), and claims data from payors, standardizes the formatting of the data, and passes along the relevant populations to the Michigan Data Collaborative.

The Michigan Data Collaborative (MDC) receives data from MiHIN and uses that data to both build the patient data dashboards and share data with the MCT2D Coordinating Center to build reports.

Blue Cross Blue Shield of Michigan is the primary funder for the development of the CQI Population Health Registry and is developing incentives that will contribute to data sharing and the success of this model. BCBSM also shares claims data for use in the Population Health Registry.

DATA FLOW

DATA SOURCES

	Electronic Health Record	Claims Data	Additional Data Sources
Current State	BCSM & BCN Physician Payer Quality Collaborative (PPQC)	BCBSM PPO, BCBS-MA, BCN-A, BCN	None
In The Works	All Payor PPQC	Medicaid	Patient Empowerment Toolkit Data, Social Determinants of Health Data
Future State	Consolidated Clinical Document Architecture (CCDAs)	Medicare, Other Private Payors	Patient Reported Outcomes

REPORTING AVAILABLE TO MCT2D PARTICIPANTS

Patient Identification Tool

The patient identification tool allows users to search for patients of interest based on clinical criteria, such as A1C > 7.5% or patients on specific classes of medications.

Summary Measures Dashboard

The summary measures tab allows users to compare how their organization performs in key areas such as medication and CGM prescribing, and A1c control.

PO Reports

Our data analysts use a raw data extract from MDC to create quarterly reports for each participating PO, comparing practice level performance.

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ROLES & RESPONSIBILITIES

PO Level

PO ADMIN LEAD

Time Commitment:

~5-10%

FTE

The **PO Administrative Lead** is responsible for the operations of the program, maintaining general oversight over the PO's participation in MCT2D, including the PO's participating practices.

Responsibilities

1. Ensure required documents are reviewed and signed (e.g. the participation agreement, data use agreement, business associates agreement).
2. Form a team at your PO (e.g. coordinating with the clinical champion and data lead) and serve as your PO's primary contact with the MCT2D coordinating center.
3. Participate in MCT2D collaborative wide calls and meetings.
4. Develop your PO's approach to diabetes quality improvement work, in collaboration with the PO and practice clinical champions.
5. Share MCT2D information (such as upcoming meetings, important dates, etc.) from the MCT2D coordinating center with participating practices.
6. Work with practices to identify patient advisors to participate in the collaborative.

PO CLINICAL CHAMPION

Time Commitment:

~5%

FTE

The **PO Clinical Champion** is responsible for disseminating performance/QI/educational information to sites and helping to advance best practices.

Responsibilities

1. Attend collaborative wide calls and meetings.
2. Take what is learned at those sessions and disseminate to participating sites, similar to the role of a clinical champion in other existing CQI programs.
3. Participate in train-the-trainer programs on continuous glucose monitoring and low-carb diets, for example, so the PO can provide these trainings to the participating sites.
4. Support the recruitment of participating sites, in collaboration with your PO medical director.

PO DATA LEAD

Time Commitment:

<5%

FTE

Based on number of participating practices

The **PO Data Lead** is be responsible for oversight of the data, including working with participating sites to increase the number of data elements shared.

Responsibilities

1. Ensure that data is meeting the MCT2D coordinating center requirements for all participating practices.
2. Work with the Michigan Data Collaborative (MDC) to develop and improve the data sharing process.
3. Work with practice liaisons to solve any data-related issues at the practices and advance data sharing.
4. Serve as the primary data contact for MCT2D at your PO.

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ROLES & RESPONSIBILITIES

Practice Level

PRACTICE CLINICAL CHAMPION

Time Commitment:

12-14 HOURS
IN YEAR 1

The **Practice Clinical Champion** is the MCT2D lead at the practice level, acting as the main contact between the PO and the practice. The clinical champion has additional responsibilities that other clinicians in the practice do not—see the *MCT2D Responsibilities: Clinicial Champions* handout for more info.

Responsibilities

1. Work with the PO clinical champion and PO admin lead to disseminate MCT2D information to others in the practice.
2. Lead as the PO's main contact at the practice level.
3. Support and encourage the practice on working on the MCT2D goals.
4. Complete the MCT2D recorded trainings (first year of joining the collaborative).
5. Represent the practice at twice yearly regional meetings.

Clinical champions may be either a MD, DO, PA, NP, PharmD, RDN, or RN Care Manager who have an strong interest in diabetes care.

PRACTICE LIAISON

Time Commitment:

<5%
FTE

The **Practice Liaison** is a non-clinical role at each participating practice, who supports the administrative component of MCT2D. The practice liaison will be copied on emails to the PO practice clinical champion. There are no officially assigned requirements to the practice liaison role.

Responsibilities

1. Assist the PO clinical champion in following up to make sure tasks are complete.
2. Serve as the main contact if their PO has questions about practice-specific data.

IDEAL CANDIDATES: Office manager or equivalent role

PARTICIPATING PHYSICIANS

Time Commitment:

2 - 3 HOURS
PER YEAR

Physicians participating in the Michigan Collaborative for Type 2 Diabetes are eligible to earn 5% value-based reimbursement on their BCBSM PPO patients.

Responsibilities

1. Incorporate the three pillars of MCT2D's strategy into their practice to improve care for patients with type 2 diabetes.
2. Meet the physician-level MCT2D Learning Community requirement on an annual basis.

See the *MCT2D Responsibilities: Participating Physician* handout for more info.

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CLINICAL CHAMPION

The Michigan Collaborative for Type 2 Diabetes requires each participating practice to identify a clinical champion to represent the practice and disseminate information with the other clinicians they work with.

Roles that can serve as clinical champion include: physician, nurse practitioner, physician assistant, nurse, dietitian, pharmacist, or a care manager. Clinical champions have additional responsibilities within the practice.

They will work with the physician organization (PO) clinical champion and PO administrative lead to disseminate MCT2D information to others in the practice. They will be the PO's main contact at the practice. The clinical champion supports and encourages the practice on working on the MCT2D goals. Additionally, clinical champions are responsible for completing the MCT2D trainings (first year of joining the collaborative) and representing the practice at the twice-yearly regional meetings.

CLINICAL CHAMPION REQUIREMENTS

1. Attend both the spring and fall regional meetings on an annual basis.
2. Complete trainings on continuous glucose monitors, medication interventions, and low carbohydrate eating patterns upon joining MCT2D.
3. Share information about MCT2D with other clinicians in the practice.
4. Forward emails from the coordinating center to other clinicians in the practice when requested about requirements, learning community events, etc.
5. Follow up with physicians in the practice to ensure they complete the physician level learning community requirement.
6. Ensure that their practice has met the practice level learning community requirement.
7. Give feedback and input as requested from the collaborative.
8. Attend clinical champion meetings as required by your physician organization.

REGIONAL MEETINGS

MCT2D has divided participating practices into seven regions across the state. Clinical champions from each practice will be required to attend these meetings in the Spring (April-May) and fall (October-November).

These meetings are two hours, in person, from 6-8pm. Regional meetings are meant to provide clinicians an opportunity to learn from each other and discuss best practices for implementing the quality initiatives.

CLINICAL CHAMPION TRAINING

Each clinical champion in the collaborative will be required to participate in approximately six hours of training. CME will be offered for participating in the trainings.

The trainings will cover the MCT2D quality initiatives- guideline directed medication prescribing, low carbohydrate eating patterns, and use of continuous glucose monitors, and how all three of these interventions work together.

TIME COMMITMENT OF A CLINICAL CHAMPION IN MCT2D IS ESTIMATED TO BE 12 TO 14 HOURS THE INITIAL YEAR, AND 6-8 HOURS IN SUBSEQUENT YEARS.

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PHYSICIANS

Physicians participating in the Michigan Collaborative for Type 2 Diabetes are eligible to earn **5% value-based reimbursement** on their BCBSM PPO patients.

EXPECTATIONS

All participating physicians in MCT2D are expected to incorporate the three pillars of MCT2D's strategy into their practice to improve care for patients with type 2 diabetes:

- Promoting guideline directed medication prescribing.
- Increasing use of continuous glucose monitors
- Supporting low carbohydrate eating patterns.

For the initial year of participation in MCT2D, all the measures for the collaborative will be participation based. In future years, MCT2D will move to performance-based measures that look at process changes and patient outcomes.

TIME COMMITMENT

2 - 3 hours per year

RESPONSIBILITIES

In addition to implementing the initiatives, physicians in the collaborate must meet the physician level learning community requirement on an annual basis. The ways this can be met are detailed below.

- Submit feedback on a physician focused tool
- Attend a live Learning Community Event with CME credit
- Watch a recorded Learning Community event
- Try a CGM and complete program survey

TIME COMMITMENT OF A PHYSICIAN PARTICIPATING IN MCT2D IS ESTIMATED TO BE 2-3 HOURS ON AN ANNUAL BASIS.