2024 JANUARY
BIANNUAL MEETING

https://www.moqc.org
Welcome
Keli DeVries, LMSW
### Morning Session | 9:00 am – 12:00 pm

#### 9:00 am Welcome & MOQC News
- MOQC
- POQC
- Steering Committee Report
- Palliative and End-of-Life Care Task Force
- Equity Task Force
- Oncology Stewardship & YesRx

#### 9:40 am MOQC Performance

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:40</td>
<td>MOQC Performance</td>
<td>Jennifer Griggs, MD, MPH, FASCO</td>
</tr>
</tbody>
</table>

#### 10:40 am Break

#### 10:50 am The Voice of the Patient & Caregiver

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:50</td>
<td>The Voice of the Patient &amp; Caregiver</td>
<td>Michael Dudley, POQC</td>
</tr>
</tbody>
</table>

#### 11:00 am Keynote Presentation

*Creating a Plan to Improve Cancer Equity*

Karen M. Winkfield, MD, PhD - Executive Director, Meharry-Vanderbilt Alliance

#### 12:00 pm Lunch | 12:00 – 12:30 pm

#### Afternoon Session | 12:30 – 3:25 pm

#### 12:30 pm Creating an Equity Action Plan

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:30</td>
<td>Creating an Equity Action Plan</td>
<td>Keli DeVries, LMSW</td>
</tr>
</tbody>
</table>

#### 1:15 pm Drug Shortages: Impact, Mitigation and Prevention

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:15</td>
<td>Drug Shortages: Impact, Mitigation and Prevention</td>
<td>Andrew Shuman, MD, FACS, HEC-C</td>
</tr>
</tbody>
</table>

#### 2:15 pm Break

#### 2:25 pm Justice in Healthcare

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2:25</td>
<td>Justice in Healthcare</td>
<td>Megan Albertson, MPH</td>
</tr>
</tbody>
</table>

#### Close | 3:25 – 3:30 pm

#### 3:25 pm Closing Items

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3:25</td>
<td>Closing Items</td>
<td>Keli DeVries, LMSW</td>
</tr>
</tbody>
</table>
Introductions

Please rename yourself to include your
1) Full name
2) Organization
3) Pronouns

Participants on the Phone
Please rename yourself or put your name in the chat
Reminder – How to Mute/Unmute

To mute your microphone

To unmute your microphone

*6 to mute/unmute
Reminder – Chat

Use Chat to ask/answer questions
Add your reactions
Confidentiality Reminder

Taking pictures/videos of data slides is prohibited. This is a confidential professional peer review and quality assurance document of the Michigan Oncology Quality Consortium.

Unauthorized disclosure or duplication is absolutely prohibited. It is protected from disclosure pursuant to the provisions of Michigan Statutes MCL 333.20175; MCL 333.21513; MCL 333.21515; MCL 331.531; MCL 331.532; MCL.331.533 or such other statutes as may be applicable.
Disclosure Statement

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

The following planner and/or presenter has disclosed a financial relationship with an ineligible company:

- Karen Winkfield - Consultant, Merck

This planner and/or presenter has attested that this financial relationship in no way affects their planning or delivery of content in this accredited activity and has no relation to the content of this accredited activity.

There are no conflicts of interest or financial relationships with an ineligible company that have been disclosed by the rest of the planners and presenters of this learning activity.
In support of improving patient care, this activity is planned and implemented by The National Center for Interprofessional Practice and Education Office of Interprofessional Continuing Professional Development (OICPD) and the Michigan Oncology Quality Consortium. The National Center OICPD is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

**Physicians:** The National Center OICPD designates this activity for a maximum of 5.75 AMA PRA Category 1 Credit(s)™. Physicians should only claim credit commensurate with their participation.

**Nurses:** Participants will be awarded up to 5.75 contact hours of credit for attendance at this activity.

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

**Pharmacists and Pharmacy Technicians:** This activity is approved for 5.75 contact hours (.575 CEU)

**Social Workers:** As a Jointly Accredited Organization, the National Center OICPD is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. The National Center OICPD maintains responsibility for this course. Social workers completing this course receive up to 5.75 continuing education credits.

**Athletic Trainers:** The National Center OICPD (JA#: 4008105) is approved by the Board of Certification, Inc. to provide continuing education to Athletic Trainers (ATs). This program is eligible for a maximum of 5.75 Category A hours/CEUs. ATs should claim only those hours actually spent in the educational program.

**IPCE:** This activity was planned by and for the healthcare team, and learners will receive 5.75 Interprofessional Continuing Education (IPCE) credits for learning and change.
MOQC Resources

- MOQC has a variety of free resources for your patients, caregivers, and practice sites
- Virtual and printed formats available
- https://www.moqc.org/resources/
MOQC Resources

- Measure videos
- Measure information sheets
Welcome to MOQC

Dilhara Muthukuda, MPH
Project Manager
Welcome to MOQC

Karen Jovanelly
Administrative Specialist
2023 Practice Award Winners!

Rhonda Jones & Dr. Cynthia Vakhariya, Newland Medical Associates
Dr. Jennifer Lawhorn, Munson Otsego Memorial
Reverend Diane Smith, Angela Hospice
Sparrow Herbert-Herman Cancer Center
Dr. Benjamin Mize, KCI at McLaren Flint
Jared Stone, Henry Ford Health Gyn Onc
Lauren Lawrence, Karmanos Cancer Network

Dan Phillips, Taylor Herlein, & Dr. Gordon Srkalovic, Sparrow Herbert-Herman Cancer Center
Munson Healthcare
Kelly Bristow, Henry Ford Health
Hematology Oncology Consultants, a Division of MHP
Megan Beaudrie, Therese Hecksel, & Colleen Schwartz, Abstraction Team
Dr. Khalil Katato, Genesee Hematology Oncology
Cindy Michelin, Munson Healthcare
POQO News
Sharon Kim, POQC
POQC Recruitment and Retention

RACE & ETHNICITY

LGBTQIA+

DISABILITY STATUS

ARMED SERVICES

POQC Membership
23 Current Members

2023 Additions
11 Members

2024 Target
30 Members

Self-Representation 2023 Target
30%

End-of-Year Status:
46%

2024 Targets
TBA
POQC Recruitment and Retention

2024 Goals
Community Partnerships

• Create awareness of POQC and POQC’s work
• Drive POQC recruitment in historically marginalized population groups
• Amplify the voices of those populations
• Partner with other POQC workgroups
POQC Financial Navigation

MOQC and PAF Proposal

MDHHS Project (pending)
• May 1 – September 30, 2024
• Participation in focus groups
• Report with recommendations for further action
• Reach out to Natalia Simon (nsimon@moqc.org) if interested!

Educational Flyers
• Medicare/Medicaid and COBRA flyers available
• Have an idea? Share in the chat or email Natalia!
POQC Patient & Caregiver Resources

• Resources Search Engine
  • Ongoing additions & evaluation of resources
• Caregiver navigator grant
• Resource outreach
• Email moqc@moqc.org
The Michigan Oncology Quality Consortium (MOQC) is a group formed in 2009, whose goal is to improve the quality of care cancer patients receive across the state. MOQC is supported by Blue Cross Blue Shield of Michigan (BCBSM) and work is coordinated at the University of Michigan. MOQC focuses on all cancer patients, especially those who receive chemotherapy, with or without insurance.

**Patient and Caregiver Oncology Quality Council (POQC) Contributions**

POQC Members are able to:
- Provide the voice of patients and caregivers in focus groups or for patient-facing materials review
- Share stories of how they have faced challenges in accessing the health care system, and ideas for how systems can be created to better serve patients and loved ones

**POQC Workgroups**

**Patient and Caregiver Resources:**

Patient and Caregiver Resources Workgroup Cancer affects not only people who are diagnosed but also their families, caregivers and friends. Getting a cancer diagnosis can be overwhelming, and the Patient and Caregiver Resources Workgroup is working to make things a little easier for everyone on this difficult journey. The goal of this workgroup is to find, evaluate and provide useful information, so it's easy for those impacted by cancer to find help, support, and guidance.

Contact: moqc@moqc.org
Steering Committee Report

Dawn Severson, MD
Steering Committee Members

Kevin Brader, MD
University of Michigan Health West

Tracey Cargill-Smith, POQC
POQC Member

Tim Cox, MD
Bronson Cancer Center

Diane Drago, MD
POQC Member

Donna Edberg
Great Lakes Cancer Management Specialists

Nick Erikson, MBA
Trinity Health

Tom Gribbin, MD
The Cancer and Hematology Centers

Michael Harrison, POQC
POQC Member

Cynthia Koch, POQC
POQC Member

Diana Kostoff, PharmD, BCPS, BCOP
Henry Ford Health

Kathy LaRaia
Munson Healthcare

Sherry Levandowski, MD
MyMichigan Health

Michele Loree, MSW
KCI @ McLaren Greater Lansing

Aimee Ryan
Great Lakes Cancer Management Specialists

Kate Schumaker, RHIT, CTR
Trinity Health

Colleen Schwartz
West Michigan Cancer Center

Dawn Severson, MD
Henry Ford Health

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

Heather Spotts, MSW
KCI @ McLaren Greater Lansing

Mike Stellini, MD, MS
Karmanos Cancer Center

Ammar Sukari, MD
Karmanos Cancer Institute

Padmaja Venuturumilli, MD
Hematology Oncology Consultants

Shannon Wills, PhD, MS, PA-C
Henry Ford Health
Steering Committee Report

• Continuing Medical Education (CME)
• MOQC June 2024 Biannual Meeting
  • Clinician Wellbeing
  • Patient distress
  • Measure debate
Palliative Care and End-of-Life Task Force

Phillip Rodgers, MD
## Palliative Care and EOL Task Force Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kevin Brader, MD</td>
<td>University of Michigan Health West</td>
</tr>
<tr>
<td>Patrick Miller, RN, MBA, MHSA</td>
<td>Hospice of Michigan</td>
</tr>
<tr>
<td>Beth Sieloff, MPH, RYT-200</td>
<td>Cancer Prevention and Control Inter-Tribal Council of Michigan</td>
</tr>
<tr>
<td>Diane Drago, POQC</td>
<td>POQC Member</td>
</tr>
<tr>
<td>Gustavo Morel, MD</td>
<td>Dickinson Hematology Oncology</td>
</tr>
<tr>
<td>Maria Silveira, MD, MA, MPH</td>
<td>Michigan Medicine</td>
</tr>
<tr>
<td>Hope Dudek, LMSW</td>
<td>AccentCare Hospice</td>
</tr>
<tr>
<td>Thomas O’Neil, MD</td>
<td>Arbor Hospice</td>
</tr>
<tr>
<td>Jim Spears, RN</td>
<td>Henry Ford Health</td>
</tr>
<tr>
<td>Michael Harrison, POQC</td>
<td>POQC Member</td>
</tr>
<tr>
<td>Phillip Rodgers, MD</td>
<td>Michigan Medicine</td>
</tr>
<tr>
<td>Mike Stellini, MD, MS</td>
<td>Karmanos Cancer Center</td>
</tr>
<tr>
<td>Chris Korest, MSW</td>
<td>Corsocare Hospice</td>
</tr>
<tr>
<td>Andrew Russell, MD</td>
<td>Michigan Medicine</td>
</tr>
<tr>
<td>Mike Trexler, MD</td>
<td>Ascension Borgess</td>
</tr>
<tr>
<td>Kathy LaRaia, MS</td>
<td>Munson Healthcare</td>
</tr>
<tr>
<td>Jerome Seid, MD</td>
<td>Great Lakes Cancer Management Specialists</td>
</tr>
<tr>
<td>Taylor Wofford, MD</td>
<td>MyMichigan Hospice</td>
</tr>
</tbody>
</table>
Palliative Care and End-of-Life Task Force

- VitalTalk
  - Navigating Serious Conversations
  - Mastering Tough Conversations

Spots still available!
Email by 2/16: nsimon@moqc.org

- MOQC Palliative Care Certification

- Expanded access to hospice
Equity Task Force
Tracey Cargill-Smith, POQC
Equity Task Force Members

Lydia Benitez Colon, PharmD, BCOP
Michigan Medicine

Tracey Cargill-Smith, POQC
POQC Member

Michael Dudley, POQC
POQC Member

Suzanne Fadly, PharmD
KCI at McLaren Greater Lansing

Cindy Fenimore, CMOM
Great Lakes Cancer Management Specialists

Beth Fisher-Polasky, POQC
POQC Member

Zachary Hector-Word, MD
Munson Healthcare

Yelena Kier, DO
Munson Healthcare

Sharon Kim, POQC
POQC, Member

Geetika Kukreja, MD
Henry Ford Health

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

Rev. Diane Smith, MDiv, BCC
Angela Hospice

Elena Stoffel, MD, MPH
Michigan Medicine

Shannon Wills, PA
Henry Ford Health
MEASUREMENT & CHANGE
- Stratified Analyses
- Selection of Initiatives
- Selection of Measures
- MOQC Excellence in Quality Certification

LEADERSHIP
- Collaboration with MSHIELD
- Equity Task Force
- POQC
- Professional Development

MOQC

MEETING PATIENT AND CAREGIVER NEEDS
- Financial Navigation
- YesRx Drug Repository
- Comfort Cuisine Meal Delivery Program
- Patient & Caregiver Search Engine
- Palliative Care & EOL Task Force
- Resource Translation
- Patient-Reported Outcomes
- Palliative Radiation Pathways
Equity Task Force

- Multivariate Analysis of MOQC Data
- Equity Action Plan
- Comfort Cuisine Meal Delivery Program
- Educational Opportunities
Oncology Stewardship & YesRx
Keli DeVries, LMSW
Oncology Stewardship (OncoStew)

2-year project
June 2023 – June 2025

Phase 1
Exploration

Phase 2
Transition

Phase 3
Implementation

Phase 4
Evaluation

We are here!
Oncology Stewardship (OncoStew)

Phase 1
Exploration

Nominations – Spring 2023
Funding approved – June 2023
Focus groups – Sep /Nov 2023
Report created
Manuscript submitted (*The Oncologist*) – Jan 2024

Phase 2
Transition

Debriefing meeting – Feb 2024
Create implementation plan
Present at regional meetings
Present to CQI and BCBSM
Disseminate to MOQC members – Dec 2024

Phase 3
Phase 4
Fall 2024 – Summer 2025

MOQC
MICHIGAN ONCOLOGY QUALITY CONSORTIUM

moqc.org
As of Today - 18 CDR Programs Are Active in Michigan

CDR GROWTH TIMELINE
# of CDR Programs in Michigan Since Public Act of 2006

2006
2021 1
2022 8
2023 9
18

AUGUST 2023
YesRx Network Launched

www.yesrx.org
YesRx Network Engagement

Bi-weekly network meetings
Hosted by YesRx for Network Members to collaborate on best practices and resource sharing and to report on milestone achievements

Weekly inventory updates
Prepared by YesRx and distributed to Network Members for their internal distributed to clinicians, financial navigators, etc.

---

Do Not Distribute. For YesRx Network Member Use Only.

www.yesrx.org

CDR Inventory Update as of 1/8/24 7:30 PM
Page 1

<table>
<thead>
<tr>
<th>Generic</th>
<th>Brand</th>
<th>Strength</th>
<th>Qty</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABEMACICLIB</td>
<td>VERZENIO</td>
<td>50 mg</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100 mg</td>
<td>&gt;120</td>
</tr>
<tr>
<td></td>
<td></td>
<td>150 mg</td>
<td>&gt;120</td>
</tr>
<tr>
<td></td>
<td></td>
<td>200 mg</td>
<td>&gt;120</td>
</tr>
<tr>
<td></td>
<td></td>
<td>300 mg</td>
<td>&gt;120</td>
</tr>
<tr>
<td>ABIRATERONE</td>
<td></td>
<td>250 mg</td>
<td>30-60</td>
</tr>
<tr>
<td>ACALABRUTINIB</td>
<td>CALQUENCE</td>
<td>100 mg</td>
<td>&gt;120</td>
</tr>
<tr>
<td>ALPELISIB</td>
<td>PIQRAY</td>
<td>150 mg</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td></td>
<td>200 mg</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td></td>
<td>250 mg</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td></td>
<td>300 mg</td>
<td>60-120</td>
</tr>
<tr>
<td>ANASTROZOLE</td>
<td>ARIMIDEX</td>
<td>1 mg</td>
<td>&gt;120</td>
</tr>
<tr>
<td>AXTINIB</td>
<td>INLYTA</td>
<td>1 mg</td>
<td>&gt;180</td>
</tr>
<tr>
<td>BINIMETINIB</td>
<td>MEKTOVI</td>
<td>15 mg</td>
<td>60-120</td>
</tr>
<tr>
<td>CAPECITABINE</td>
<td></td>
<td>500 mg</td>
<td>60-120</td>
</tr>
<tr>
<td>CEDAZURIDINE/DECITABINE</td>
<td>INQOVI</td>
<td>35-100 mg</td>
<td>5</td>
</tr>
<tr>
<td>DABRafenib</td>
<td>TAFINLAR</td>
<td>75 mg</td>
<td>60-120</td>
</tr>
<tr>
<td>DASATINIB</td>
<td>SPRYCEL</td>
<td>100 mg</td>
<td>&gt;120</td>
</tr>
<tr>
<td>ELTOMBOPAG</td>
<td>PROMACTA</td>
<td>50 mg</td>
<td>60-120</td>
</tr>
<tr>
<td>ENZALUTAMIDE</td>
<td>XTANDI</td>
<td>80 mg</td>
<td>30-60</td>
</tr>
<tr>
<td>EVEROLIMUS</td>
<td>AFINTOR</td>
<td>2.5 mg</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 mg</td>
<td>30-60</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7.5 mg</td>
<td>30-60</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10 mg</td>
<td>30-60</td>
</tr>
<tr>
<td>EXEMESTANE</td>
<td></td>
<td>25 mg</td>
<td>30</td>
</tr>
<tr>
<td>FEDRATINIB</td>
<td>INREBC</td>
<td>100 mg</td>
<td>60-120</td>
</tr>
<tr>
<td>GEFTINIB</td>
<td>IRESSA</td>
<td>250 mg</td>
<td>60-120</td>
</tr>
<tr>
<td>IBRUtinib</td>
<td>IMBRUVICA</td>
<td>140 mg</td>
<td>60-120</td>
</tr>
<tr>
<td>IMPATINIB</td>
<td>GLEEVEC</td>
<td>250 mg</td>
<td>&gt;120</td>
</tr>
<tr>
<td>IVOSIDENIB</td>
<td>TIBSOVO</td>
<td>250 mg</td>
<td>30</td>
</tr>
</tbody>
</table>

**ANTICANCER AGENTS**

* EXPIRING WITHIN 3 MONTHS *

<table>
<thead>
<tr>
<th>Generic</th>
<th>Brand</th>
<th>Strength</th>
<th>Qty</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABEMACICLIB</td>
<td></td>
<td>150 mg</td>
<td></td>
</tr>
<tr>
<td>ALPELISIB</td>
<td></td>
<td>200 mg</td>
<td></td>
</tr>
<tr>
<td>IBRUtinib</td>
<td></td>
<td>280 mg</td>
<td></td>
</tr>
<tr>
<td>IMPATINIB</td>
<td></td>
<td>400 mg</td>
<td></td>
</tr>
</tbody>
</table>

www.yesrx.org
YesRx Network 6-Month Outcomes
July 1 – December 31, 2023

• 106 prescriptions provided at no cost to patients in need
  Valued at $1.3 million

• Donated medications saved from being wasted
  Valued at $2.4 million
Join the Growing YesRx Network in 2024

• **Free to join.** YesRx serves patients by supporting clinicians across the YesRx Network who want to improve medication access.

• **Customize your participation.** YesRx can offer different levels of support to help CDR resources reach your practice.

No space to store medication donated by your patients?
No resources or budget to get medication?
No resources to dispense CDR medication to your patients?

**That's ok! We have you covered!**

www.yesrx.org
MOQC Practice Performance

Jennifer J. Griggs, MD, MPH
Thank You, Data Abstractors

• Denise Gregoire, MHP Downriver
• Julie Boylan, Hematology Oncology Consultants
• Amy Flietstra, Cancer & Hematology Centers
• Alexandra Gehrke, Cancer & Hematology Centers
• Ann Webster, Cancer & Hematology Centers
• Leah Murphy, Cancer & Hematology Centers
• Kelly Bristow, Henry Ford Health
• Lisa May, Henry Ford Health
• Holly Boyle, Henry Ford Health
• Patricia Baker, Henry Ford Health
• Vanessa Schroeder, Henry Ford Health
• Allycia Lilla, Henry Ford Health
• Katie Dombecki, Huron Medical Center
• Alicia Kehoe, Huron Medical Center
• Megan Beaudrie, Karmanos Cancer Center
• Vickie Foley, Karmanos Bay Oncology Hematology
• Wendy Mielens, Karmanos Bay Oncology Hematology

• Amanda Vernier, Karmanos Cancer Institute at McLaren Macomb
• Kelly Guswiler, Munson Oncology
• Renae Vaughn, Munson Oncology
• Blair Pease, West Michigan Cancer Center
• Erika Burkland, Dickinson Hematology/Oncology
• Heather Spotts, KCI McLaren Greater Lansing Hospital
• Stacy Lantrip, KCI McLaren Greater Lansing Hospital
• Jeanne Melton, KCI McLaren Northern Michigan

MOQC Team & MOQC by Proxy
Kleanthe Kolizeras, Heather Behring, Cindy Michalek, Heather Rombach, Deborah Turner, Shawn Winsted, Deana Jansa, Jennifer Broadhurst, Colleen Schwartz, Therese Hecksel, Megan Beaudrie
## 2023 Medical Oncology Measures

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Measure Description</th>
<th>VBR measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>101b</td>
<td>Tobacco cessation counseling administered, or patient referred in past year</td>
<td>X</td>
</tr>
<tr>
<td>108a</td>
<td>Complete family history documented for patients with invasive cancer</td>
<td>X</td>
</tr>
<tr>
<td>111</td>
<td>GCSF administered to patients who received chemotherapy for non-curative intent (lower score – better)</td>
<td></td>
</tr>
<tr>
<td>114</td>
<td>NK1RA for low or moderate emetic risk cycle 1 chemotherapy (lower score – better)</td>
<td>X</td>
</tr>
<tr>
<td>115</td>
<td>NK1RA &amp; olanzapine for high emetic risk chemotherapy</td>
<td>X</td>
</tr>
<tr>
<td>126a</td>
<td>Hospice enrollment</td>
<td>X</td>
</tr>
<tr>
<td>126b</td>
<td>Enrolled in hospice for over 7 days</td>
<td></td>
</tr>
<tr>
<td>126c</td>
<td>Enrolled in hospice for over 30 days</td>
<td></td>
</tr>
<tr>
<td>127</td>
<td>Chemotherapy administered within the last 2 weeks of life (lower score - better)</td>
<td></td>
</tr>
</tbody>
</table>
2023 Value-Based Reimbursement Summary

Region-Level
Meet 4 of the following 5

- NK1RA & olanzapine given with high emetic risk chemotherapy 30%
- NK1RA given for low or moderate emetic risk cycle 1 chemotherapy 10%
- Hospice enrollment 60%
- Hospice enrollment within 7 days of death 35%
- Complete family history documented 35%

3% Opportunity

Practice-Level
Meet all 5 region-level measures

2% Opportunity

Collaborative-Wide

- Tobacco cessation counseling administered or patient referred in past year 70%

2% Opportunity
Additional Criteria for Receiving VBR

<table>
<thead>
<tr>
<th>Level</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Level</td>
<td>At least <strong>one physician and one practice manager</strong> from the practice must attend <strong>both</strong> MOQC regional meetings and <strong>at least one</strong> biannual meeting during that year</td>
</tr>
<tr>
<td>Physician Level</td>
<td>Provider must be enrolled in PGIP for at least one year</td>
</tr>
<tr>
<td></td>
<td><strong>New requirement beginning Round 1 2024</strong></td>
</tr>
<tr>
<td>Practice Level</td>
<td>Practice must have 10 charts in the denominator per VBR measure per round -Exceptions may be made for EOL measures</td>
</tr>
</tbody>
</table>
Measures

- ↑ or ↓ indicates statistically significant improvement or decline in performance between time periods (p<0.05)

- Practices with no eligible cases in the denominator and/or missing data from one of the time periods are not shown
101b: Tobacco Cessation Counseling Administered or Patient Referred in Past Year
2023, n = 2,018

Target = 70%

Proportion %

- Improvement in Performance
- Decline in Performance
111: GCSF Administered to Patients who Received Chemotherapy for Non-Curative Intent (Lower Score = Better)
2023, n = 2,233

= Improvement in Performance
= Decline in Performance
114: NK1 Receptor Antagonist Prescribed or Administered for Low or Moderate Emetic Risk Cycle 1 Chemotherapy (Lower Score = Better)

2023, n = 2,427

= Improvement in Performance
= Decline in Performance
115: NK1 Receptor Antagonist and Olanzapine Prescribed or Administered with High Emetic Risk Chemotherapy
2023, n = 1,466

= Improvement in Performance
= Decline in Performance
126a: Hospice Enrollment
2023, n = 2,944

Target = 60%

= Improvement in Performance
= Decline in Performance
126b: Hospice Enrollment More than 7 Days Before Death
2023, n = 1,538

Target = 60%

= Improvement in Performance
= Decline in Performance
126c: Hospice Enrollment More than 30 Days Before Death
2023, n = 1,538

= Improvement in Performance
= Decline in Performance
127: Chemotherapy Administered Within the Last 2 Weeks of Life
(Lower Score = Better)
2023, n = 2,806

= Improvement in Performance
= Decline in Performance
Discussion
<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Measure Description</th>
<th>VBR Measure</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>101b</td>
<td>Tobacco cessation counseling administered or referral for tobacco users once/year</td>
<td>X</td>
<td>75</td>
</tr>
<tr>
<td>108a</td>
<td>Complete family history documented for patients with invasive cancer</td>
<td>X</td>
<td>40</td>
</tr>
<tr>
<td>111</td>
<td>GCSF administered to patients who received chemotherapy for non-curative intent</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td></td>
<td><em>(lower score = better)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>114</td>
<td>NK1RA for low or moderate emetic risk cycle 1 chemotherapy</td>
<td>X</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td><em>(lower score = better)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>115</td>
<td>NK1RA and olanzapine for high emetic risk chemotherapy</td>
<td>X</td>
<td>55</td>
</tr>
<tr>
<td>126a</td>
<td>Hospice enrollment</td>
<td>X</td>
<td>65</td>
</tr>
<tr>
<td>126b</td>
<td>Enrolled in hospice more than 7 days before death</td>
<td>X</td>
<td>60</td>
</tr>
<tr>
<td>126c</td>
<td>Enrolled in hospice more than 30 days before death</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>127</td>
<td>Chemotherapy administered within the last 14 days of life</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td></td>
<td><em>(lower score = better)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>128</td>
<td>Non-chemotherapy anticancer agent administered within the last 14 days of life</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td></td>
<td><em>(lower score = better)</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MOQC Excellence in Quality Certification – New Measures

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Measure Description</th>
<th>Target</th>
<th>National Performance*</th>
</tr>
</thead>
<tbody>
<tr>
<td>130</td>
<td>Beginning a new anti-cancer regimen within the last 14 days of life (lower score = better)</td>
<td>30</td>
<td>70</td>
</tr>
<tr>
<td>129</td>
<td>Palliative care consultation more than 90 days before death</td>
<td>25</td>
<td>30</td>
</tr>
<tr>
<td>103</td>
<td>Designated advocate documented on a legally recognized document in the inpatient or outpatient medical record</td>
<td>20</td>
<td>20</td>
</tr>
</tbody>
</table>

*Based on published patterns of care
2024 Value-Based Reimbursement Summary

Region-Level
Meet 4 of the following 5

• NK1RA & olanzapine 55% for high emetic risk chemotherapy
• NK1RA for low or moderate emetic risk cycle 1 chemotherapy 10%
• Hospice enrollment 65%
• Hospice enrollment > 7 days before death 60%
• Complete family history documented 40%

3% Opportunity

Collaborative-Wide

• Tobacco cessation counseling administered or patient referred once/year 75%

2% Opportunity

Practice-Level

• Meet all 5 region-level measures

2% Opportunity
MOQC Excellence in Quality Certification
MOQC Excellence in Quality Certification

MOQC Excellence in Quality

- Achieve targets
- Schedule site visit
- Collect PROs
- Submit equity action plan
Certification Timeline – 2024 and 2025

1. Begin data collection into MOQCLink for measurement period Jan-Oct 2024
   - January 1, 2024

2. Review certification details and decide if your practice will pursue certification
   - January-April 2024

3. Deadline for requesting a site visit. Email moqc@moqc.org.
   - April 30, 2024

   - June 30, 2024

5. Begin scheduling site visits. Visit must occur in 2024 or 2025.*
   - July 2024
   *QOPI Certified practices do not need a site visit

6. Performance is evaluated for certification for 2024.
   - November 2024

7. Final results for 2024 MOQCLink certification eligibility are submitted to BCBSM.
   - December 1, 2024
Certification Timeline – 2024 and 2025

1. Begin data collection into MOQCLink for measurement period Jan-Oct 2024
   - JANUARY 1, 2024

2. Review certification details and decide if your practice will pursue certification
   - JANUARY-APRIL 2024

3. Deadline for requesting a site visit. Email moqc@moqc.org.
   - APRIL 30, 2024

   - JUNE 30, 2024

5. Begin scheduling site visits. Visit must occur in 2024 or 2025.*
   - "QOP! Certified practices do not need a site visit
   - JULY 2024

6. Performance is evaluated for certification for 2024.
   - NOVEMBER 2024

7. Final results for 2024 MOQC certification eligibility are submitted to BCBSM.
   - DECEMBER 1, 2024

8. Submit action plan for measures that were not met in 2024 data.
   - MARCH 31, 2025

   - JUNE 30, 2025

10. Deadline for collecting patient-reported outcomes (PROs).
    - NOVEMBER 15, 2025

11. Performance is evaluated for certification for 2025.
    - NOVEMBER 2025

12. Final results for 2025 MOQC certification eligibility are submitted to BCBSM.
    - DECEMBER 1, 2025
### Certification Requirements

<table>
<thead>
<tr>
<th>Required Elements for Certification</th>
<th>2024 (Year 1)</th>
<th>2025 (Year 2 and beyond)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit data</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Achieve targets for 80% of measures</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Plan to meet remaining targets</td>
<td>No</td>
<td>Yes Due by March 31, 2025 (based on previous year’s data)</td>
</tr>
<tr>
<td>Site visit* (performed in 2024 or 2025)</td>
<td>Schedule by November 15, 2024</td>
<td>Yes Every 2 years until certified Every 3 years once certified</td>
</tr>
<tr>
<td>Equity action plan</td>
<td>Yes Due by June 30, 2024</td>
<td>Yes Due by June 30, 2025</td>
</tr>
<tr>
<td>Collection of patient-reported outcomes (PROs)</td>
<td>Encouraged, not required</td>
<td>Yes Due by November 15, 2025</td>
</tr>
</tbody>
</table>

*Not necessary if practice is currently QOPI® certified*
Patient-Reported Outcomes
Patient-Reported Outcomes (PROs)

Overview

• 8 practices collected PROs in 2023
• Response numbers:
  – 250 completed survey
  – 196 (78.4%) provided identifying information
Patient-Reported Outcomes (PROs)

Social Needs

- 47/247 (19.0%) patients reported at least 1 social need

Proportion of Respondents

<table>
<thead>
<tr>
<th>Social Need</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ate Less Because of Cost</td>
<td>9%</td>
</tr>
<tr>
<td>Lack of Companionship</td>
<td>8%</td>
</tr>
<tr>
<td>Reading Difficulty</td>
<td>4%</td>
</tr>
<tr>
<td>No Transportation</td>
<td>3%</td>
</tr>
<tr>
<td>Did Not See Doctor Due to Cost</td>
<td>3%</td>
</tr>
<tr>
<td>Stable Housing</td>
<td>2%</td>
</tr>
<tr>
<td>Shut Off Services</td>
<td>2%</td>
</tr>
<tr>
<td>ChildCare</td>
<td>0%</td>
</tr>
</tbody>
</table>
Resources Search Engine

https://cancerhelp.moqc.org/
Additional Resources

211
Get Connected. Get Help.™
Patient-Reported Outcomes (PROs)

Distribution of Patient-reported Pain Interference Score

- PROMIS Pain Interference Score
- Facility ID:
  - 13
  - 18
  - 22
  - 29
  - 31
  - 32
  - 35
  - 38
Patient-Reported Outcomes (PROs)

Distribution of Patient-reported Fatigue Score

PROMIS Fatigue Score

Facility ID
The Voice of the Patient & Caregiver
Michael Dudley, POQC
Creating a Plan to Improve Cancer Equity
Karen Winkfield, MD, PhD
Closing the Gap in Cancer Care Equity

Karen Winkfield, MD, PhD
Executive Director, Meharry-Vanderbilt Alliance
Ingram Professor of Cancer Research
Professor of Radiation Oncology
Vanderbilt University Medical Center

Professor of Internal Medicine
Meharry Medical College

Michigan Oncology Quality Consortium
January 18, 2024
What is health equity?

Equity is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification.

-World Health Organization

Health equity means that everyone has a fair and just opportunity to be healthier.

This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

-Robert Wood Johnson Foundation
Health Equity = Everyone has a fair opportunity to live a long and healthy life.
Populations at Greatest Risk for Inequitable Cancer Care

- Racial/Ethnic Minorities
- Rural vs. Urban
- Adolescent/Young Adult
- Geriatric/Older Adult Populations
- LGBTQ+/Sexual & Gender Minorities
- The differently abled

\underline{Lower Socioeconomic Status}
# Social Determinants of Health (SDOH)

## Economic Stability
- Employment
- Income
- Expenses
- Debt
- Medical bills

## Neighborhood and Physical Environment
- Housing
- Transportation
- Safety
- Parks
- Playgrounds
- Walkability
- Zip code / geography

## Education
- Literacy
- Language
- Early childhood education
- Vocational training
- Higher education

## Food
- Hunger
- Access to healthy options

## Community and Social Context
- Social integration
- Support systems
- Community engagement
- Discrimination
- Stress

## Health Care System
- Health coverage
- Provider availability
- Provider linguistic and cultural competency
- Quality of care

---

**Health Outcomes**
- Mortality
- Morbidity
- Life Expectancy
- Health Care Expenditures
- Health Status
- Functional Limitations

*Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity: 2018*
What is a health system?

- Patient
- INGOs
- Pharmaceutical companies
- Insurance companies
- Prevention & care
- Clinics
- Doctors & nurses
- Employers
- Services
- Government
“Our hope is that every patient with cancer and their loved ones will receive the absolute best care”
The Health System and SDOH

http://www.cdc.gov/socialdeterminants/
UNDESIGN THE RED LINE
Interactive Exhibit

Connecting the history of housing discrimination and segregation to the political and social issues of today.

www.enterprisecommunity.org/undesign-the-redline

Explore the history. Share your perspective. Transform your communities.

http://www.clevelandnp.org/undesigntheredline/
Promoting Health Equity in Cancer Care: Proceedings of a Workshop
Be Intentional: What Question Are you trying to Answer??
Eliminating Racial Disparities in Colorectal Cancer in the Real World: It Took a Village

Stephen S. Grubbs, Delaware Cancer Consortium, Dover; and Helen F. Graham Cancer Center, Newark, DE
Blase N. Polite, The University of Chicago, Chicago, IL
John Carney Jr, US House of Representatives, Washington, DC
William Bowser, Delaware Cancer Consortium, Dover, DE
Jill Rogers, Delaware Division of Public Health, Dover, DE
Nora Katurakes, Delaware Cancer Consortium, Dover; and Helen F. Graham Cancer Center, Newark, DE
Paula Hess, Delaware Cancer Consortium, Dover, DE
Electra D. Paskett, College of Medicine and Comprehensive Cancer Center, Ohio State University, Columbus, OH

Colorectal cancer (CRC) is the third most common cancer in the United States, with more than 107,000 new patients diagnosed each year. Screening rates among minorities lag behind those of non-Hispanic whites. Both timely resolution of abnormal findings and initiation and completion of appropriate follow-up care are critical.
Leveraging community services to enhance provision of comprehensive health care
PAVING THE ROAD TO
HEALTH EQUITY

Health Equity
is when everyone has the opportunity
to be as healthy as possible

Programs
Successful health equity strategies

Measurement
Data practices to support the advancement of health equity

Policy
Laws, regulations, and rules to improve population health

Infrastructure
Organizational structures and functions that support health equity

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
Right-sizing Interventions

- MOQC has 53 practices at 84 sites.
- 28 of the practices have 1-3 physicians
- 20 practices have 4-10 physicians
- 5 practices have more than 10 physicians (n = 11, 23, 27, 35, and 70 (Rogel Cancer Center))

What patients need may differ
The types of interventions available will differ
Doing a REAL Community Assessment

- Catchment area data:
  - Demographics
  - Racial/ethnic cancer disparities
  - Geographic cancer disparities
  - Behavioral risk and protective factors
- Community feedback on health priorities and strategies
- Identify needs, gaps, potentially effective strategies
- Respond to community-identified goals for engagement & research

Adapted from slide by D. Friedman
Acting on the Identified Needs

#BeIntentional

**PLAN**
- Propose change idea and how it will be tested
- Predict what will happen

**DO**
- Implement change idea
- Collect data
- Reflect on how well the plan was followed

**ACT**
- Share final reflections
- Conclude whether to Adopt, Adapt, or Abandon change idea

**STUDY**
- Analyze data collected
- Compare results to predictions
- Capture learnings
Your Advocacy Matters

**Awareness**
- Get to know the issues
- Understand the social context
- Identify care gaps in your community

**Advocacy**
- Policy Matters!!
- Resource allocation decisions:
  - Political, economic, and social systems
  - Institutions

**Action!!!**
Thank you!!

www.drkarenwinkfield.com
3blackdocs.com

@DrWinkfield
@3BlackDocs

Questions?
Creating an Equity Action Plan

Keli DeVries, LMSW
MOQC Excellence in Quality

- Achieve targets
- Schedule site visit
- Collect PROs
- Submit equity action plan
MOQC Excellence in Quality

- Achieve targets
- Collect PROs
- Schedule site visit
- Submit equity action plan
Equity Action Plan

- Designed to improve equity in care

Requirement for practices participating in MOQC Excellence in Quality Certification Pathway
(Due by June 30, 2024)

- Encouraged for all MOQC practices
Domains to Address

• **Data**
  – Current state
  – Desired state
  – Action steps to close the gap

• **Education**

• **Practice**
Domain Examples
Data Domain - Examples

• Expand choices for documenting race/ethnicity on intake forms
  – Race options:
    Select all that apply:
    ✓ American Indian or Alaska Native
    ✓ Asian
    ✓ Black or African American
    ✓ Hispanic or Latino
    ✓ Middle Eastern or North Africa
    □ Native Hawaiian or Pacific Islander
    □ White
    □ Another race: _______________
    □ Unknown
    □ Decline

  – Ensure race is collected in a private and confidential way

• Collect language of care from patients when scheduling first appointment
Current State Description

• Includes an overview of how things are currently done at the practice

• Example:
  – The current patient intake form allows patients to select only 1 race, and there are limited choices available, without a write-in option.
Desired State Description

• Includes an overview of how the practice would like things to be done

• Example
  – The patient intake form allows multiple races to be selected with more inclusive categories.
Action Steps

• Includes the action steps needed to move from the current to the desired state

• Examples
  – Identify new race options that should be included on patient intake form
    • Model after new census proposal
  – Update intake form with new race categories
  – Change instructions on intake form to allow for more than one option to be selected
  – Standardize who collects these data, where to collect, how to explain to patients
Education Domain - Examples*
Include all relevant staff members/roles

• Care of transgender patients
• Cultural humility vs. cultural competence
• Inclusive care of obese patients
• Understanding stigma
• Importance of collecting patient information on race, ethnicity, language of care

*MOQC will provide these education opportunities or direct you to resources if we don’t already provide it
Practice Domain - Examples

• Provide all patient materials in patient & caregiver’s language(s) of care*
• Ensure documents are at an accessible reading level (6th grade)
• Become a YesRx participating site
• Participate in the Meal Delivery Initiative
• (Coming soon) Address equity gaps in performance on measures

*MOQC is translating our resources & others into all requested languages. These will be available free of charge on our website.
Equity Action Plan Support

• If your practice needs support in creating or carrying out your equity action plan, please reach out to MOQC at moqc@moqc.org
  – Educational opportunities
  – Resources
  – Anything else
Equity Action Plan – Minimum Requirements

At a minimum, the plan should include the following:

- **Data**
  - Current state: overview of how data are currently collected at the practice
  - Desired state: overview of how the practice would like things to be done
  - Action steps to close the gap

- **Education**
  - Educational Opportunity/Training Topic
  - Target Audience
  - Planned Date of Completion

- **Practice**
  - Initiative/Project
Equity Action Plan – Template

Equity Action Plan

CONTACT INFORMATION
Practice Name
Contact Name
Email

DATA
Current State
Future State
Action Steps

Resource: MSHLD, Best Practices Guide

INTERPROFESSIONAL EDUCATION
Educational Opportunity
Target Audience
Planned Date of Completion

Educational Opportunity
Target Audience
Planned Date of Completion

PRACTICE
Check all that apply, at least one
- Provide all patient materials in patient & caregiver’s language(s) of care
- Ensure all patient materials and documents are at an accessible reading level (6th grade)
- Become a MyData cancer data repository
- Begin screening for social needs
- Participate in the Comfort Cuisine Meal Delivery Program (only available to eligible practices)
- Other, please specify
- Other, please specify
- Other, please specify

Please provide details regarding the plan to accomplish the choice(s) checked above. If you need MOQC to provide resources, please indicate which resources are needed.

QUESTIONS?
Visit: https://moqc.org
Email: moqc@moqc.org
Equity Action Plan – Example

**DATA**

Current State
Not collecting race and ethnicity of patients

Future State
Would like to add race & ethnicity question to intake form

Action Steps
Action step 1
Action step 2
Action step 3

Resources
MISHIELD Best Practices Guide

**PRACTICE**

Check all that apply; at least one:

- Provide all patient materials in patient & caregiver's language(s) of care
- Ensure all patient materials and documents are at an accessible reading level (6th grade)
- Become a YesRx cancer drug repository
- Begin screening for social needs
- Participate in the Comfort Cuisine Meal Delivery Program (only available to eligible practices)
- Other, please specify:
  - Other, please specify:
  - Other, please specify:

Please provide details regarding the plan to accomplish the choice(s) checked above. If you need MOQC to provide resources, please indicate which resources are needed.

**INTERPROFESSIONAL EDUCATION**

At least one; feel free to include an attachment with any additional educational opportunities

Educational Opportunity
Cultural Humility

Target Audience
All providers and practice staff

Planned Date of Completion
Fall 2024

Contact MOQC
Meet with YesRx team
Provide training for all staff on YesRx
Questions?
Screening for Social Needs

• Collecting information on social needs can help care teams understand and address how these factors impact their patients’ health.
Screening for Social Needs

• The MSHIELD Readiness Assessment has 3 parts:
  – Readiness Assessment
  – What to Expect: Preparing for Implementation
  – Where to Start: Actions and Considerations for Implementation

How to Use this Readiness Assessment
Use this tool to help identify your practice’s readiness to implement screening and referrals for health-related social needs. In the table below, check “Yes” or “Not Yet” for each readiness marker. Use the notes column to reflect on the status and any actions needed.

<table>
<thead>
<tr>
<th>Readiness Marker</th>
<th>Yes</th>
<th>Not Yet</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your team and leadership have a shared understanding of social determinants of health (SDOH) and health-related social needs (HRSN) and the difference between the two terms?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Do you have leadership support to implement HRSN screening?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Does your hospital, health system, or physician organization have a process for implementing HRSN screening?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Have all staff and members of the care team been made aware of the interest in implementing HRSN screening and referrals?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Have you identified a champion and made sure they have protected time to dedicate to leading these efforts? The champion’s responsibilities include:</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Serve as the main contact with MSHIELD and your CB;</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Oversee and track progress on the project;</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Attend meetings and share reports;</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Send screening data reports.</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Do you have at least one of the following connections to community resources to address patients’ HRSN?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>In addition to checking “Yes” or</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>
Screening for Social Needs

- Let’s do a quick assessment! Use the Zoom poll to respond.

1. Rate the level of your team’s understanding of social determinants of health and health-related social needs.
   - No understanding
   - Some understanding
   - A lot of understanding
   - Unsure
   - Not Applicable
Screening for Social Needs

2. Does your practice currently screen for social needs, such as food, housing, transportation, etc.?
   - Yes
   - No, and we are interested in screening
   - No, and we do not plan to start screening
   - Unsure
   - Not Applicable
Screening for Social Needs

• Use the Zoom chat to enter your response

3. What is the most significant barrier keeping you from implementing social needs screening?
Drug Shortages: Impact, Mitigation and Prevention

Andrew G. Shuman, MD, FACS
Drug Shortages: Impact, Mitigation and Prevention

Andrew G. Shuman, MD, FACS

January 2024
Disclosure

• No financial interests, disclosures, or conflicts of interest regarding the content of this presentation.

• Funding provided by BCBS Foundation of Michigan, and Michigan Medicine.

• My views do not represent the government of the United States.
A Dilemma
Pfizer says supply of some drugs may be disrupted after NC tornado

Reuters

July 24, 2023 5:01 PM EDT - Updated 2 days ago
Objectives

This presentation is designed to:

- Describe drug shortages and understand why they occur
- Introduce the ethical tenets inherent to managing drug shortages
- Apply these principles to prevention and mitigation approaches
Outline

- Introduction to modern drug shortages
- Ethical assessment of the dilemma
- Policy implications and potential solutions
Drug shortages have emerged as a major problem both on a societal level as well as at the bedside.

The inability to access critical medications creates major barriers for clinicians tasked with providing patient care.

Political, economic and legislative aspects of the problem are formidable.
Drug Shortages Are an Ongoing Problem

National Drug Shortages
New Shortages by Year
January 2001 to June 30, 2023, % Injectable

ChooseVA

131
Drug Shortages Are an Ongoing Problem

National Drug Shortages
Active Shortages by Quarter – 10 Year Trend
Michigan Medicine Data

Drug Shortage Tracking

- FDA website
- ASHP website
- Michigan Medicine Pharmacy
35 active shortages
Drug Shortages Affect Outcomes

- Mechlorethamine: developed post-WWII, part of standard MOPP lymphoma protocol, costs $180 per vial

- Pediatric Hodgkin’s Lymphoma Consortium assessed outcomes before/after mechlorethamine shortage

Drug Shortages Cause Preventable Deaths

Drug Shortages Cause Errors

- Increased number of steps for preparation; unfamiliar doses and products; increased handoffs; more equipment.

- 95% of internal medicine, anesthesiology, and emergency medicine residents have managed drug shortages with little or no training.

Drug Shortages Cost Money

- In 2004, drug shortages increased acquisition cost by $99 million … up to $360 million by 2019.

- National personnel costs for managing drug shortages were $216 million in 2011 … and in 2019, represented 9 million incremental labor hours.

- Hospital systems nationally are absorbing at least an additional $200 million per year.

Non-financial Impact

- Financial estimates ignore a massive time allotment
  - Drug procurement/allocation
  - Institutional policy-making
  - Clinicians

- The cost for patients and families of inferior treatments, errors, efforts to find scarce product, and concern about alternatives is even harder to estimate
Drug Shortages Affect Many

- 96% of surveyed anesthesiologists needed to change management due to drug shortages in 2012.

- At least 23 multi-center prospective clinical cancer trials were postponed or canceled due to drug shortages between 2010 and 2011.

- In Virginia, pancuronium was stockpiled by an execution facility, leading to shortages at local hospitals.

Tucker ME. BMJ 2012;345:e8551.
Drug Shortages Forcing Hard Decisions on Rationing Treatments

Such shortages are the new normal in American medicine. But the rationing that results has been largely hidden from patients and the public.

By SHERI PINK  JAN. 29, 2016
“Two kids in front of you, you only have enough for one. How do you choose?”

DR. YORAM UNGURU

“I believe if I had gotten it when it was first prescribed, I wouldn’t have had to go through those operations.”

DON KEATING, A CANCER PATIENT

“Patients are not equally the same. You need to look case by case.”

NING-TSU KUO

“We’ve been forced into what we think is a highly unethical corner.”

DR. PETER ADAMSON
Rising Rate of Drug Shortages Is Framed as a National Security Threat

A Senate homeland security committee examined growing health care shortages amid reports of rationing within hospitals.
Which Drugs are Unavailable?

- Cancer drugs
- Antimicrobials
- Anesthesia medications
- Electrolyte solutions / vitamins
Types of Drugs Unavailable

National Drug Shortages
Active Shortages Top 5 Drug Classes

Active Shortages June 30, 2023

- Antimicrobials: 17 (Injectable 25, Non-injectable 5)
- Chemo: 20 (Injectable 20, Non-injectable 0)
- CNS: 29 (Injectable 29, Non-injectable 0)
- Fluids/Elytes: 29 (Injectable 29, Non-injectable 0)
- Hormones: 15 (Injectable 7, Non-injectable 8)
Why are Drugs Unavailable?

• Manufacturing problems
  – Quality control
  – Outdated infrastructure
  – Supply line

• Economic priorities

• No effective/efficient “early warning” system

• Dearth of raw materials
National Drug Shortages
Reasons for Shortages as Reported by Manufacturers During UUDIS Investigation

2022

- Unknown / Would not provide: 56%
- Supply/Demand: 19%
- Manufacturing: 18%
- Business decision: 5%
- Regulatory issue: 1%
The Issue with Generics

• Drugs lose profitability due to patent expirations and Medicare price caps on generics.

• Most generic drugs are produced by few manufacturers with centralized production, limited inventory, and inefficient quality control, all designed to limit cost.

• Makes drug shortages both common and unpredictable.

• Biggest risk is generic sterile injectables.

Broadening the Discussion

• Not just “drugs” …
  – Blood products
  – Organs
  – Oxygen
  – Vaccines

Saline Shortages — Many Causes, No Simple Solution
Maryann Mazer-Amirshahi, Pharm.D., M.D., M.P.H., and Erin R. Fox, Pharm.D.

Severe and long-standing prescription-drug shortages have become a major threat to public health and patient safety. Despite increased awareness and mitigation strategies, the United States has experienced shortages of many lifesaving drugs and other supplies essential to patient care. There was already a shortage of saline solution, for example, when Hurricane Maria devastated Puerto Rico, home to a key saline manufacturer, causing the problem to reach critical levels.

Saline is an inexpensive product — it’s simply salt water — but proper manufacturing practices are required to keep it sterile, pyrogen-free, and free from particulate matter. Production demands are challenging, since very large quantities are needed: more than 40 million bags per month. Saline is required for virtually all hospitalized patients, whether as a component of a medication infusion or as a hydration, resuscitation, or irrigation fluid. Unfortunately, shortages of saline have become commonplace in recent years (see table).

Most drug shortages occur with older, generic, injectable medications that are produced by a small number of suppliers — typically three or fewer. The United States gets its saline from just three companies: Baxter International, B. Braun Medical, and ICU Medical. Most shortages are caused by a quality or production problem at the manufacturing facility — causes that apply to the current saline shortage as well. In ad-
Applying Ethical Principles

• Autonomy

• Beneficence

• Non-maleficence

• Justice
Applying Ethical Principles

• Autonomy
• Beneficence
• Non-maleficence
• Justice

Drug shortages create conditions in which principles directly conflict
Individual patient’s interest vs. Welfare of all patients
Rationing

• The concept of rationing, while politically charged, is neither novel nor insidious.

• Ethically justified by the concept of distributive justice.

• Medical resources, including capital, personnel, physical space, and medications, are finite.

• Providers must simply do the best that they can with what is available.

The Clinician’s Dilemma

• Individual doctors must be advocates for their patients first, before they act as stewards of scarce resources.

• Even a fair rationing schema does not absolve a physician of his or her primary, incontrovertible fiduciary responsibility to the patient.

• Can only be resolved by a rationing policy that transcends the doctor-patient dyad.

How to Ration?

- Typically based upon access, insurance, & ability to pay
- Different when creating a formal set of criteria/policy
- Must take into account all potential stakeholders
- May evolve based upon changes in supply and demand
- Must not rely on individual clinician judgment

Establishing Rationing Criteria

- Evidence-based
- Transparent
- Universal
- Objective

Where it Gets Messy

• What if there are no strong comparative data?

• Should amount of drug needed be a variable?

• “Most benefit” is a morally complex barometer…

• Should age be an independent variable?

• What about first-come, first-served?

• Supplies may increase or decrease quickly

• What about clinical research protocols?
Duke’s Approach

Ethics committee established guideline emphasizing:

– Transparency (policy is publicly available)
– Relevance (policy must be judged clinically relevant)
– Appeals (built-in method for people to appeal a decision)
– Enforcement (policy applies to entire institution)
– Fairness (no “special” people will receive exceptions)

Duke’s Approach

- Created multidisciplinary committee involving:
  - Ethics committee members
  - Pharmacy (clinicians and leadership)
  - Clinicians affected by shortage(s)
  - Therapeutics committee
  - Chief medical and nursing officers
  - Risk management
  - Legal counsel

- Committee wrote policy based upon guidelines

- Meets ad-hoc within 48 hours of new drug shortage
Example: preservative-free methotrexate

- Only offered to patients with:
  - Acute leukemia
  - Osteosarcoma

- NOT offered to other patients:
  - Autoimmune indications
  - Palliative regimens

- Maximum doses restricted based on evidence, and rounded to the nearest gram to minimize waste.
Some institutions are more likely to gain access because of pre-existing health care disparities which affect their ability to purchase drugs in a competitive marketplace.

This dilemma points to a problem that makes any allocation schema suspect in a market-driven system.

What happens when a just allocation schema follows from an unjust cause?
Lack of Coordination

- No comprehensive approach to predict and prevent these shortages.

- No organized approach to ensure regional mitigation plans to distribute existing product equitably across patients in need.
Policy Gaps

- Federal legislation to enable agencies to anticipate and stabilize the supply of scarce drugs
- Process to facilitate regional hospital systems to work together to ensure efficient and equitable distribution of limited product.
Federal Government Response

- Obama prioritized a response to the problem in 2011

- Food and Drug Administration Safety and Innovation Act (FDASIA), passed July 2012

- Requires all drug manufacturers to inform the FDA of impending shortages in real-time

- Facilitates many measures to allocate other resources and/or import foreign drugs

Roehr B. BMJ. 2011;343:d7158.
S.3187 (112th Congress, 2012)
One Hundred Twelfth Congress of the United States of America

AT THE SECOND SESSION

Began and held at the City of Washington on Tuesday, the third day of January, two thousand and twelve

An Act

To amend the Federal Food, Drug, and Cosmetic Act to revise and extend the user-fee programs for prescription drugs and medical devices, to establish user-fee programs for generic drugs and biosimilars, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Food and Drug Administration Safety and Innovation Act”.

SEC. 2. TABLE OF CONTENTS; REFERENCES IN ACT.

(a) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title.
Sec. 2. Table of contents; references in Act.

TITLE I—FEES RELATING TO DRUGS

Sec. 101. Short title; findings.
Sec. 102. Definitions.
Sec. 103. Authority to assess and use drug fees.
Sec. 104. Reauthorization; reporting requirements.
Sec. 105. sunset date.
Sec. 106. Effective date.
Sec. 107. Savings clause.

TITLE II—FEES RELATING TO DEVICES

Sec. 201. Short title; findings.
Sec. 203. Authority to assess and use device fees.
Sec. 204. Reauthorization; reporting requirements.
Sec. 205. Sunsets clause.
Essential Medicines

• Designed to guide global prioritization of vital drugs.

• Helps to define the “bare-bones pharmacy” necessary for a basic health system.

• First published in 1977, updated every 2 years.

• Based upon efficacy, safety, availability, portability, storability, cost-effectiveness, public health need.
Possible Approaches

• Create quality scoring systems for generic drugs (with incentives for companies to create more reliable products), and for hospitals to preferentially buy them, along with incentives for the necessary infrastructure updates to achieve this.

• Public-private agreements to strengthen manufacturing facilities and allow FDA to certify quality of generics, so that hospitals know that they are purchasing a reliable and safe drug.
• Combines push incentives to improve manufacturing infrastructure with the implementation of pull incentives through a pay for-performance program that rewards hospitals for taking steps to prevent shortages before they occur.

• Proposes a targeted government-funded buffer inventory to insure against supply chain shocks for drugs of particular public health import.
Slotkin Unveils Bill to Ease Pharmaceutical Shortages

June 9, 2023 | Press Release

The Ensuring Access to Lifesaving Drugs Act would empower the FDA to keep lifesaving drugs available

S.1961 - Pharmaceutical Supply Chain Risk Assessment Act of 2023
118th Congress (2023-2024) | Get alerts

Committees: Senate - Health, Education, Labor, and Pensions
Latest Action: Senate - 06/13/2023 Read twice and referred to the Committee on Health, Education, Labor, and Pensions.
Tracker: Introduced ➔ Passed Senate ➔ Passed House ➔ To President ➔ Became Law
PETERS, STABENOW & SLOTKIN CALL ON FDA TO TAKE ALL POSSIBLE ACTIONS TO MITIGATE CANCER DRUG SHORTAGES

To ease cancer drug shortage, FDA will allow imports from China

The agency will allow imports of the chemotherapy drug cisplatin, which is used to treat a wide variety of cancers.
• Interviews with diverse stakeholders throughout state

• Three themes emerged:
  – numerous drug shortage strategies occur simultaneously
  – inadequate resources and lead time to proactively manage shortages
  – interest in but varied attitudes toward a more collaborative approach

• Focus groups identified strategies to address

Vision: YesRx seeks to remove barriers to medication access for vulnerable & underserved people and communities.

Mission: YesRx is founded on the trust and support of these pharmacists; and is charged with empowering partners in healthcare in a sustainable ecosystem of improving medication access and eliminating medication waste.
Take–Home Points

- Drug shortages are common and multifactorial
- Anticipation and mitigation are critical but insufficient
- Rationing schema must be evidence-based, transparent, universal and objective
- Institutional approaches require dedicated workflows and multidisciplinary teams
- Federal action is the key to prevention
Questions and Discussion

andrew.shuman@va.gov

shumana@med.umich.edu
Justice in Healthcare

Megan Albertson, MPH
AGENDA

Perspectives
Care at the margins

Justice
Working on and working in

Chat
Heads and hearts

Stuff We Did
The next most beautiful step
MEGAN IRENE ALBERTSON, MPH

Director, Jackson Care Hub

(she/they)
Perspectives
Perspectives

JACKSON HEALTH NETWORK
Clinically integrated network
Perspectives

- **JACKSON HEALTH NETWORK**
  Clinically integrated network

- **JACKSON COLLABORATIVE NETWORK**
  Collective impact network
Perspectives

JACKSON HEALTH NETWORK
Clinically integrated network

JACKSON COLLABORATIVE NETWORK
Collective impact network

JACKSON CARE HUB
Community information exchange
Perspectives

- **JACKSON HEALTH NETWORK**
  Clinically integrated network

- **JACKSON COLLABORATIVE NETWORK**
  Collective impact network

- **JACKSON CARE HUB**
  Community information exchange
Clinical Quality Scope of Need
Clinical Quality Scope of Need

Healthcare
Clinical Quality Scope of Need

Healthcare

Social Support
Clinical Quality Scope of Need

Healthcare

Social Support

Aligned Communities
EMERGENCY DEPARTMENT UTILIZATION

December 1, 2022 - November 30, 2023
EMERGENCY DEPARTMENT UTILIZATION

December 1, 2022 - November 30, 2023

$805.12

All Patients

Cost per Patient among all patients that presented at the ED during the timeframe
EMERGENCY DEPARTMENT UTILIZATION

December 1, 2022 - November 30, 2023

**All Patients**
Cost per Patient among all patients that presented at the ED during the timeframe

$805.12

**0 Social Needs**
Cost per Patient among patients that reported no social needs

$786.56
EMERGENCY DEPARTMENT UTILIZATION

December 1, 2022 - November 30, 2023

$805.12

All Patients
Cost per Patient among all patients that presented at the ED during the timeframe

$786.56

0 Social Needs
Cost per Patient among patients that reported no social needs

$860.12

1+ Social Need
Cost per Patient among patients that reported at least 1 social need
EMERGENCY DEPARTMENT ADMISSIONS

December 1, 2022 - November 30, 2023

$474.19

All Patients
Cost per Patient among all ED admissions that were admitted to the hospital
EMERGENCY DEPARTMENT ADMISSIONS
December 1, 2022 - November 30, 2023

$474.19
All Patients
Cost per Patient among all ED admissions that were admitted to the hospital

$450.41
0 Social Needs
Cost per Patient among admitted patients that reported no social needs
EMERGENCY DEPARTMENT ADMISSIONS

December 1, 2022 - November 30, 2023

$474.19
All Patients
Cost per Patient among all ED admissions that were admitted to the hospital

$450.41
0 Social Needs
Cost per Patient among admitted patients that reported no social needs

$526.20
1+ Social Need
Cost per Patient among admitted patients that reported at least 1 social need
Margins

Healthcare

Community Capacity

Societal Compassion
Cancer Mortality
Cancer Mortality

Compared cancer mortality rates across counties based on persistent poverty classifications

Persistent Poverty Counties: at least 20% of residents in poverty since 1980

Current Poverty Counties: at least 20% of residents in poverty per 2007 - 2012
American Community Survey

Cancer Mortality

Compared cancer mortality rates across counties based on persistent poverty classifications.

Conclusion: Cancer mortality was higher in persistent poverty counties than other counties, including those experiencing current poverty.

Figure 1. 2007–2011 age-adjusted cancer mortality rates for non-persistent poverty versus persistent poverty counties. Cancer mortality rates are expressed as deaths per 100,000 people per year, except breast and cervical cancers (deaths per 100,000 females per year) and prostate cancer (deaths per 100,000 males per year).
Social Drivers of Health

How does the cost of care differ by the presence of social needs among people that have cancer and present to the Emergency Department?

December 1, 2022 - November 30, 2023
Transportation

AVERAGE COST PER ED PATIENT: CANCER DIAGNOSIS WITH/OUT REPORTED TRANSPORTATION NEED

$668

No Transportation Need  Transportation Need
Transportation

AVERAGE COST PER ED PATIENT: CANCER DIAGNOSIS WITH/OUT REPORTED TRANSPORTATION NEED

$668
No Transportation Need

$882
Transportation Need
Utilities

AVERAGE COST PER ED PATIENT: CANCER DIAGNOSIS WITH/OUT REPORTED UTILITY NEED

$669

No Utilities Need

Utilities Need
Utilities

Average cost per ED patient: Cancer diagnosis with/out reported utility need

No Utilities Need: $669
Utilities Need: $994
Housing

Average Cost Per ED Patient: Cancer Diagnosis With/Out Reported Housing Need

$672

No Housing Need

Housing Need
Housing

AVERAGE COST PER ED PATIENT: CANCER DIAGNOSIS WITH/OUT REPORTED HOUSING NEED

No Housing Need: $672

Housing Need: $1,040
Safety

AVERAGE COST PER ED PATIENT: CANCER DIAGNOSIS WITH/OUT REPORTED SAFETY NEED

No Safety Need

$670

Safety Need
Safety

AVERAGE COST PER ED PATIENT: CANCER DIAGNOSIS WITH/OUT REPORTED SAFETY NEED

No Safety Need: $670

Safety Need: $1,434
Justice

equity by design
[pause]
What to do?
HANDLE WITH CARE
Immunizations
Birth - 2 years

Jackson Health Network
THANK YOU!

DO YOU HAVE ANY QUESTIONS?
Megan Irene Albertson, MPH

Email
Malbert1@hfhs.org

Phone
517.795.6758
Closing Items

Keli DeVries, LMSW
Continuing Education Credits

This meeting has been approved for 5.75 CEU

1. MOQC will send out the evaluation to everyone’s email address as part of the follow-up email

2. Attendees should complete the evaluation

3. Attendees will receive a certificate from the CE accreditation organization with their credits
   • The certificate will be sent from ipceapps@umn.edu

Questions? Please reach out to moqc@moqc.org
MOQC Resources

- MOQC has a variety of free resources for your patients, caregivers, and clinicians
- Virtual and printed formats available

www.moqc.org
MiGHT Materials

**Michigan Genetic Hereditary Testing**

- Materials will be sent to practices
  - Patient-facing fliers on MiGHT
  - MiGHT brochures
  - Custom link and QR code to share with patients and family members

https://moqc.org/initiatives/grant-funded/might/
# Upcoming Meetings

<table>
<thead>
<tr>
<th>MOQC 2024 Spring Regional Meetings</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Metro East (ME)</td>
<td>Wednesday, March 27 (Troy)</td>
</tr>
<tr>
<td>Lake Michigan Oncology Region (LMOR)</td>
<td>Monday, April 1 (Grand Rapids)</td>
</tr>
<tr>
<td>West of Woodward (WOW)</td>
<td>Wednesday, April 10 (Plymouth)</td>
</tr>
<tr>
<td>Central Michigan Region (CMG)</td>
<td>Monday, April 15 (Saginaw)</td>
</tr>
<tr>
<td>Superior West</td>
<td>Wednesday, April 24 (Marquette)</td>
</tr>
<tr>
<td>Superior East</td>
<td>Thursday, April 25 (Petoskey)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MOQC GynOnc Biannual Meeting</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gyn Onc Biannual</td>
<td>Friday, May 3 (Plymouth)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MOQC MedOnc Biannual Meeting</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Med Onc Biannual</td>
<td>Friday, June 21 (Plymouth)</td>
</tr>
</tbody>
</table>

Register at: [https://moqc.org/events/](https://moqc.org/events/)
THANK YOU!
Cancer care. Patients first.
The best care. Everywhere.