MOQC 15 CELEBRATING

MICHIGAN ONCOLOGY QUALITY CONSORTIUM

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	Keli DeVries, LMSW
	• POQC	Sharon Kim, POQC
	• Steering Committee Report	Dawn Severson, MD
	• Palliative and End-of-Life Care Task Force	Phil Rodgers, MD
	• Equity Task Force	Tracey Cargill-Smith, POQC
	• Oncology Stewardship & YesRx	Keli DeVries, LMSW
9:40 am	**MOQC Performance**	Jennifer Griggs, MD, MPH, FASCO
10:40 am	**Break**	
10:50 am	**The Voice of the Patient & Caregiver**	Michael Dudley, POQC
11:00 am	**Keynote Presentation** **Creating a Plan to Improve Cancer Equity** Karen M. Winkfield, MD, PhD - Executive Director, Meharry-Vanderbilt Alliance	
Lunch | 12:00 – 12:30 pm		
12:00 pm	**Break for lunch**	
Afternoon Session | 12:30 – 3:25 pm		
12:30 pm	**Creating an Equity Action Plan**	Keli DeVries, LMSW
1:15 pm	**Drug Shortages: Impact, Mitigation and Prevention**	Andrew Shuman, MD, FACS, HEC-C
2:15 pm	**Break**	
2:25 pm	**Justice in Healthcare**	Megan Albertson, MPH
Close | 3:25 – 3:30 pm		
3:25 pm	**Closing Items**	Keli DeVries, LMSW

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

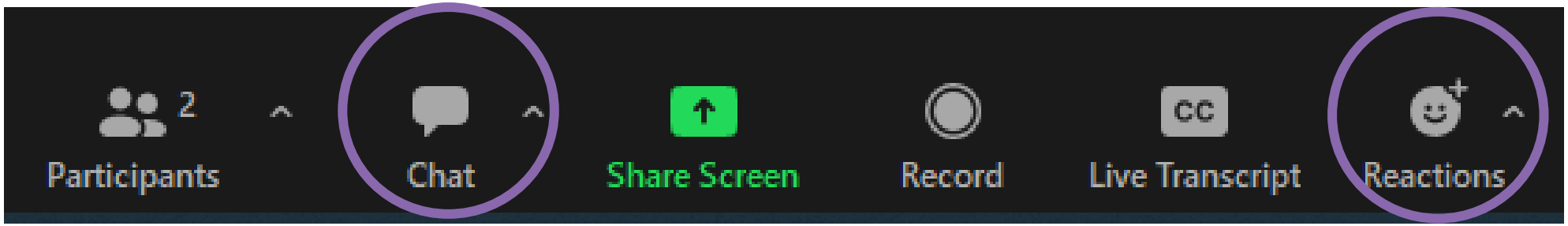
Reminder – How to Mute/Unmute

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

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PHI

Office of Interprofessional
Continuing Professional Development

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UNIVERSITY OF MINNESOTA
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NATIONAL CENTER for INTERPROFESSIONAL PRACTICE and EDUCATION

COLLEGE OF PHARMACY
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INTERPROFESSIONAL CONTINUING EDUCATION

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.

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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.

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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

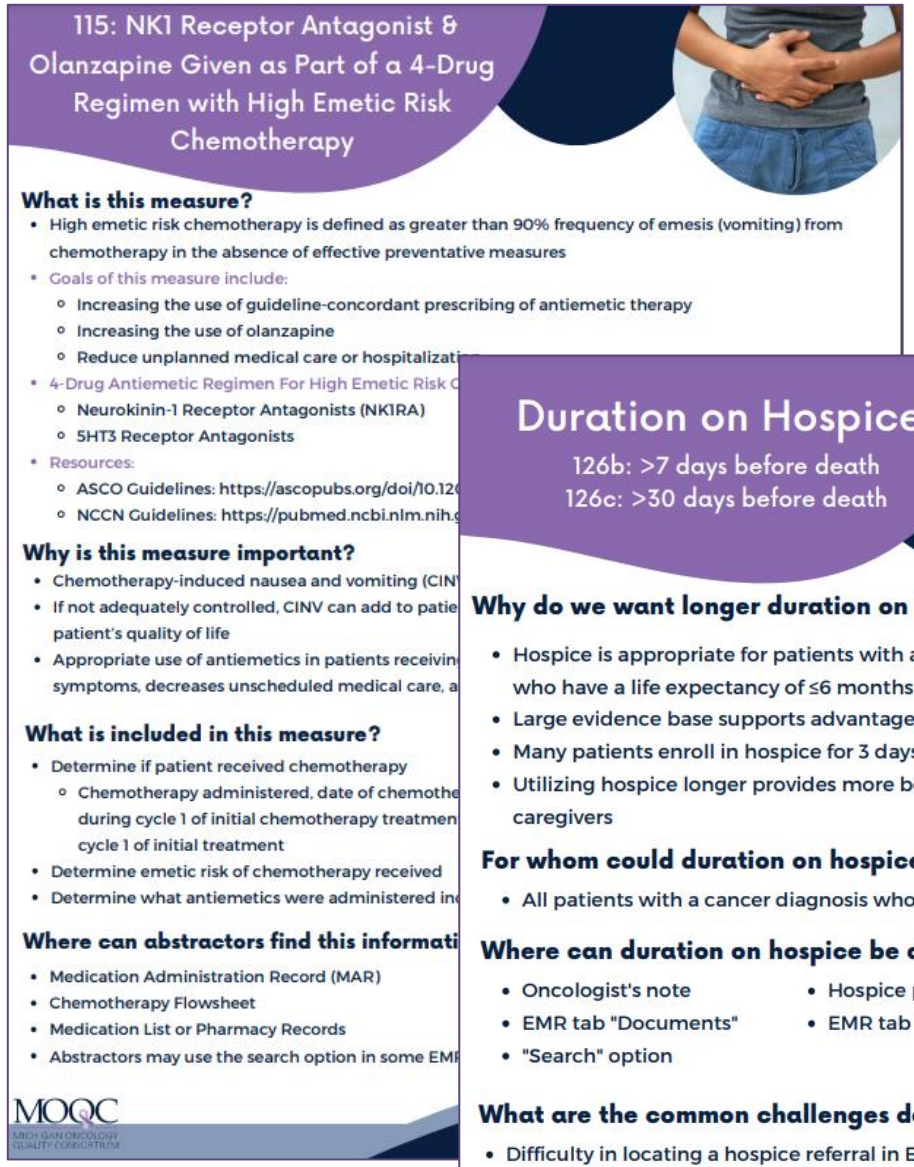
IPCE CREDIT™

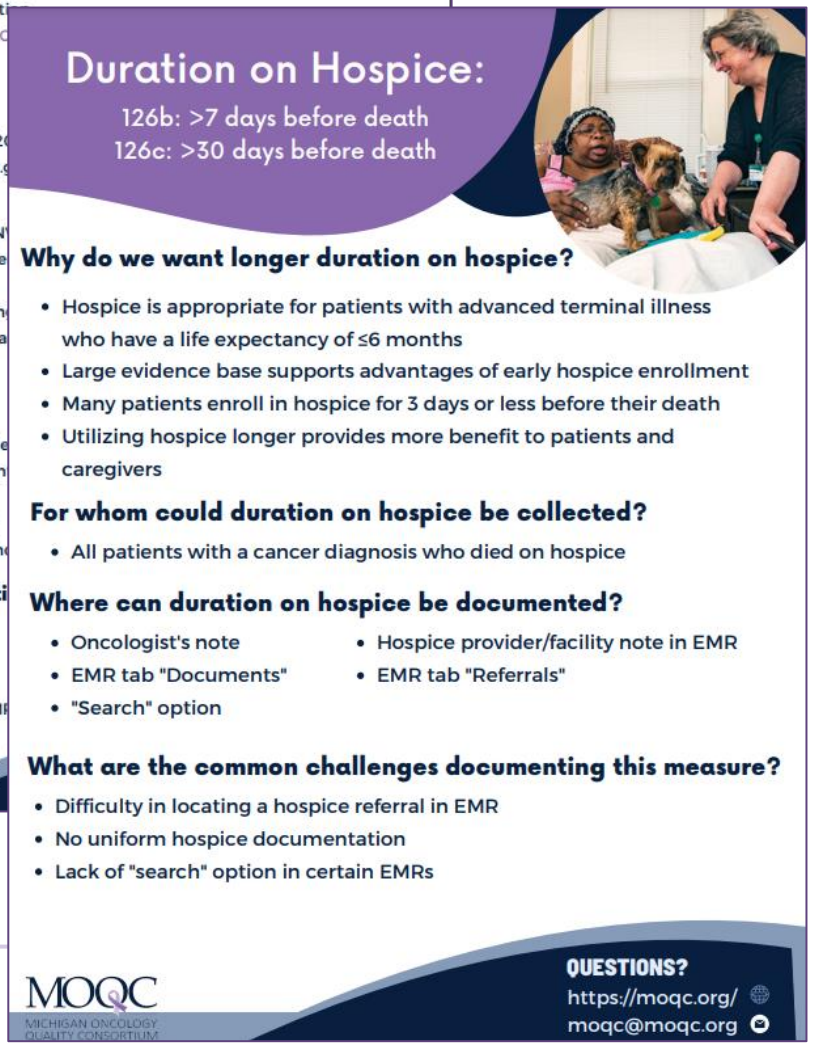
MOQC Resources

- 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





MOQC 15 CELEBRATING
MICHIGAN ONCOLOGY QUALITY CONSORTIUM

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

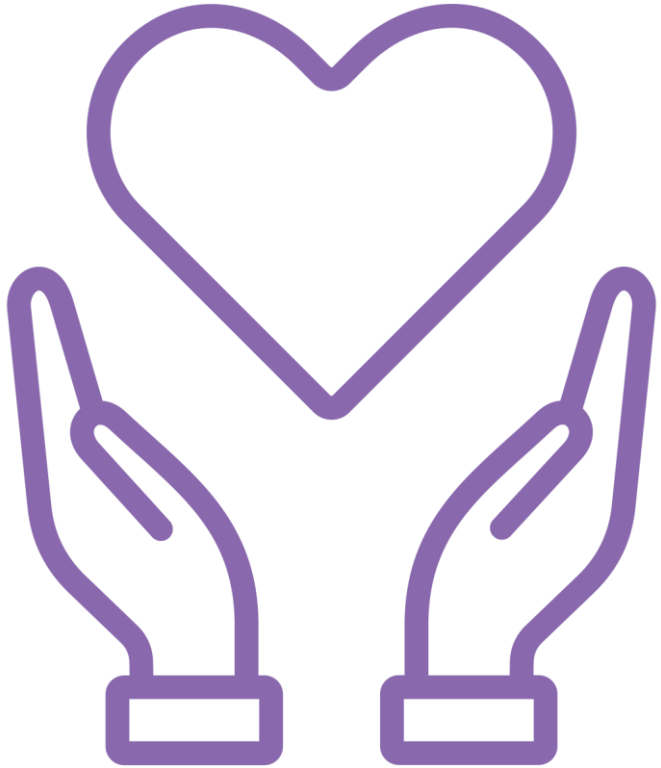
Megan Beaudrie, Therese Hecksel, & Colleen Schwartz,
Abstraction Team

Dr. Khalil Katato,
Genesee Hematology Oncology

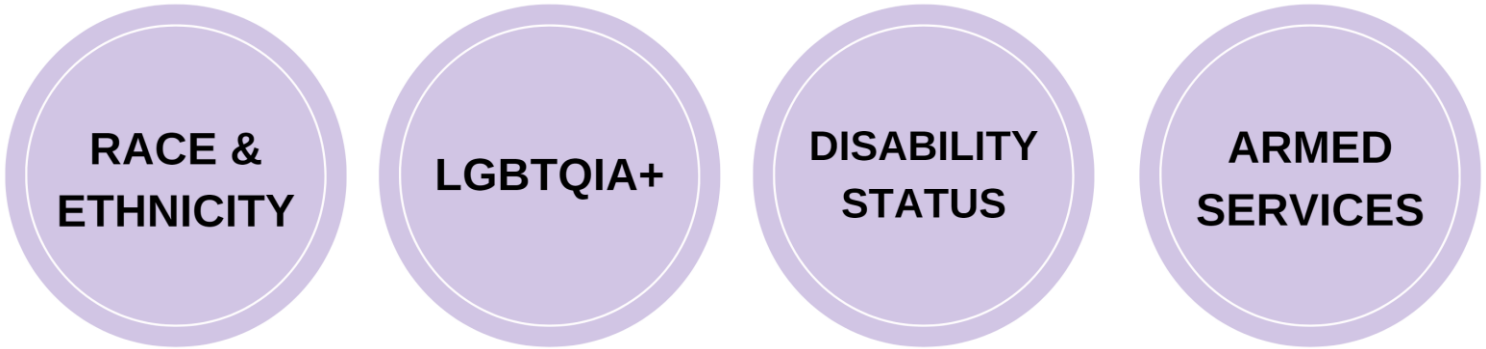
Cindy Michelin,
Munson Healthcare

POQC News

Sharon Kim, POQC



POQC Recruitment and Retention



POQC Membership
23 Current Members

2023 Additions
11 Members

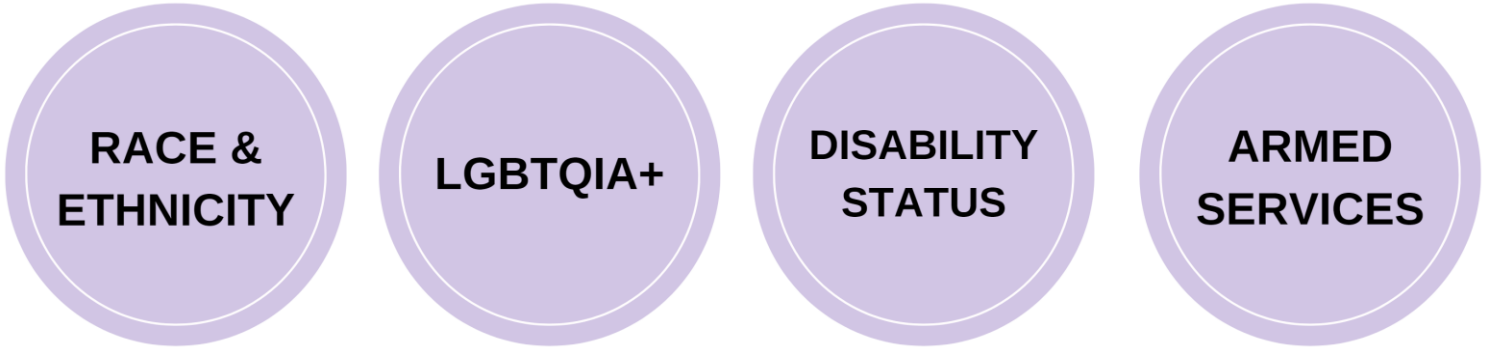
2024 Target
30 Members

Self-Representation 2023 Target
30%

End-of-Year Status:
46%

2024 Targets
TBA

POQC Recruitment and Retention



2024 Goals

Community Partnerships

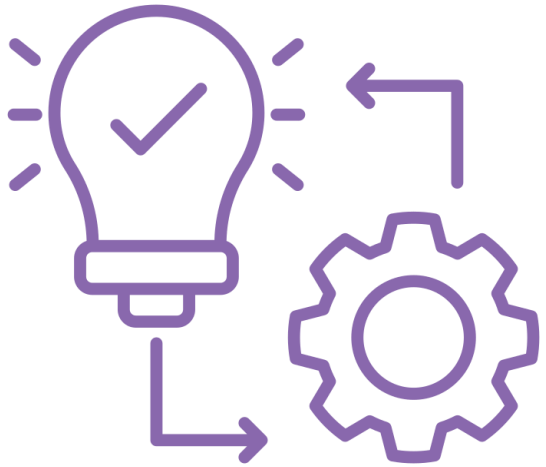
- Create awareness of POQC and POQC's work
- Drive POQC recruitment in historically marginalized population groups
- Amplify the voices of those populations
- Partner with other POQC workgroups

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!

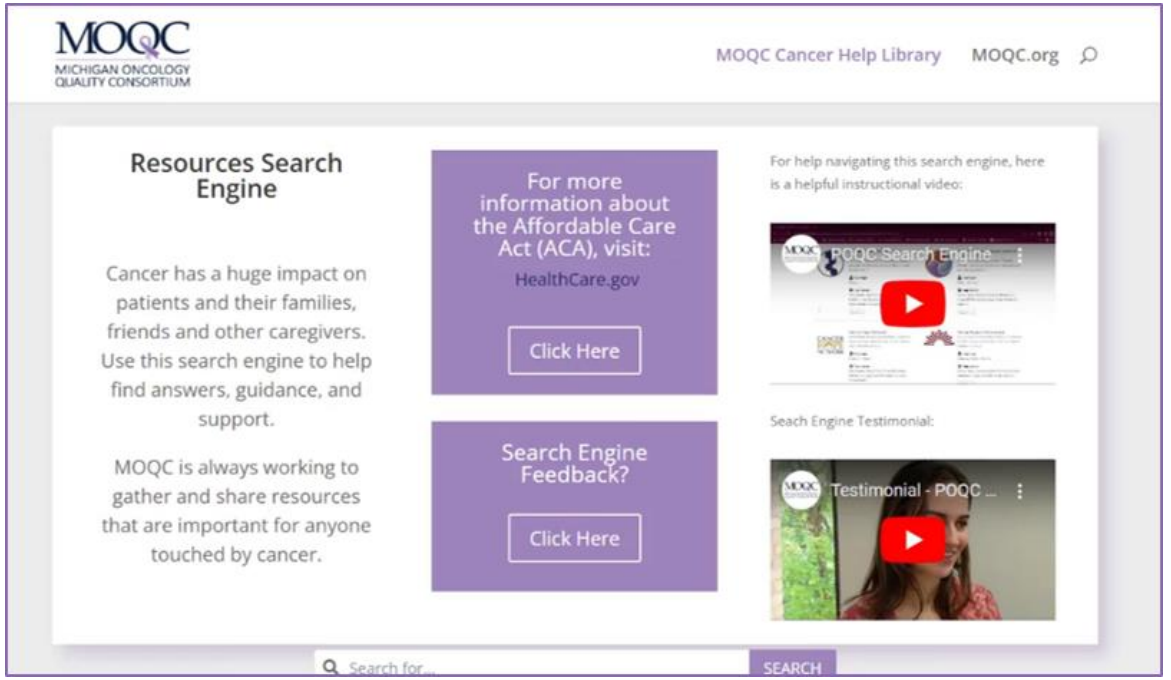


Educational Flyers

- 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



POQC Information

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

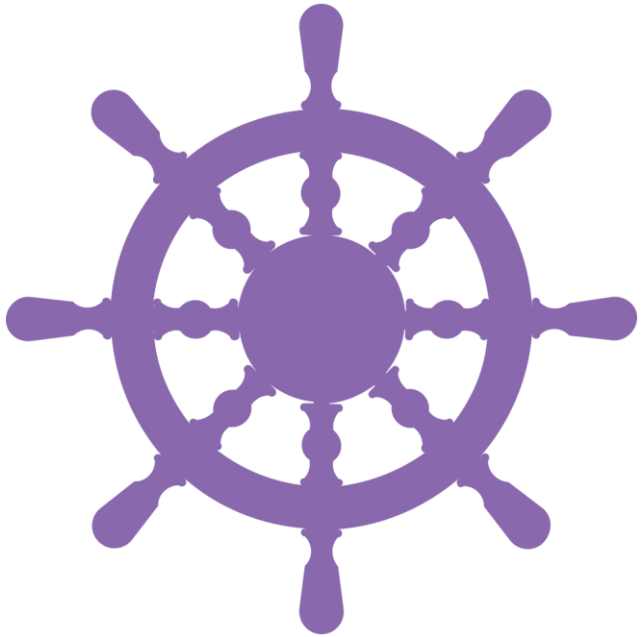
Ammar Sukari, MD
Karmanos Cancer Institute

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

Kevin Brader, MD
University of Michigan Health West

Diane Drago, POQC
POQC Member

Hope Dudek, LMSW
AccentCare Hospice

Michael Harrison, POQC
POQC Member

Chris Korest, MSW
Corsocare Hospice

Kathy LaRaia, MS
Munson Healthcare

Patrick Miller, RN, MBA, MHSA
Hospice of Michigan

Gustavo Morel, MD
Dickinson Hematology Oncology

Thomas O'Neil, MD
Arbor Hospice

Phillip Rodgers, MD
Michigan Medicine

Andrew Russell, MD
Michigan Medicine

Jerome Seid, MD
Great Lakes Cancer Management Specialists

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

Maria Silveira, MD, MA, MPH
Michigan Medicine

Jim Spears, RN
Henry Ford Health

Mike Stellini, MD, MS
Karmanos Cancer Center

Mike Trexler, MD
Ascension Borgess

Taylor Wofford, MD
MyMichigan Hospice

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 Cargilll-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

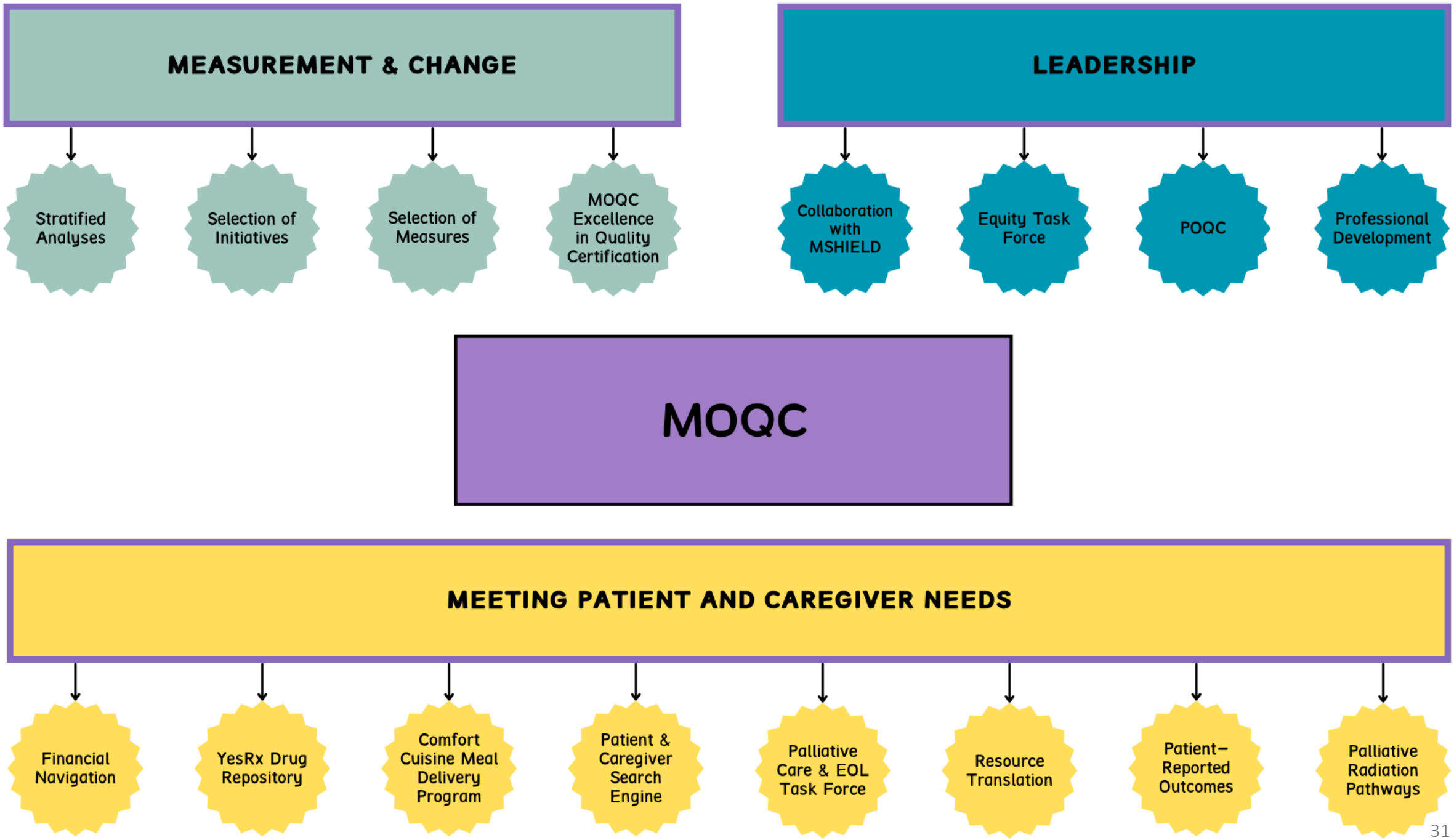
Geetika Kukreja, MD
Henry Ford Health

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

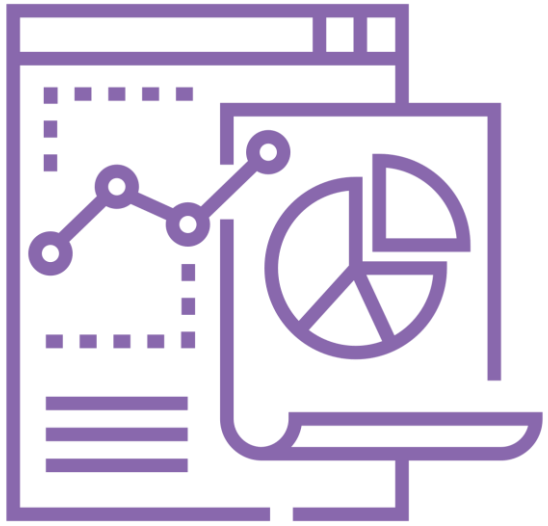
Rev. Diane Smith, MDiv, BCC
Angela Hospice

Elena Stoffel, MD, MPH
Michigan Medicine

Shannon Wills, PA
Henry Ford Health

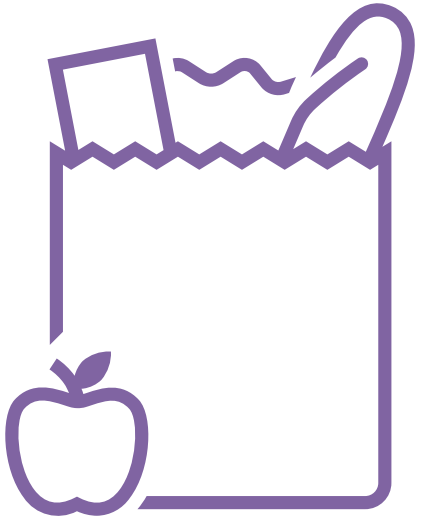

MEASUREMENT & CHANGE
Stratified Analyses
Selection of Initiatives
Selection of Measures
MOQC Excellence in Quality Certification
LEADERSHIP
Collaboration with MSHIELD
Equity Task Force
POQC
Professional Development
MOQC
MEETING PATIENT AND CAREGIVER NEEDS
Financial Navigation
YesRx Drug Repository
Comfort 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

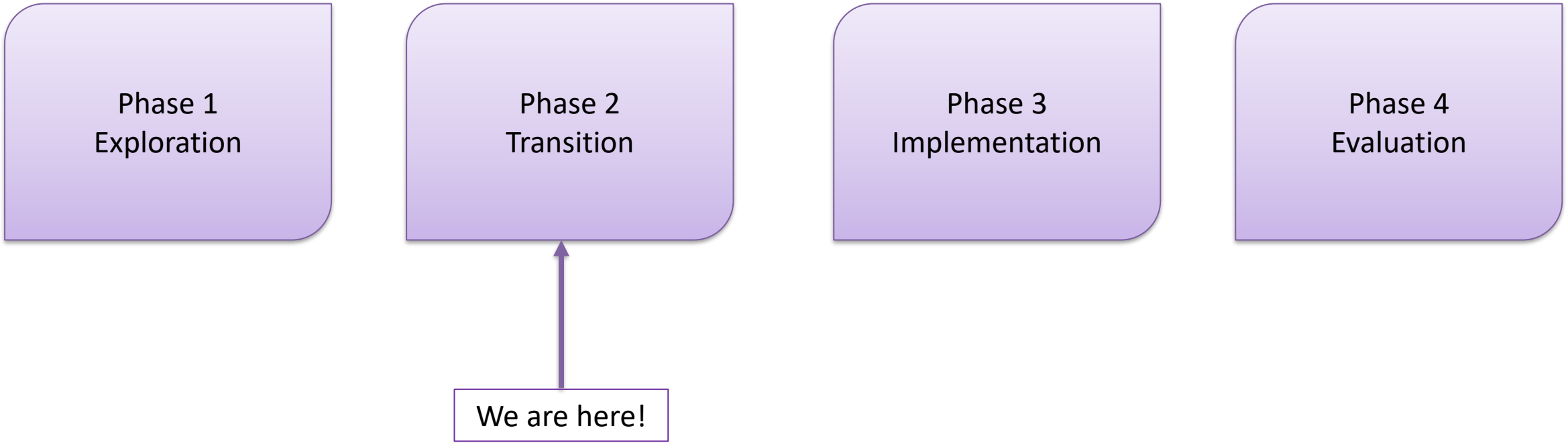
Educational Opportunities

Oncology Stewardship & YesRx

Keli DeVries, LMSW

Oncology Stewardship (OncoStew)

2-year project
June 2023 – June 2025



Oncology Stewardship (OncoStew)

Phase 1 Exploration

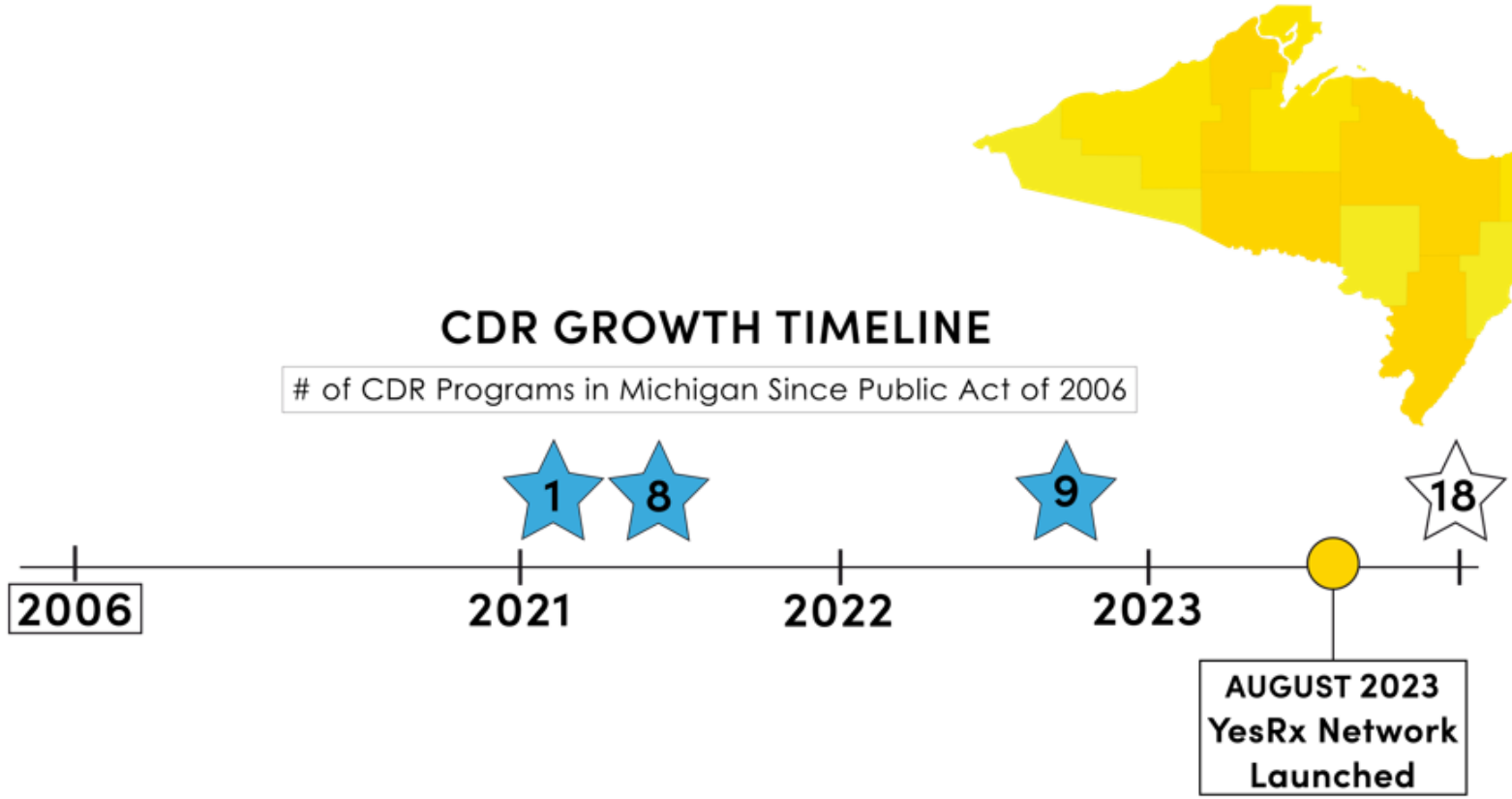
Nominations – Spring 2023
Funding approved – June 2023
Focus groups – Sep /Nov 2023
Report created
Manuscript submitted (*The Oncologist*) – Jan 2024

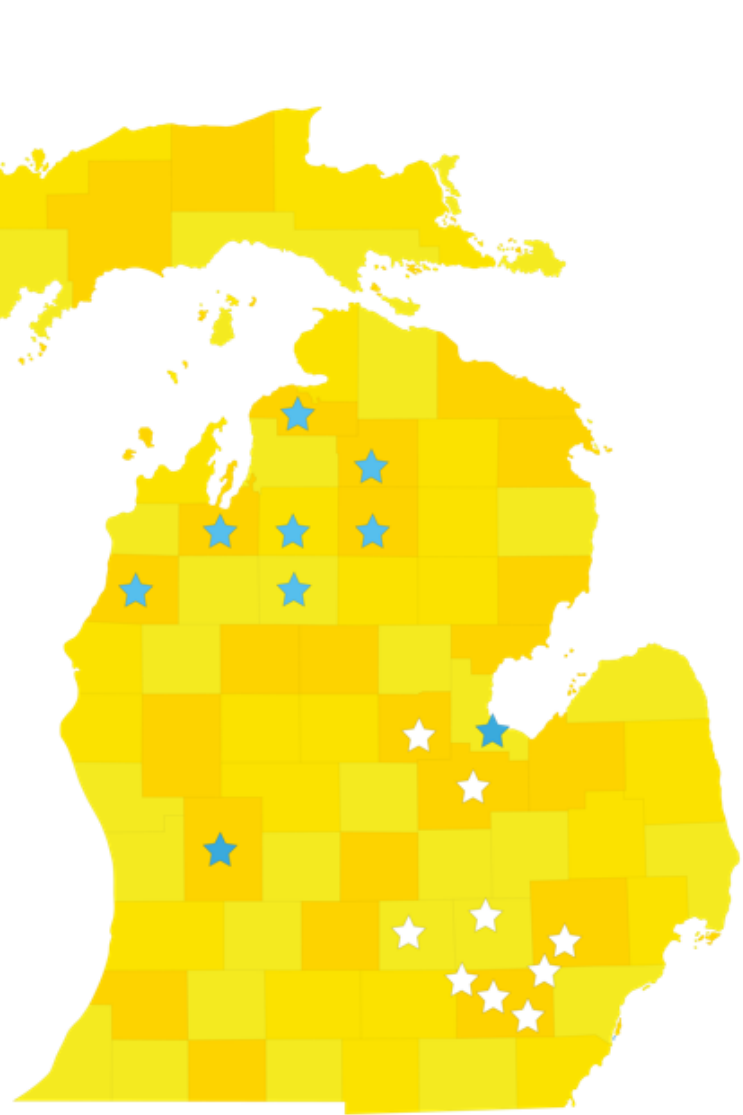
Phase 2 Transition

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

As of Today - 18 CDR Programs Are Active in Michigan





yesRx www.yesrx.org

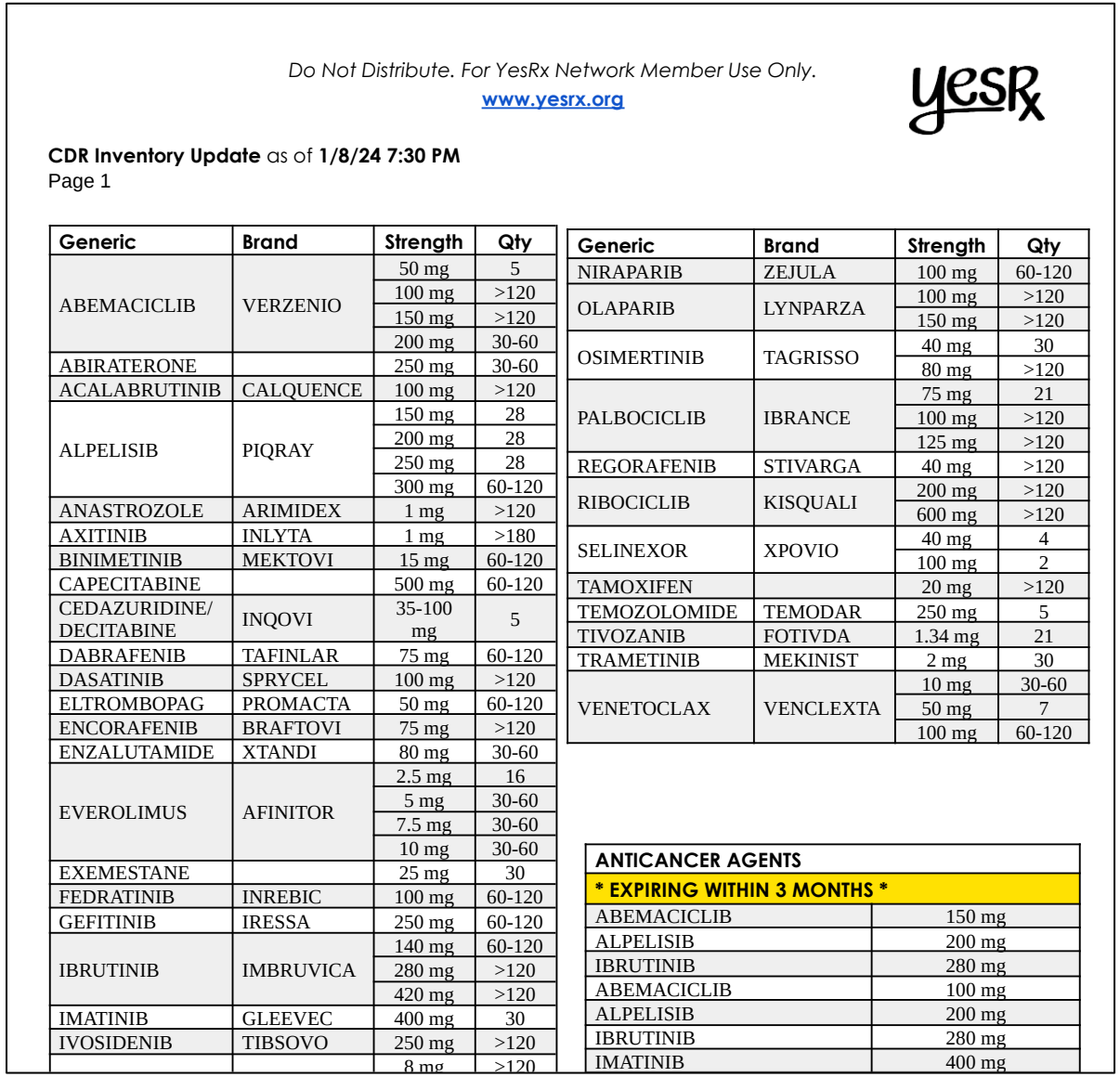
YesRx Network Engagement

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

Generic	Brand	Strength	Qty
ABEMACICLIB	VERZENIO	50 mg	5
		100 mg	>120
		150 mg	>120
		200 mg	30-60
ABIRATERONE		250 mg	30-60
ACALABRUTINIB	CALQUENCE	100 mg	>120
ALPELISIB	PIQRAY	150 mg	28
		200 mg	28
		250 mg	28
		300 mg	60-120
ANASTROZOLE	ARIMIDEX	1 mg	>120
AXITINIB	INLYTA	1 mg	>180
BINIMETINIB	MEKTOVI	15 mg	60-120
CAPECITABINE		500 mg	60-120
CEDAZURIDINE/ DECITABINE	INQOVI	35-100 mg	5
DABRAFENIB	TAFINLAR	75 mg	60-120
DASATINIB	SPRYCEL	100 mg	>120
ELTROMBOPAG	PROMACTA	50 mg	60-120
ENCORAFENIB	BRAFTOVI	75 mg	>120
ENZALUTAMIDE	XTANDI	80 mg	30-60
EVEROLIMUS	AFINITOR	2.5 mg	16
		5 mg	30-60
		7.5 mg	30-60
		10 mg	30-60
EXEMESTANE		25 mg	30
FEDRATINIB	INREBIC	100 mg	60-120
GEFITINIB	IRESSA	250 mg	60-120
IBRUTINIB	IMBRUVICA	140 mg	60-120
		280 mg	>120
		420 mg	>120
IMATINIB	GLEEVEC	400 mg	30
IVOSIDENIB	TIBSOVO	250 mg	>120
		8 mg	>120

Generic	Brand	Strength	Qty
NIRAPARIB	ZEJULA	100 mg	60-120
OLAPARIB	LYNPARZA	100 mg	>120
		150 mg	>120
OSIMERTINIB	TAGRISSO	40 mg	30
		80 mg	>120
PALBOCICLIB	IBRANCE	75 mg	21
		100 mg	>120
		125 mg	>120
REGORAFENIB	STIVARGA	40 mg	>120
RIBOCICLIB	KISQUALI	200 mg	>120
		600 mg	>120
SELINEXOR	XPOVIO	40 mg	4
		100 mg	2
TAMOXIFEN		20 mg	>120
TEMOZOLOMIDE	TEMODAR	250 mg	5
TIVOZANIB	FOTIVDA	1.34 mg	21
TRAMETINIB	MEKINIST	2 mg	30
VENETOCLAX	VENCLEXTA	10 mg	30-60
		50 mg	7
		100 mg	60-120

ANTICANCER AGENTS	
* EXPIRING WITHIN 3 MONTHS *	
ABEMACICLIB	150 mg
ALPELISIB	200 mg
IBRUTINIB	280 mg
ABEMACICLIB	100 mg
ALPELISIB	200 mg
IBRUTINIB	280 mg
IMATINIB	400 mg

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

yesRx www.yesrx.org

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!

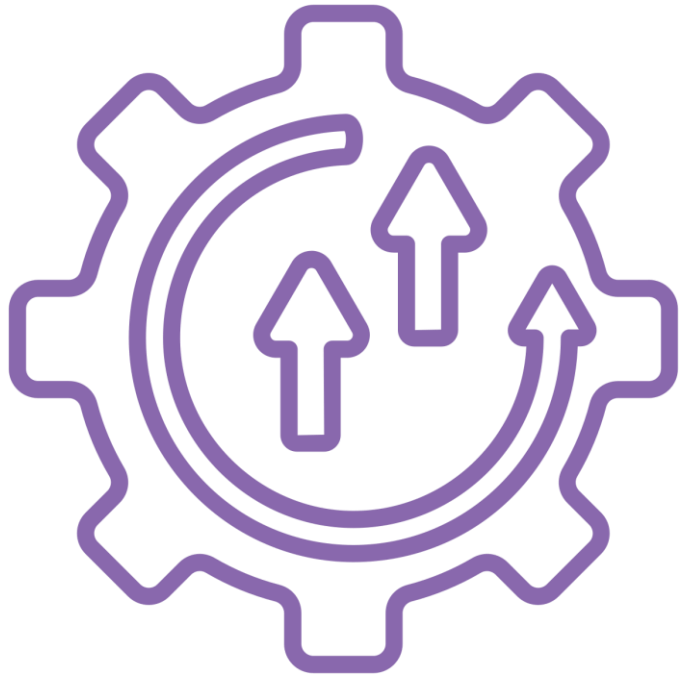
We are here to help!
Emily Mackler, PharmD, BCOP
Founder, CMO
emily@yesrx.org
734-395-3855

Siobhan Norman
Founder, CEO
siobhan@yesrx.org
734-904-5198

yesRx www.yesrx.org

MOQC Practice Performance

Jennifer J. Griggs, MD, MPH



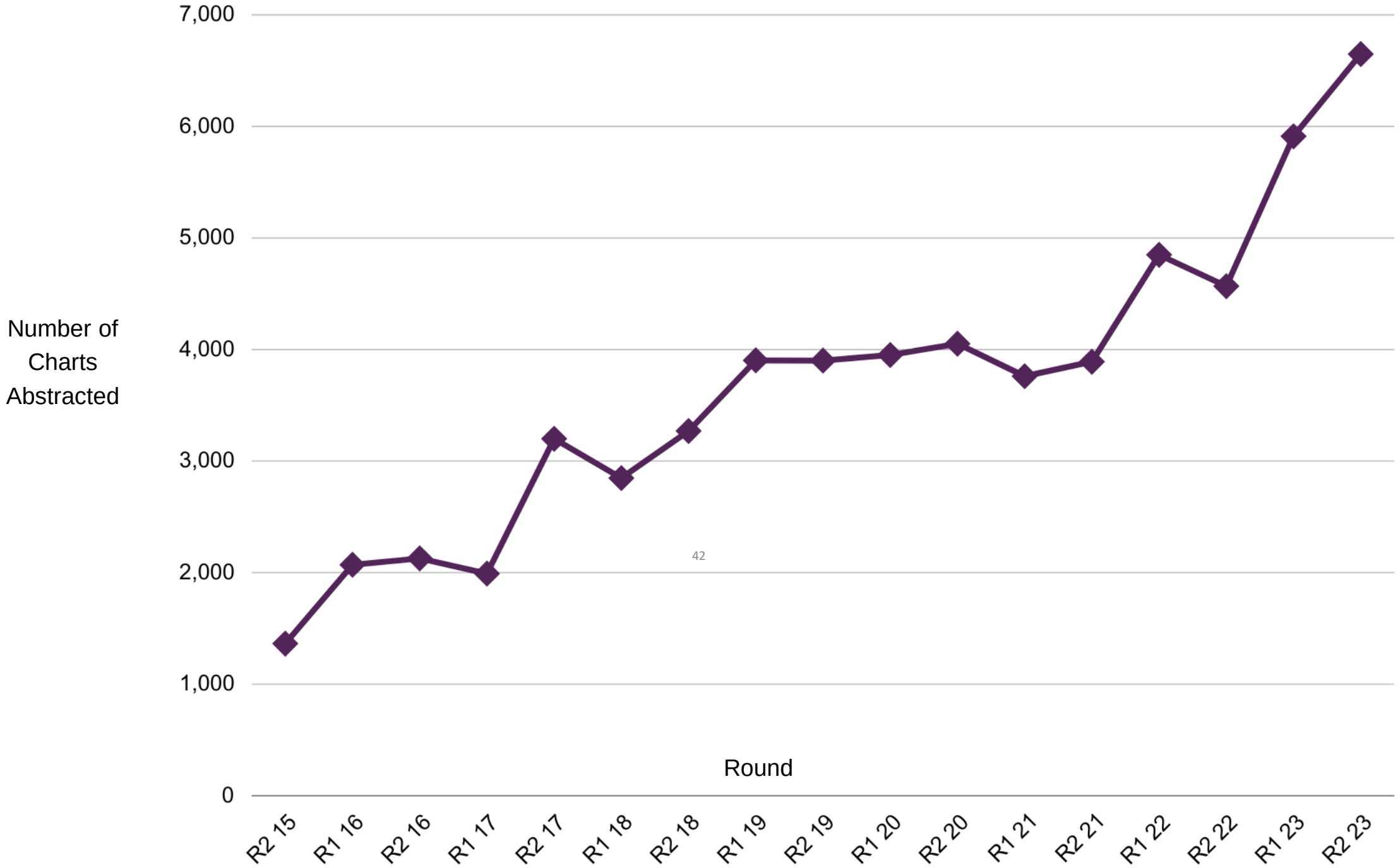
Thank You, Data Abstractors

- 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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Round
R2 15
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R1 18
R2 18
R1 19
R2 19
R1 20
R2 20
R1 21
R2 21
R1 22
R2 22
R1 23
R2 23

2023 Medical Oncology Measures

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

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

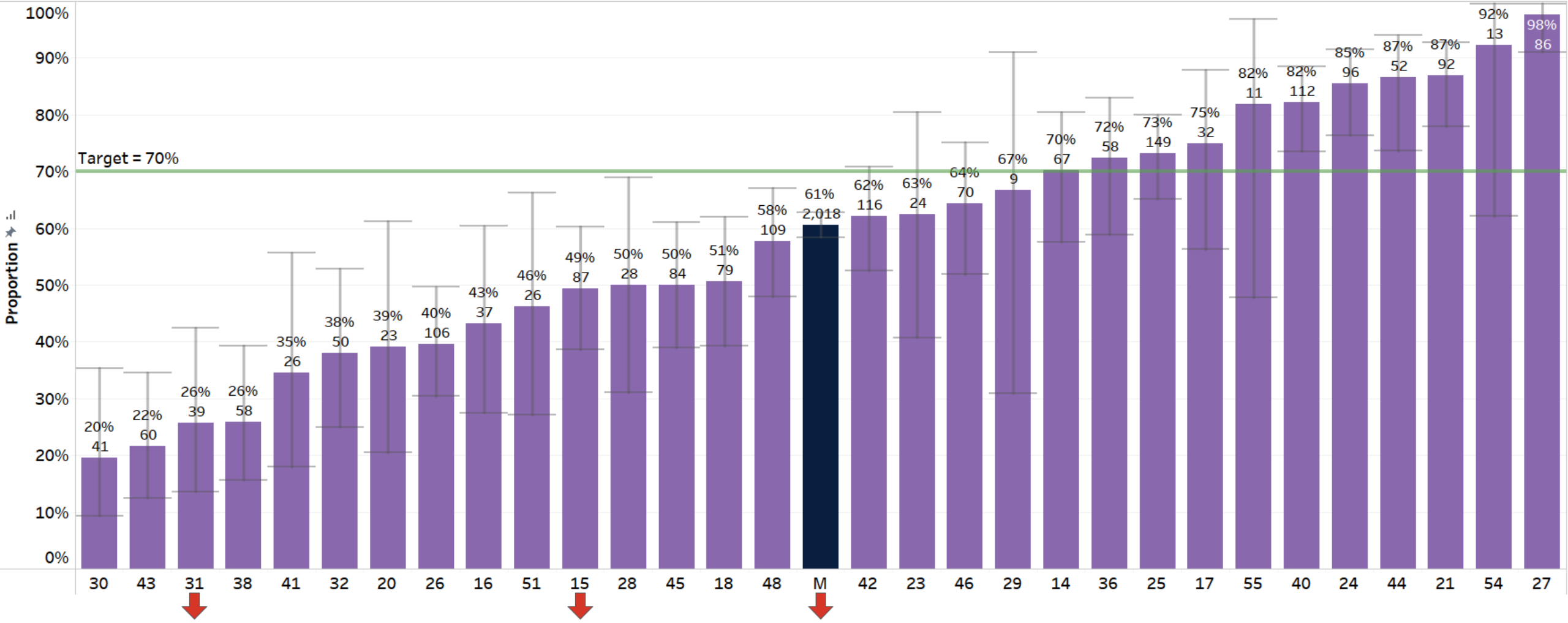
Level	Criteria
Practice Level	At least **one physician and one practice manager** from the practice must attend **both** MOQC regional meetings and **at least one** biannual meeting during that year
Physician Level	Provider must be enrolled in PGIP for at least one year
New requirement beginning Round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

Measures

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

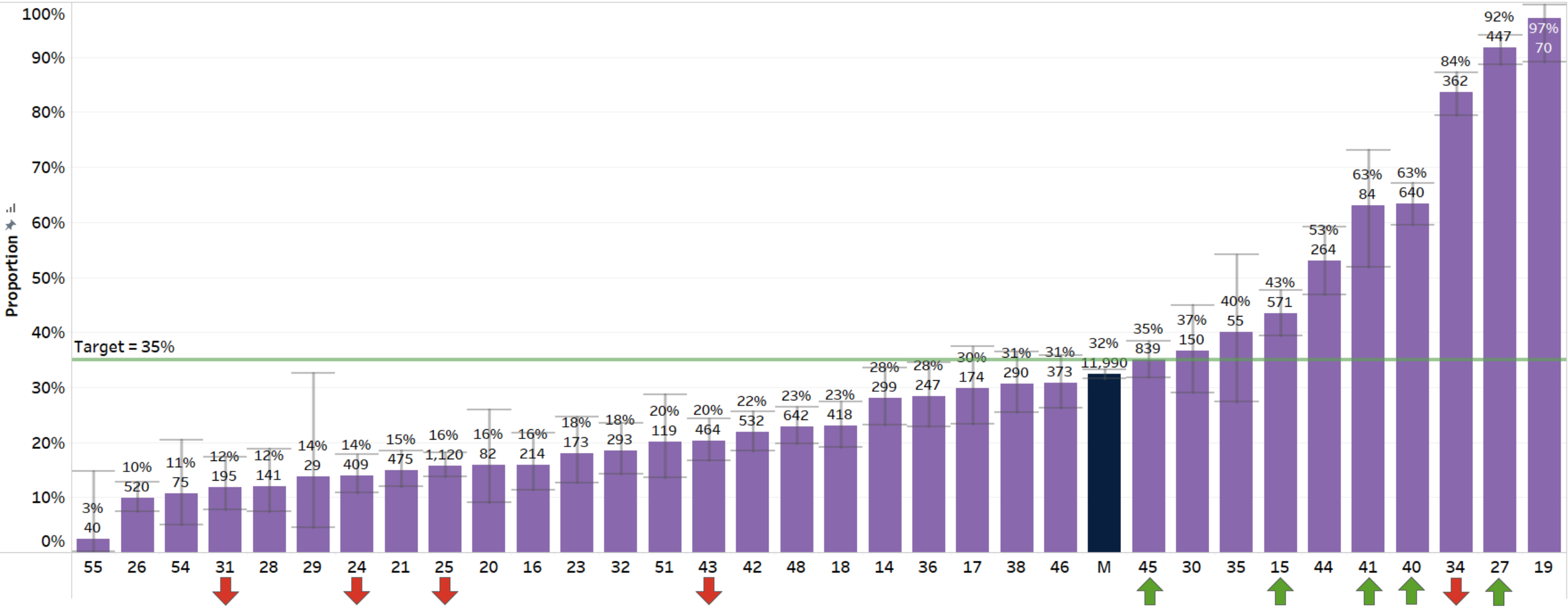
- Practices with no eligible cases in the denominator and/or missing data from one of the time periods are not shown

101b: Tobacco Cessation Counseling Administered or Patient Referred in Past Year
2023, n = 2,018



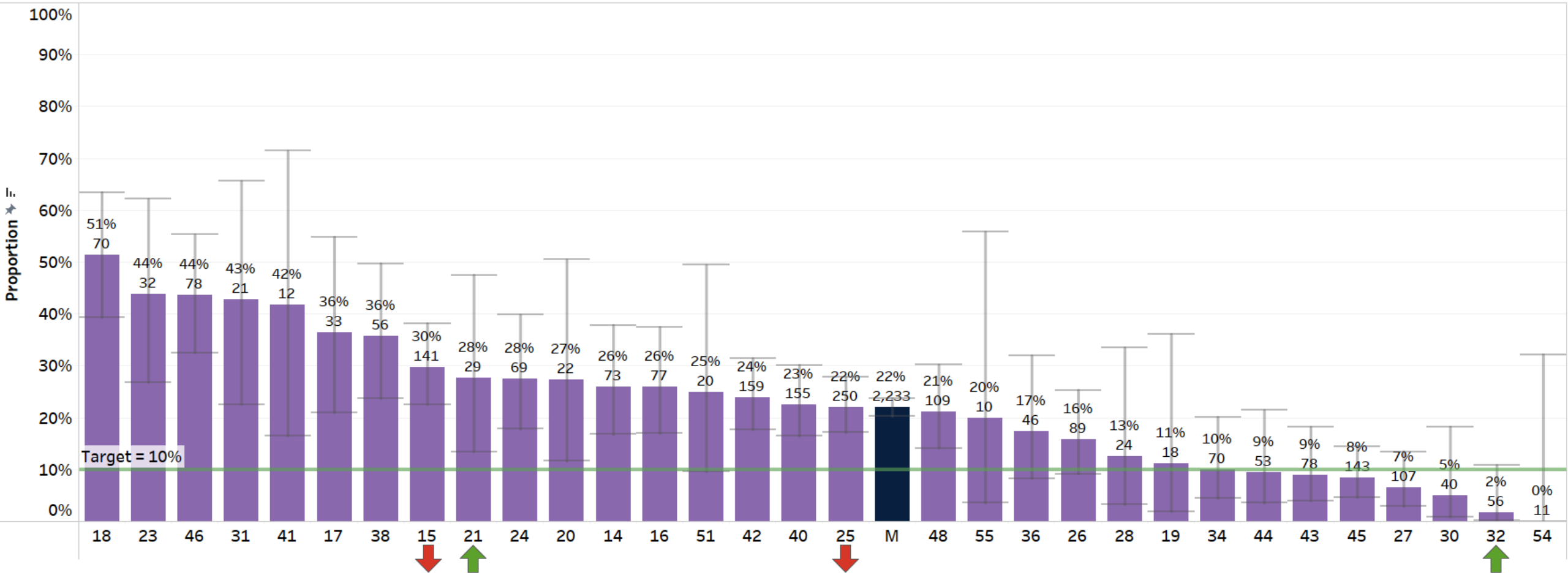
= Improvement in Performance
= Decline in Performance

108a: Complete Family History Documented for Patients with Invasive Cancer
2023, n = 11,990



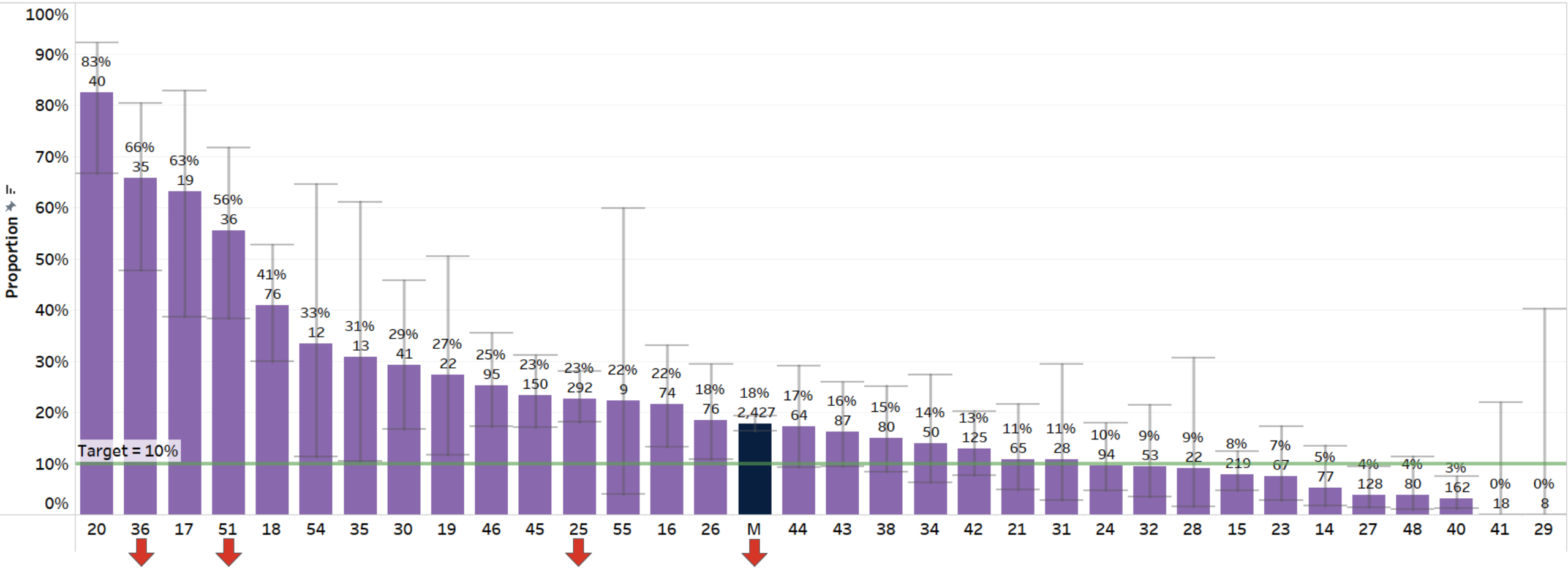
= Improvement in Performance
= Decline in Performance

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



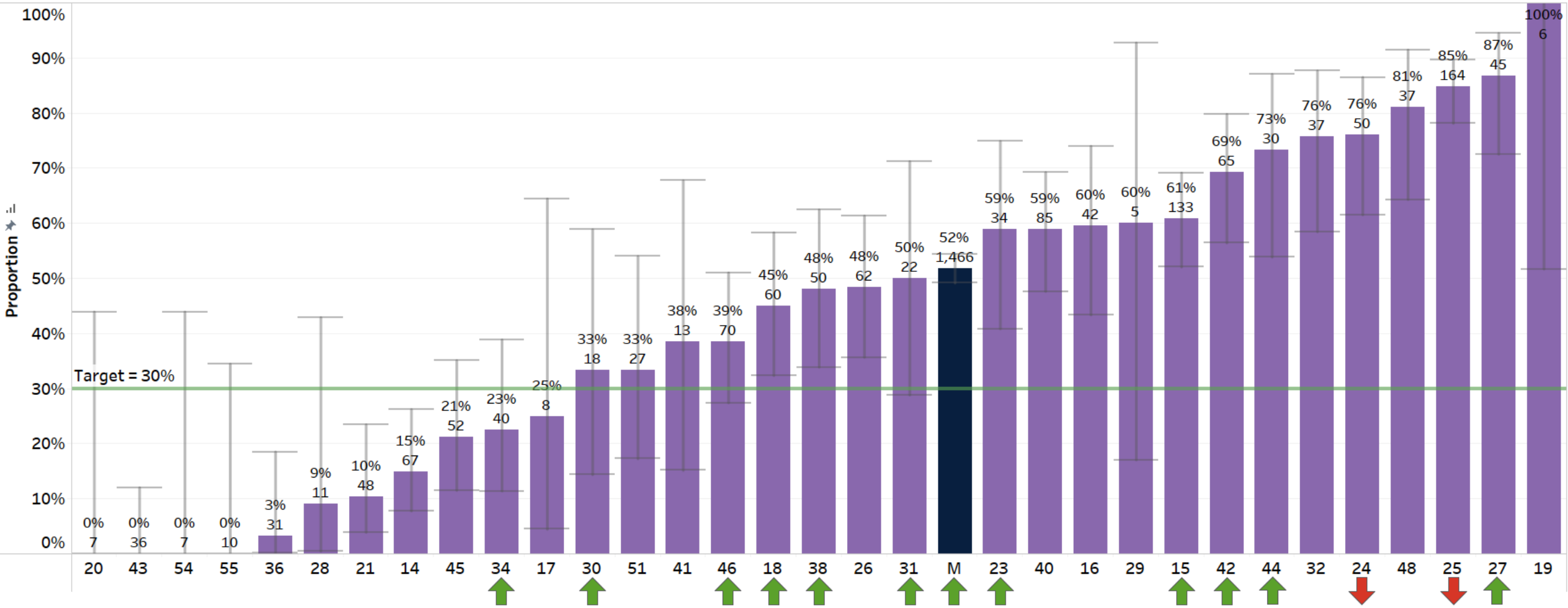
= Improvement in Performance
= Decline in Performance

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

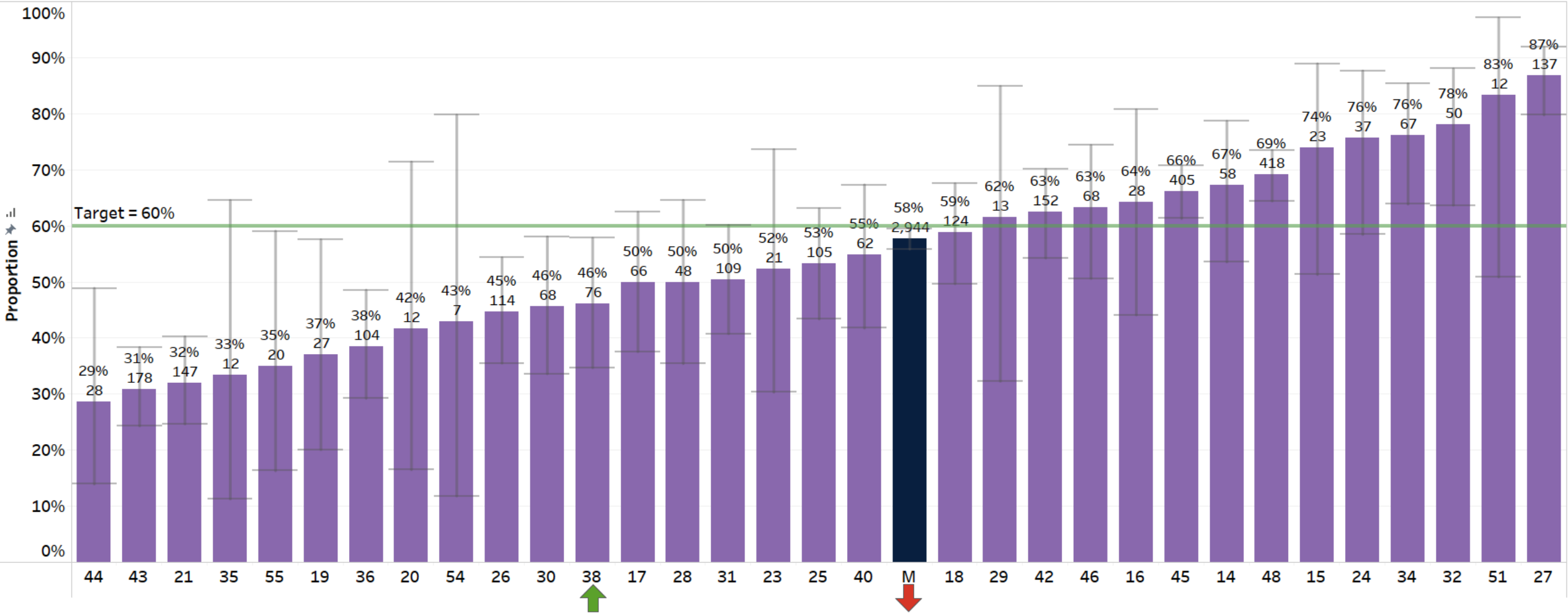
115: NK1 Receptor Antagonist and Olanzapine Prescribed or Administered with High Emetic Risk Chemotherapy 2023, n = 1,466



= Improvement in Performance
= Decline in Performance

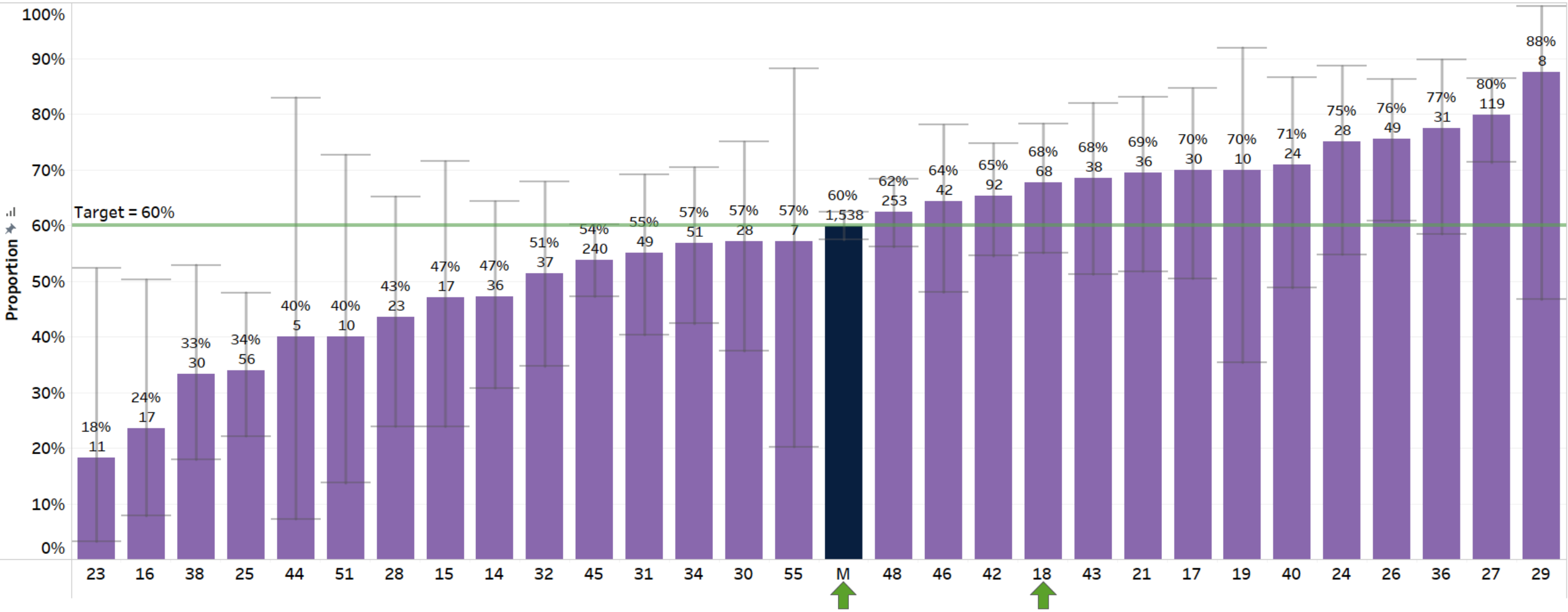
End-of-Life Measures

126a: Hospice Enrollment
2023, n = 2,944



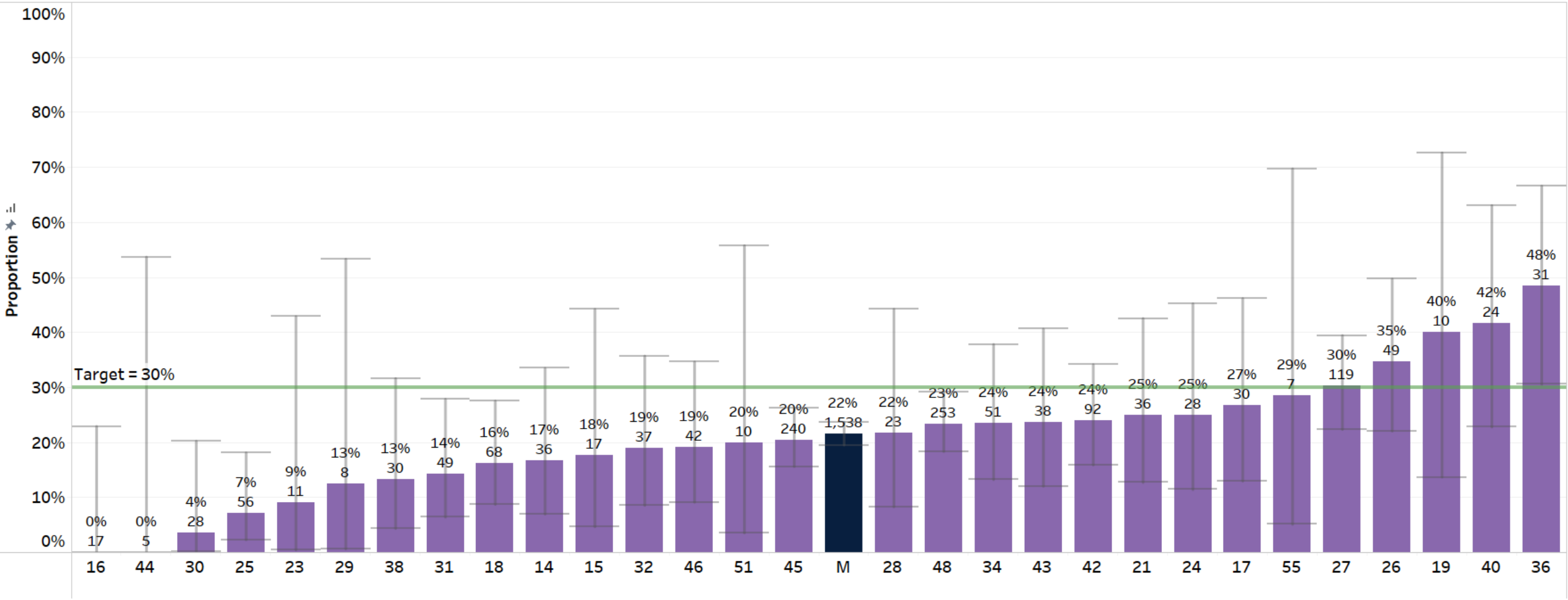
= Improvement in Performance
= Decline in Performance

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



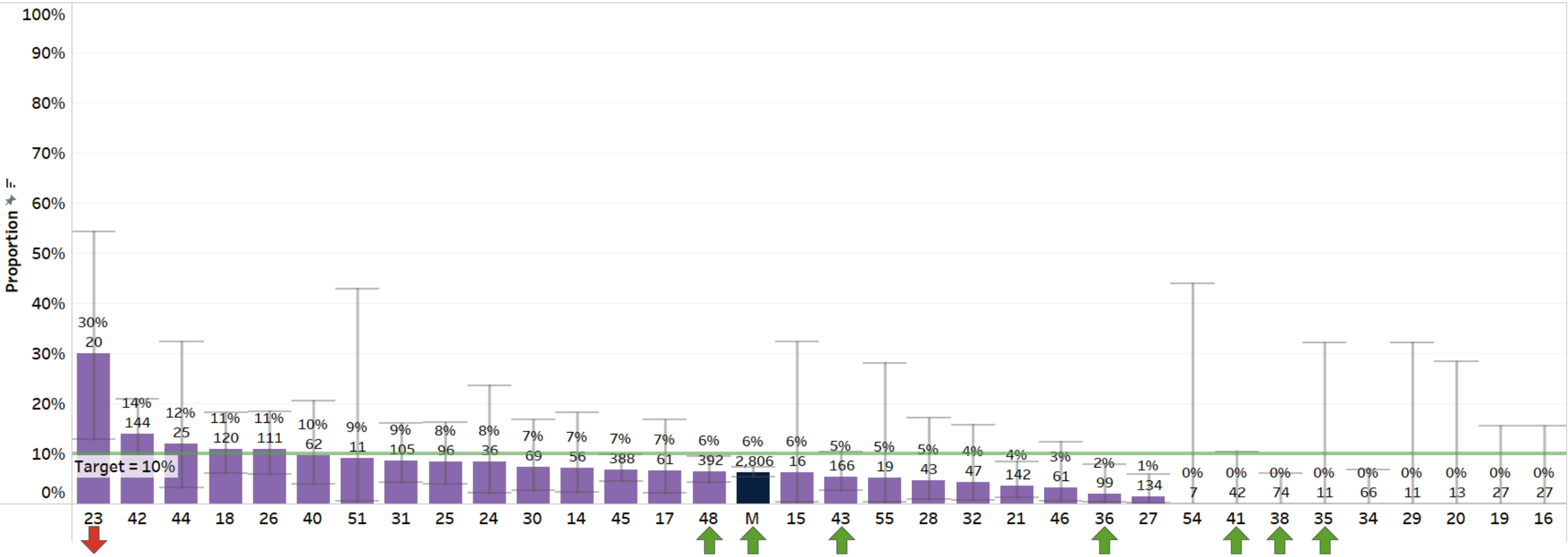
= Improvement in Performance
= Decline in Performance

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



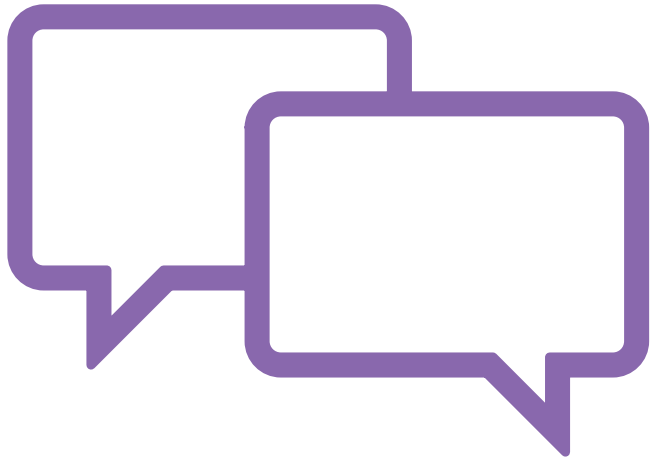
= Improvement in Performance
= Decline in Performance

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



= Improvement in Performance
= Decline in Performance

Discussion



2024 Medical Oncology Measures

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

MOQC Excellence in Quality Certification – New Measures

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

*Based on published patterns of care

2024 Value-Based Reimbursement Summary

Region-Level

Meet 4 of the following 5

- NK1RA & olanzapine for high emetic risk chemotherapy 55%
- 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

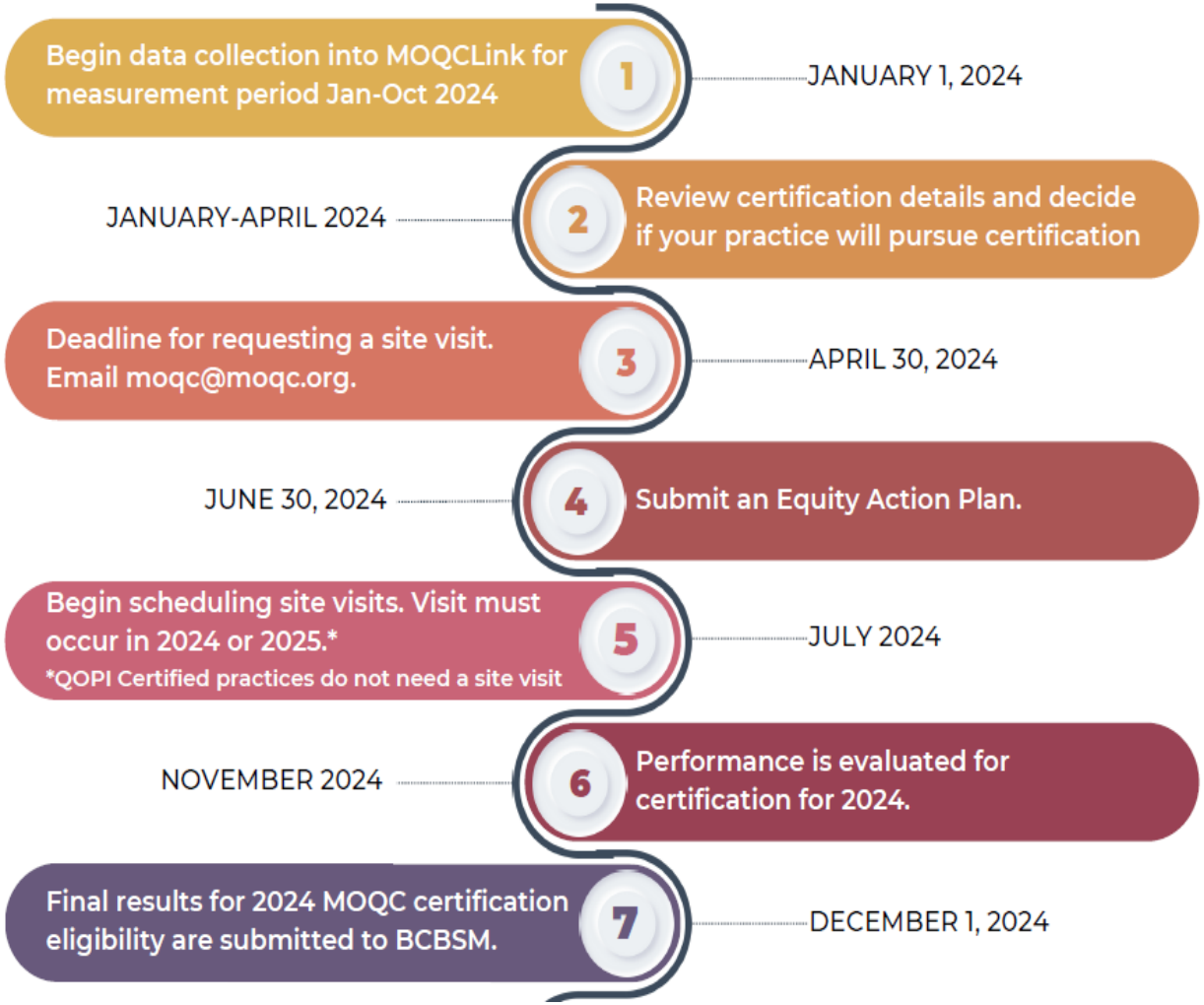
- Meet all 5 region-level measures

2% Opportunity

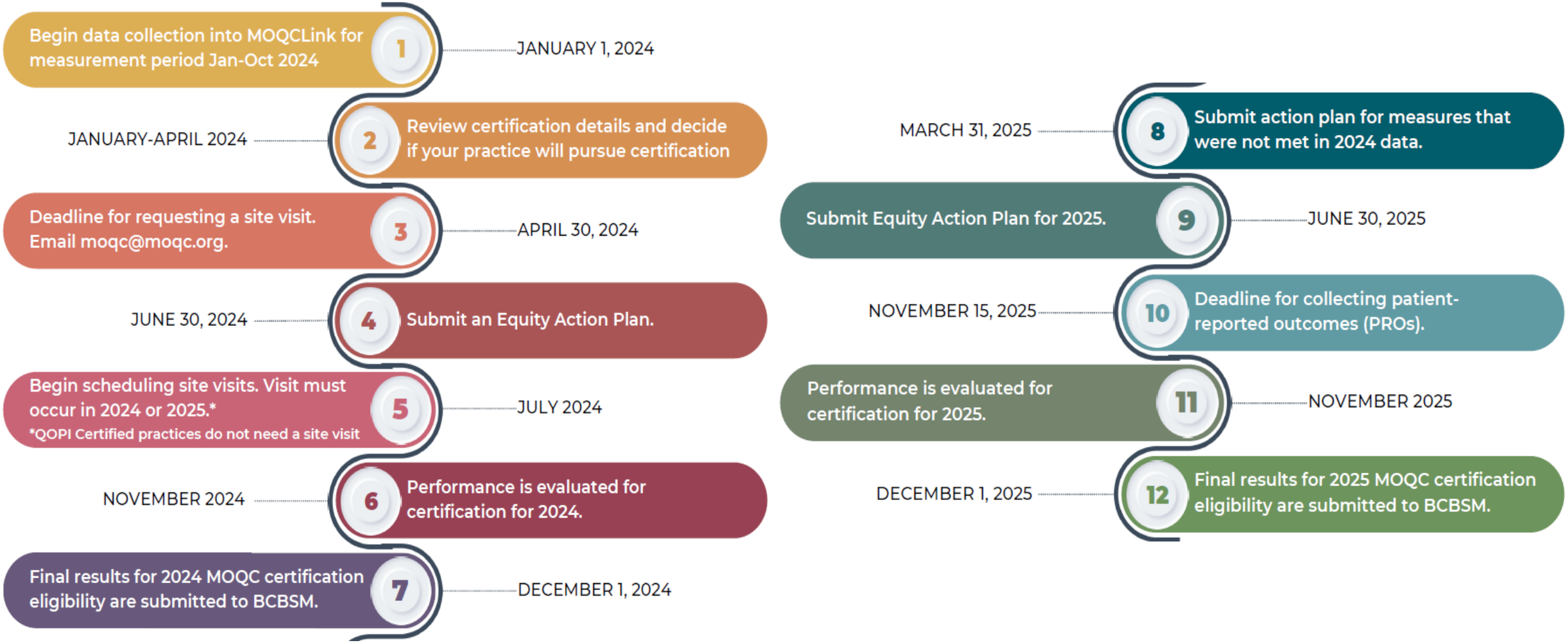
MOQC Excellence in Quality Certification

MOQC Excellence in Quality Certification

Certification Timeline – 2024 and 2025



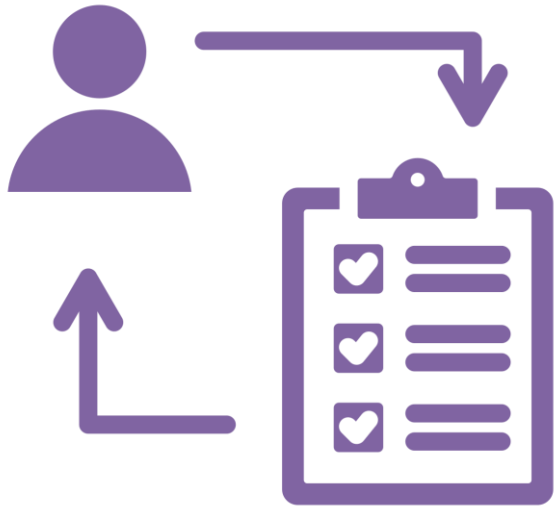
Certification Timeline – 2024 and 2025



Certification Requirements

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

*Not necessary if practice is currently QOPI® certified

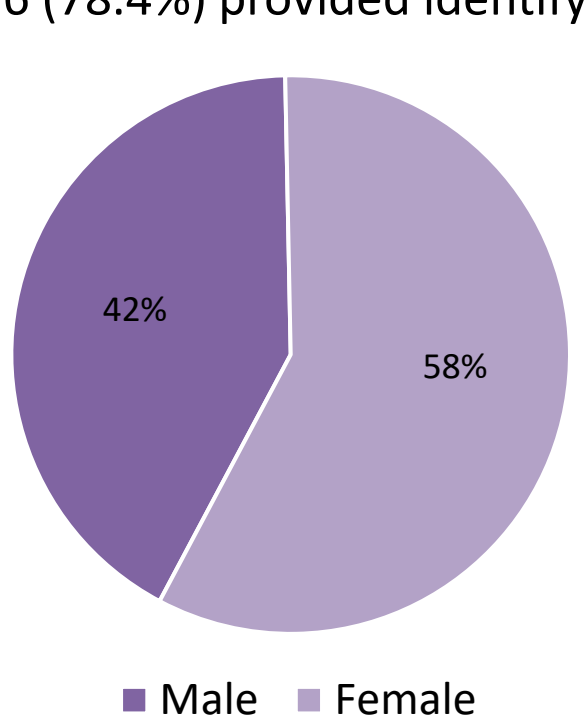


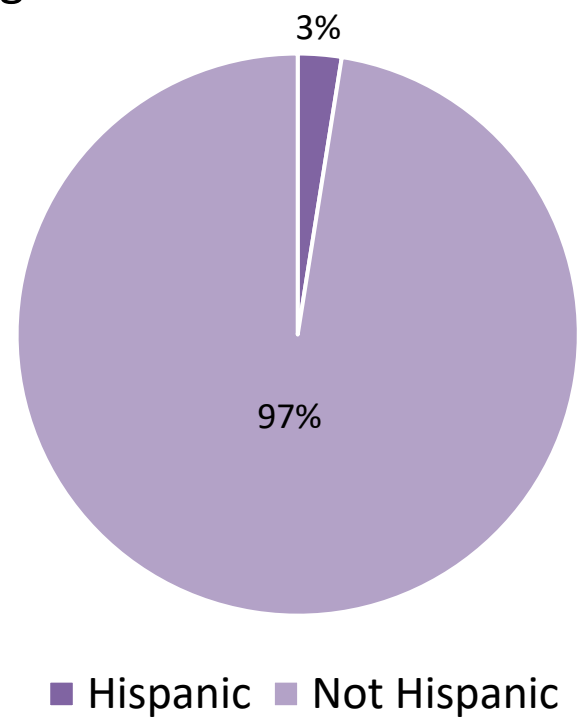
Patient-Reported Outcomes

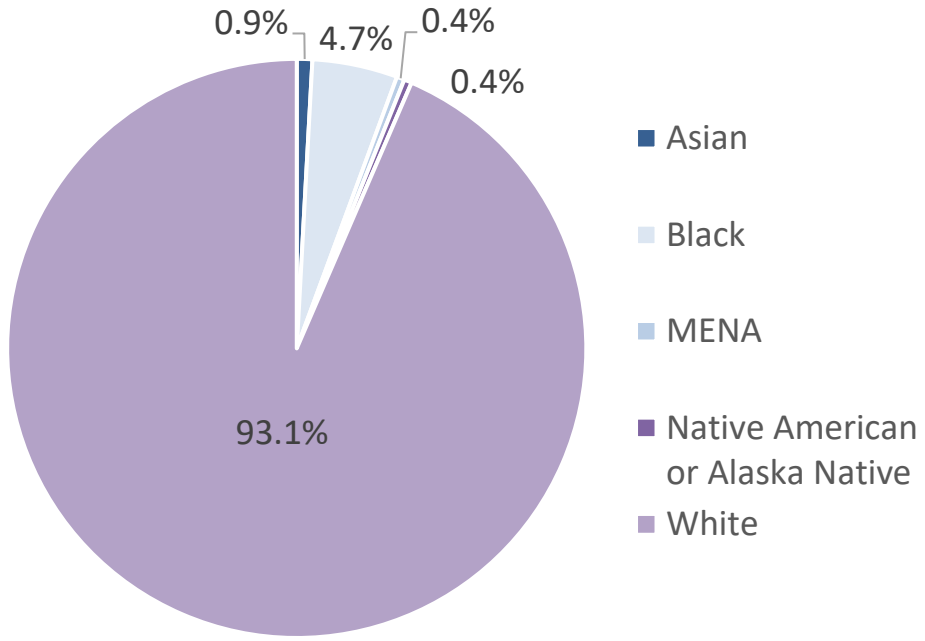
Patient-Reported Outcomes (PROs)

Overview

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



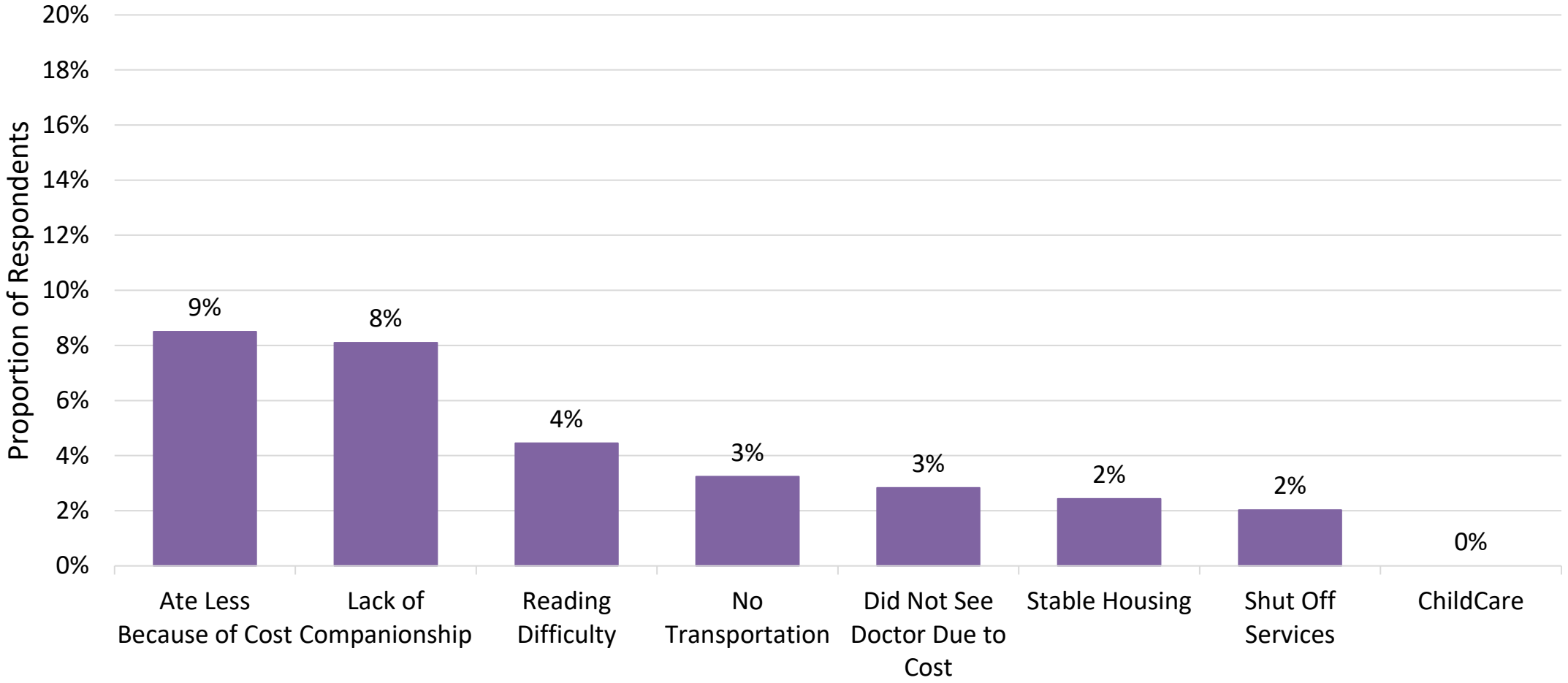




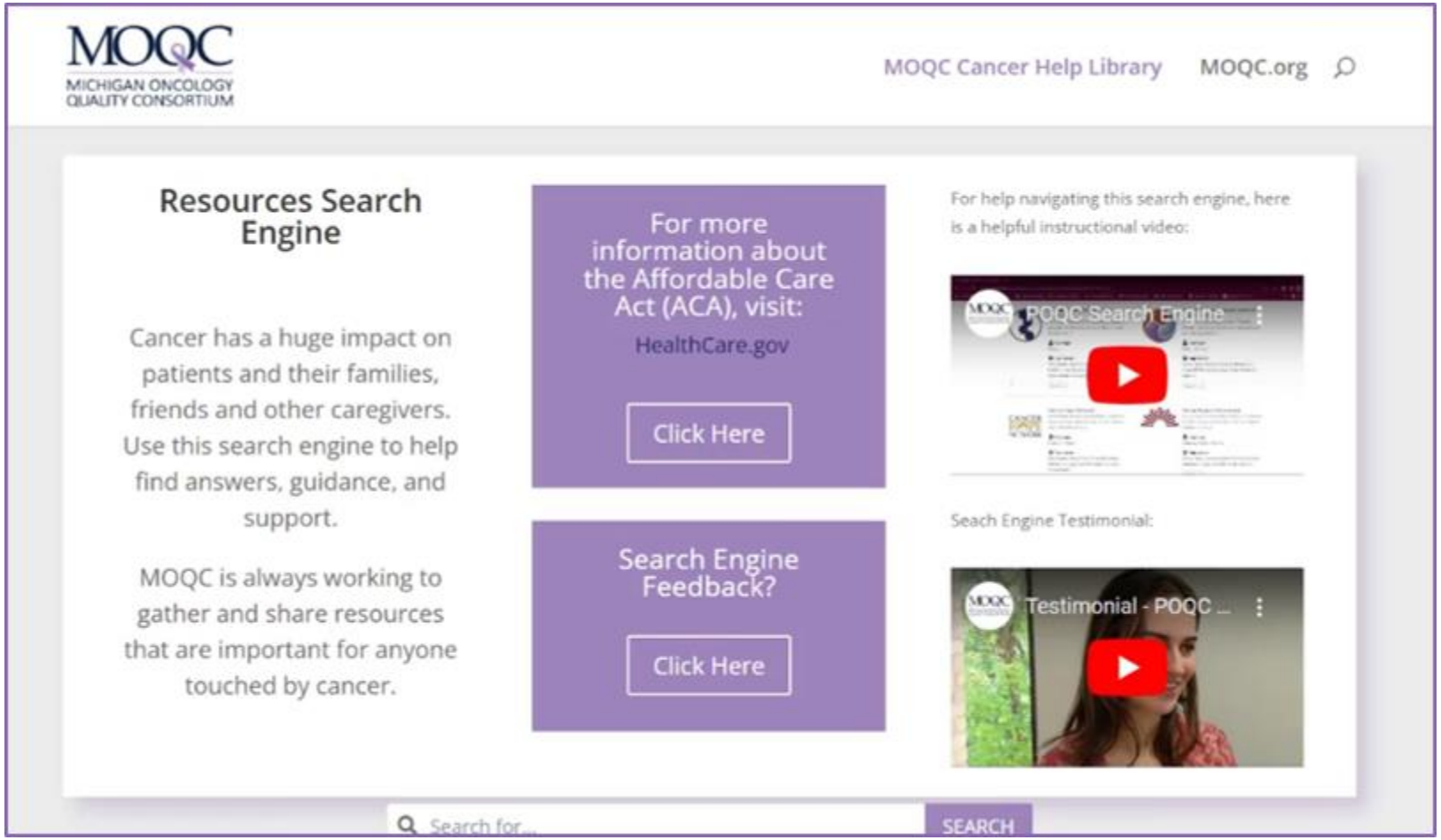
Patient-Reported Outcomes (PROs)

Social Needs

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



Resources Search Engine



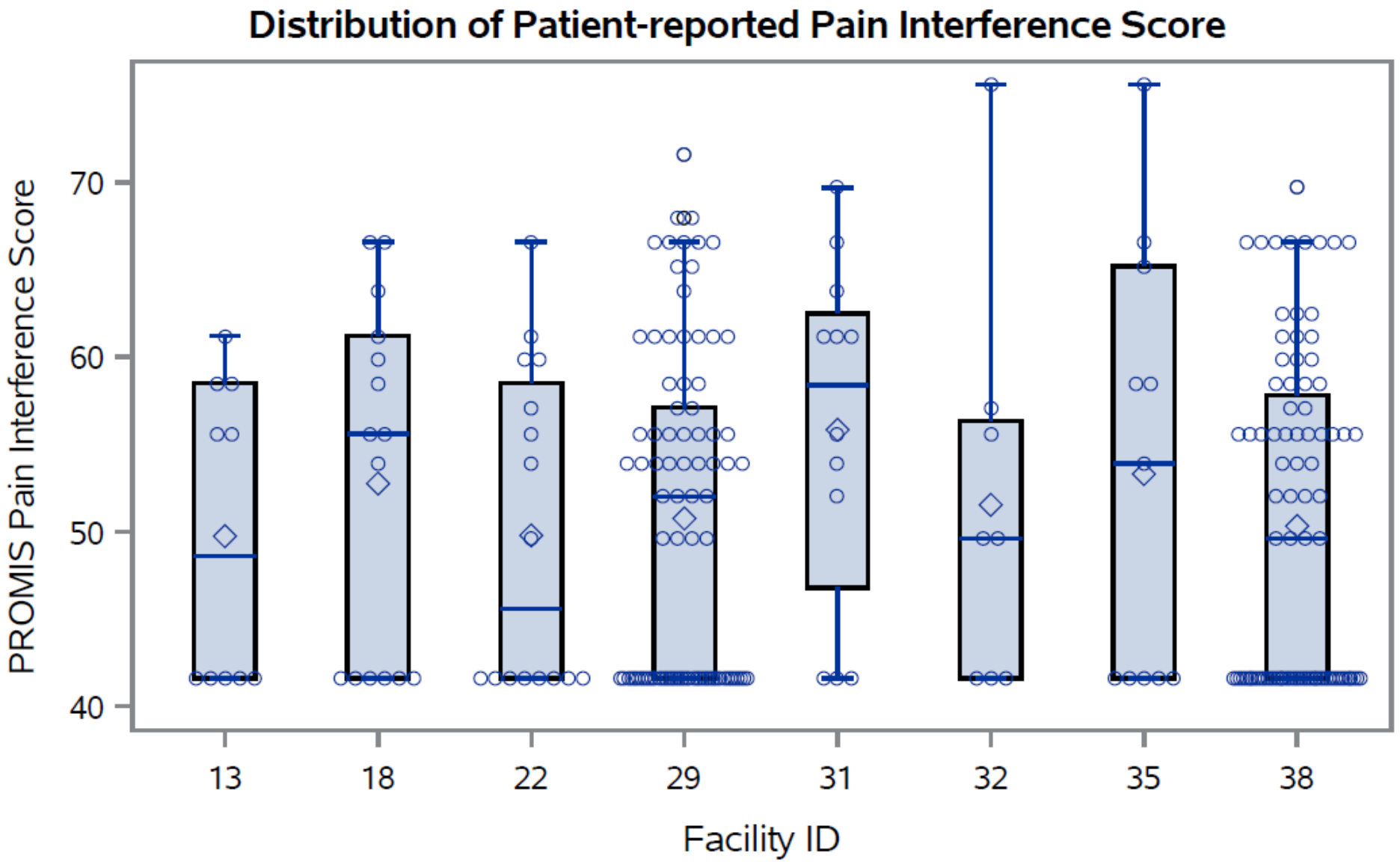
https://cancerhelp.moqc.org/

Additional Resources

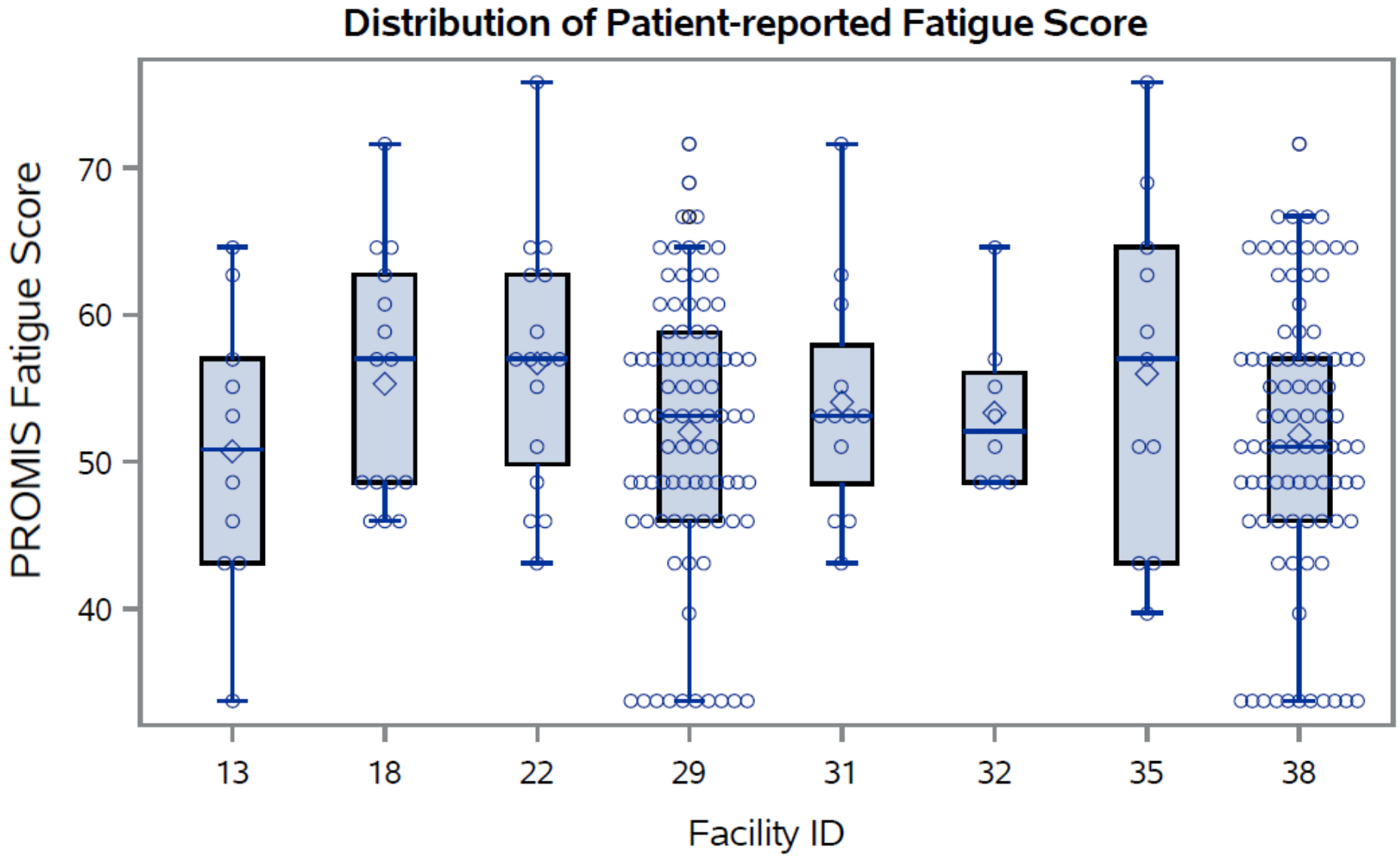
2·1·1
Get Connected. Get Help.™

COLLABORATIVE
MOQC
MIMIND
RESOURCES

Patient-Reported Outcomes (PROs)



Patient-Reported Outcomes (PROs)



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

#BeIntentional

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.


Equality
Equity
© 2017 Robert Wood Johnson Foundation.
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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

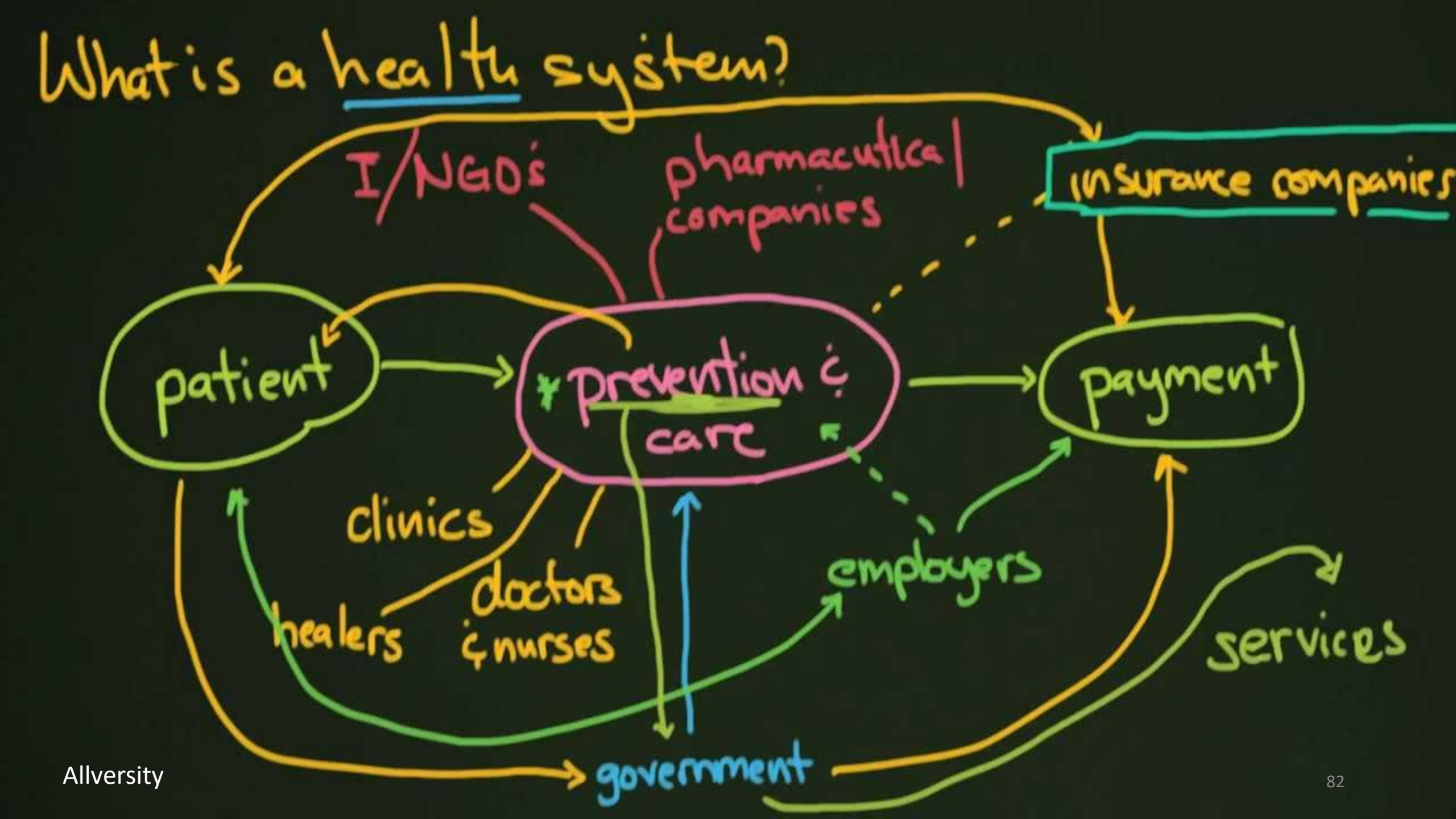
<u>Lower Socioeconomic Status</u>

Social Determinants of Health (SDOH)

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

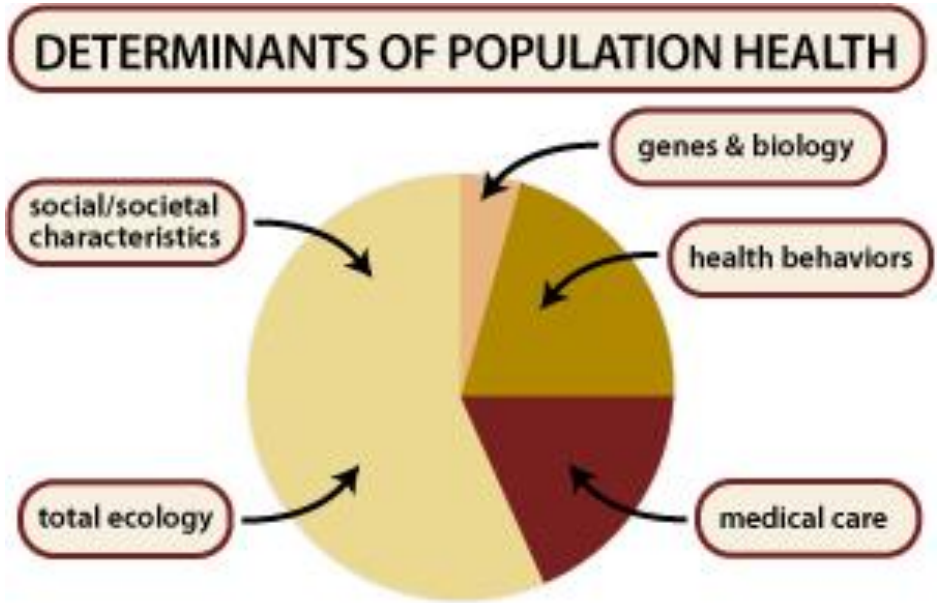
- Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity; 2018

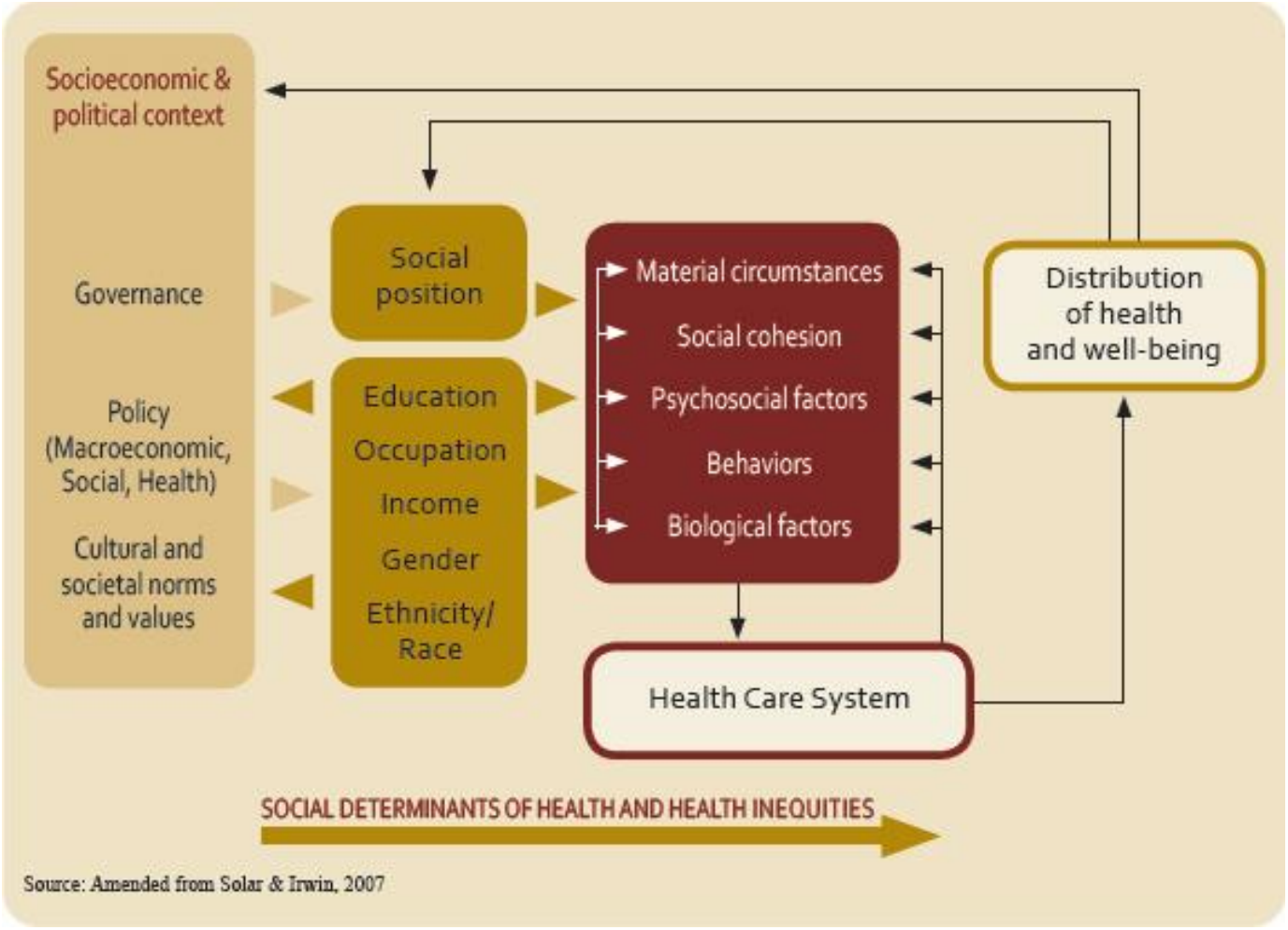

What is a health system?
I/NGO's
pharmaceutical companies
insurance companies
patient
prevention & care
payment
clinics
healers
doctors & nurses
employers
services
government

MOQC
MICHIGAN ONCOLOGY
QUALITY CONSORTIUM

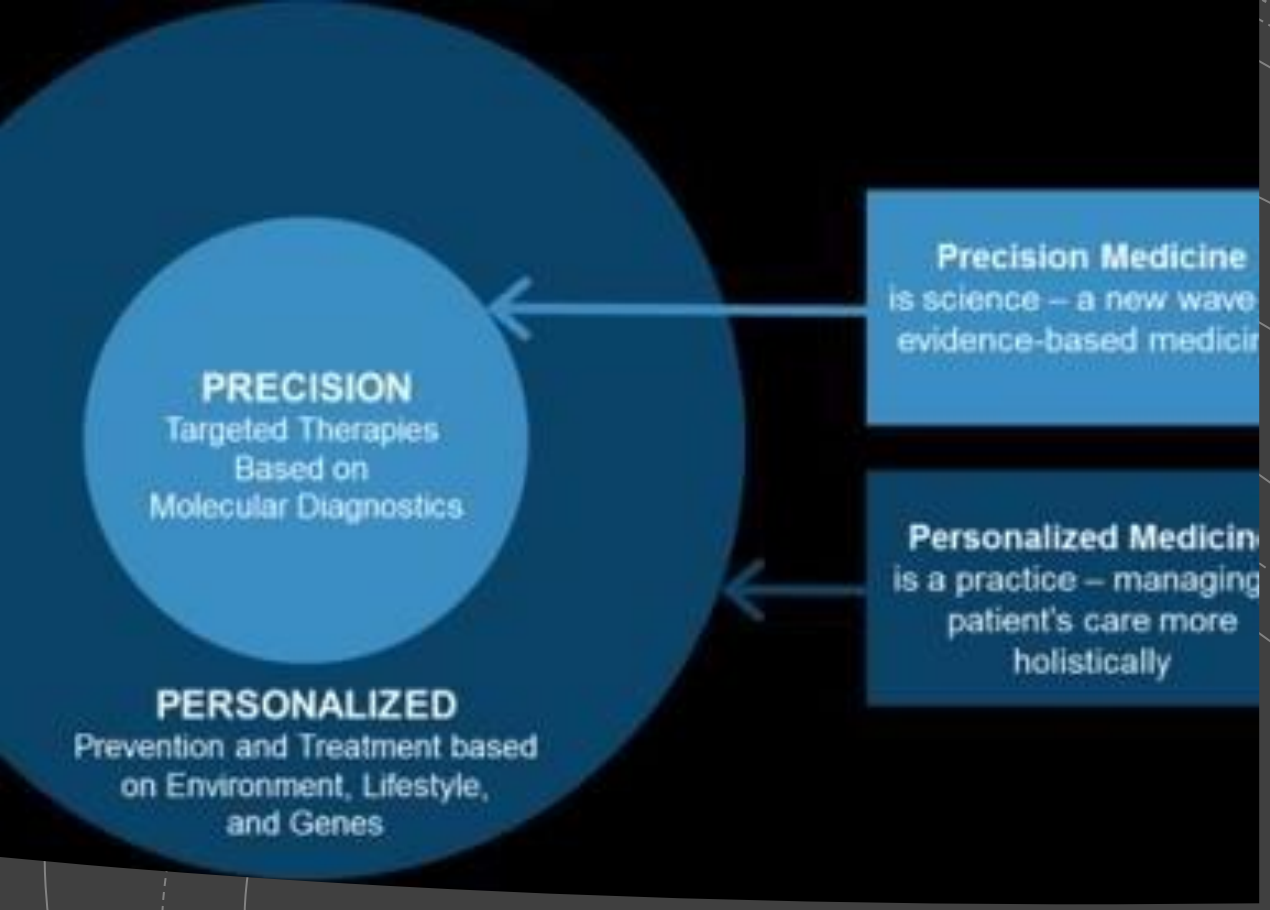
"Our hope is that every patient with cancer and their loved ones will receive the absolute best care"

The Health System and SDOH





http://www.cdc.gov/socialdeterminants/



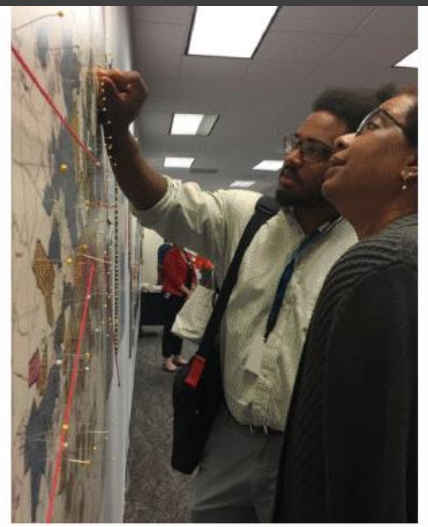
- Glady, Gilbert. (2019). The Bio Immune(G)ene Medicine or How to Use a Maximum of Molecular Resources of the Cell for Therapeutic Purposes. Edelweiss Applied Science and Technology. 26-29. 10.33805/2576-8484.164.

ROSE WONG

https://www.teenvogue.com/story/what-is-redlining-united-states

Politics

What Is Redlining? How Residential Segregation Shaped U.S. Cities









UNDESIGN THE RED LINE

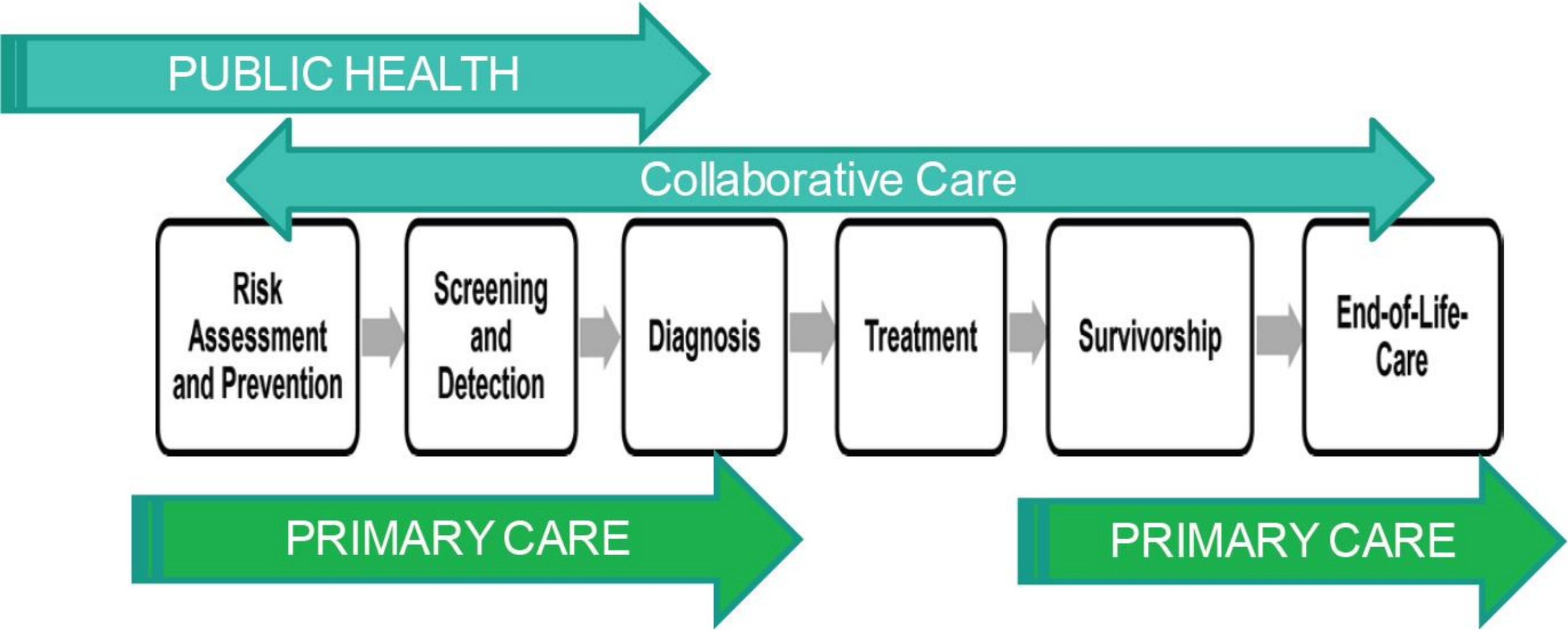
Interactive Exhibit

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

www.enterprisecommunity.org/undesign-the-redline

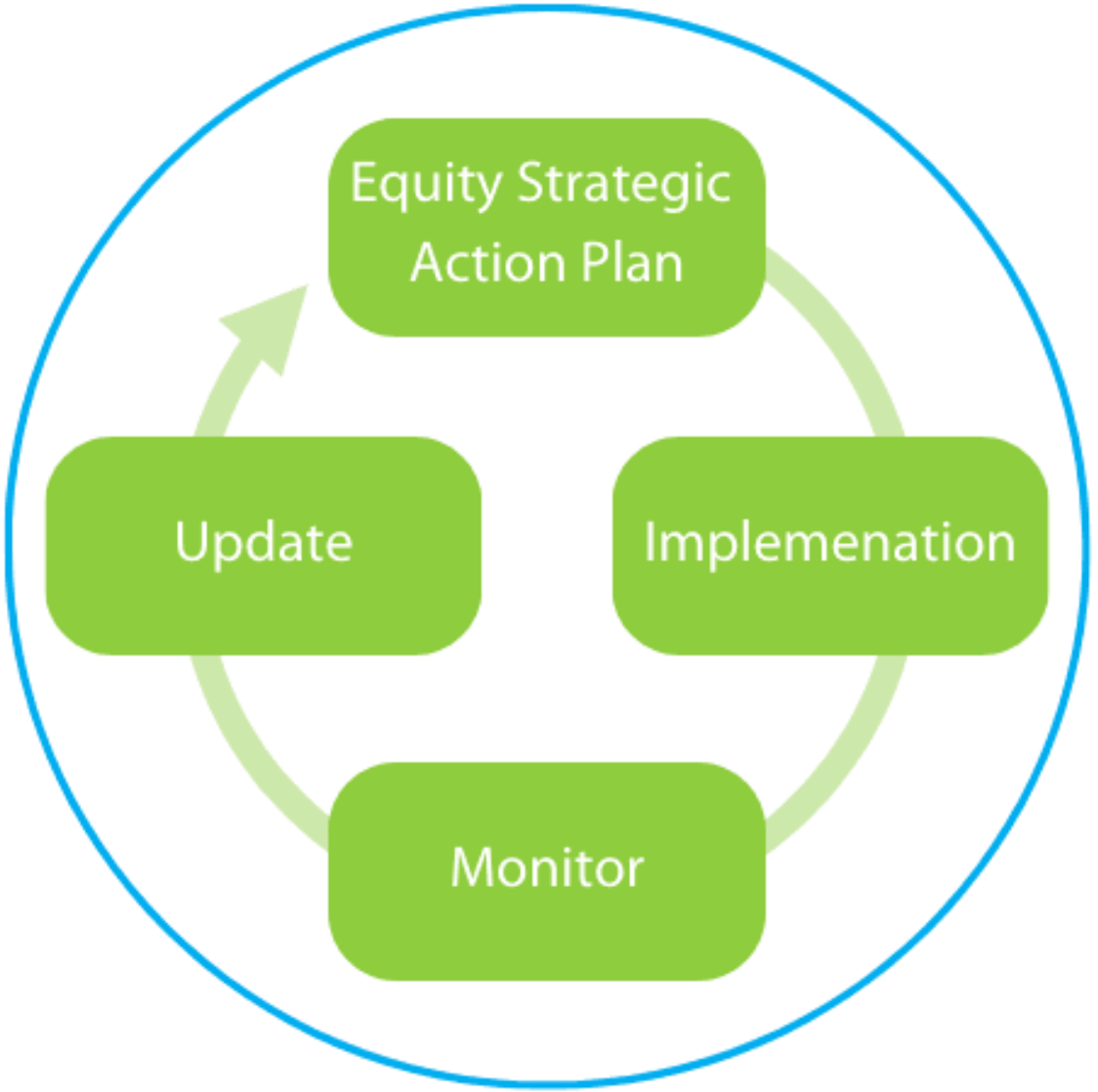
Explore the history.
Share your perspective.
Transform your communities.

http://www.clevelandnp.org/undesigntheredline/



Promoting Health Equity in Cancer Care: Proceedings of a Workshop
National Academies of Sciences, Engineering, and Medicine. 2022. Promoting Health Equity in Cancer Care: Proceedings of a Workshop. Washington, DC: The National Academies Press. https://doi.org/10.17226/26661.

Be Intentional: What Question Are you trying to Answer??



Case Study – *Delaware Cancer Treatment Program*

VOLUME 31 · NUMBER 16 · JUNE 1 2013

JOURNAL OF CLINICAL ONCOLOGY

COMMENTS AND CONTROVERSIES

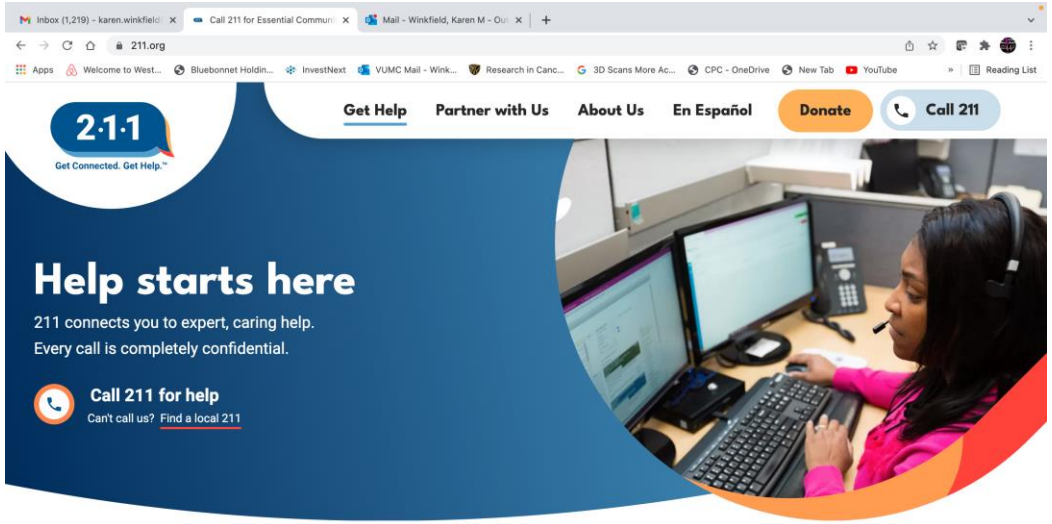
Eliminating Racial Disparities in Colorectal Cancer in the Real World: It Took a Village

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 102,000 new patients diagnosed per

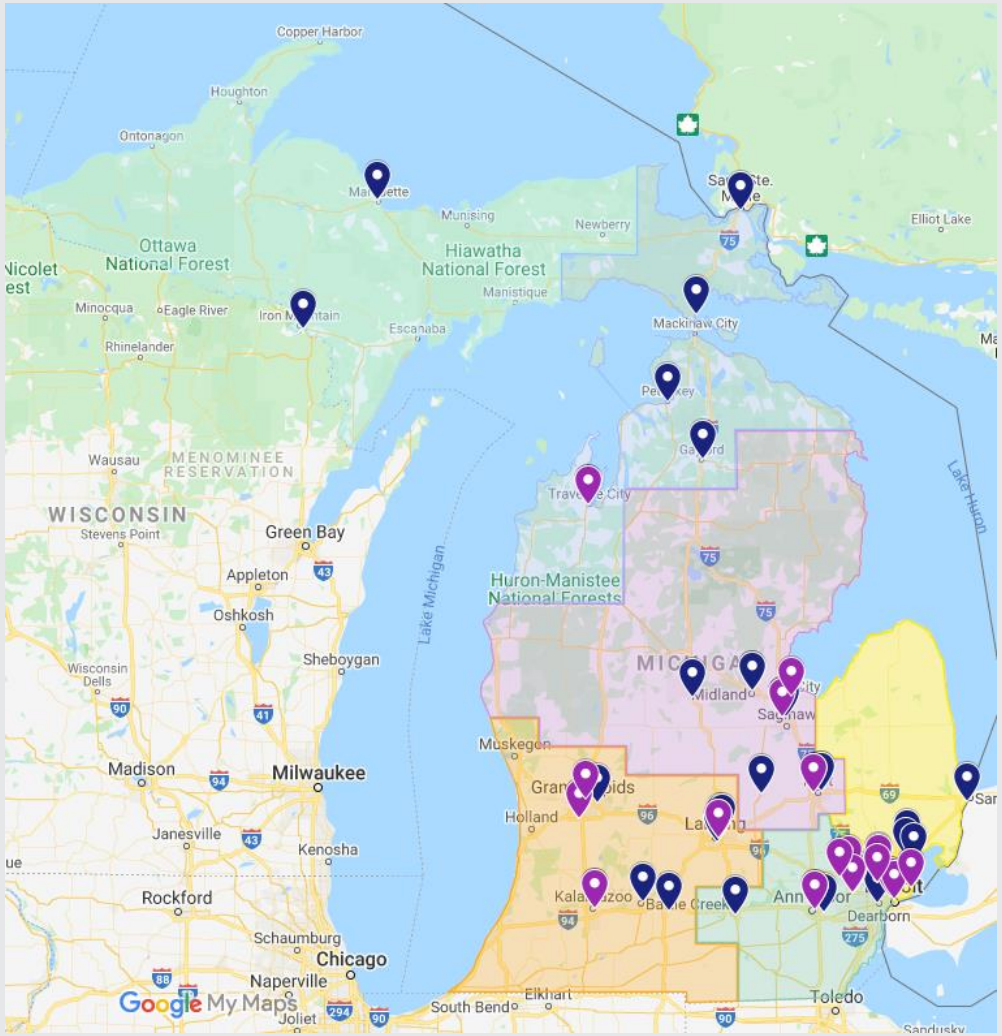
screening rates among minorities; two, target quality treatment, including both timely resolution of abnormal findings and initiation and comple-

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
CDC
U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

MOQC Regions



Member Locations

Med/Onc Gyn/Onc

Regions

- Superior West
- Metro East
- West of Woodward
- Lake Michigan Oncology Region
- Central Michigan Group
- Superior East

MOQC
MICHIGAN ONCOLOGY QUALITY CONSORTIUM

Slide c/o J. Griggs

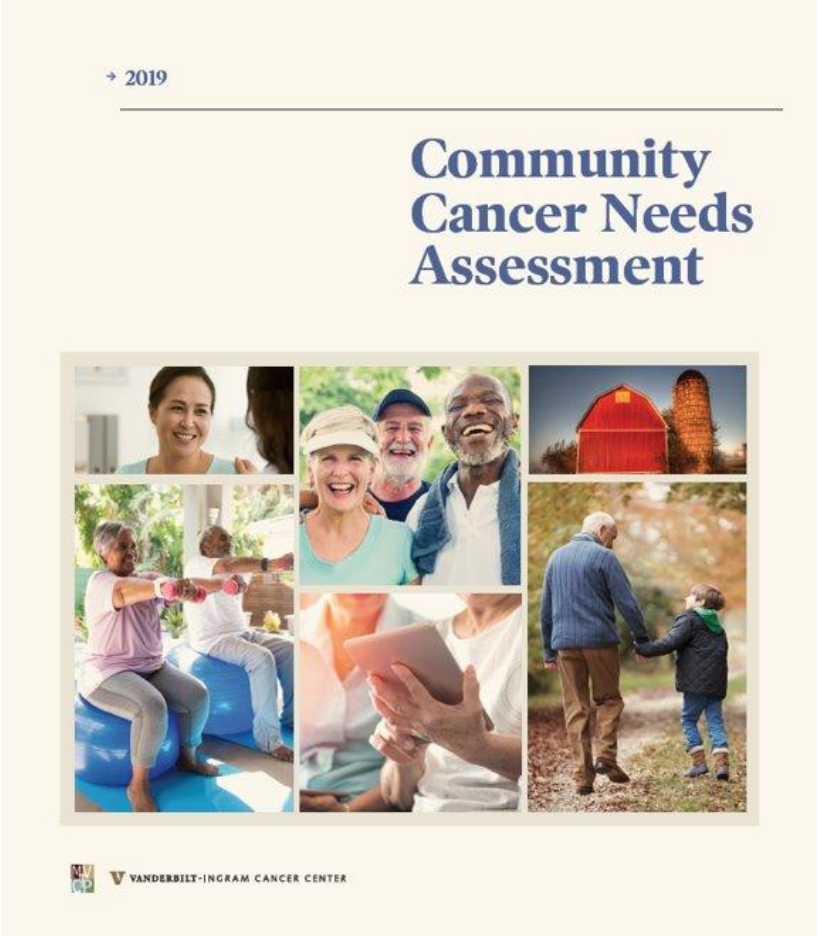
Right-sizing Interventions

- 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

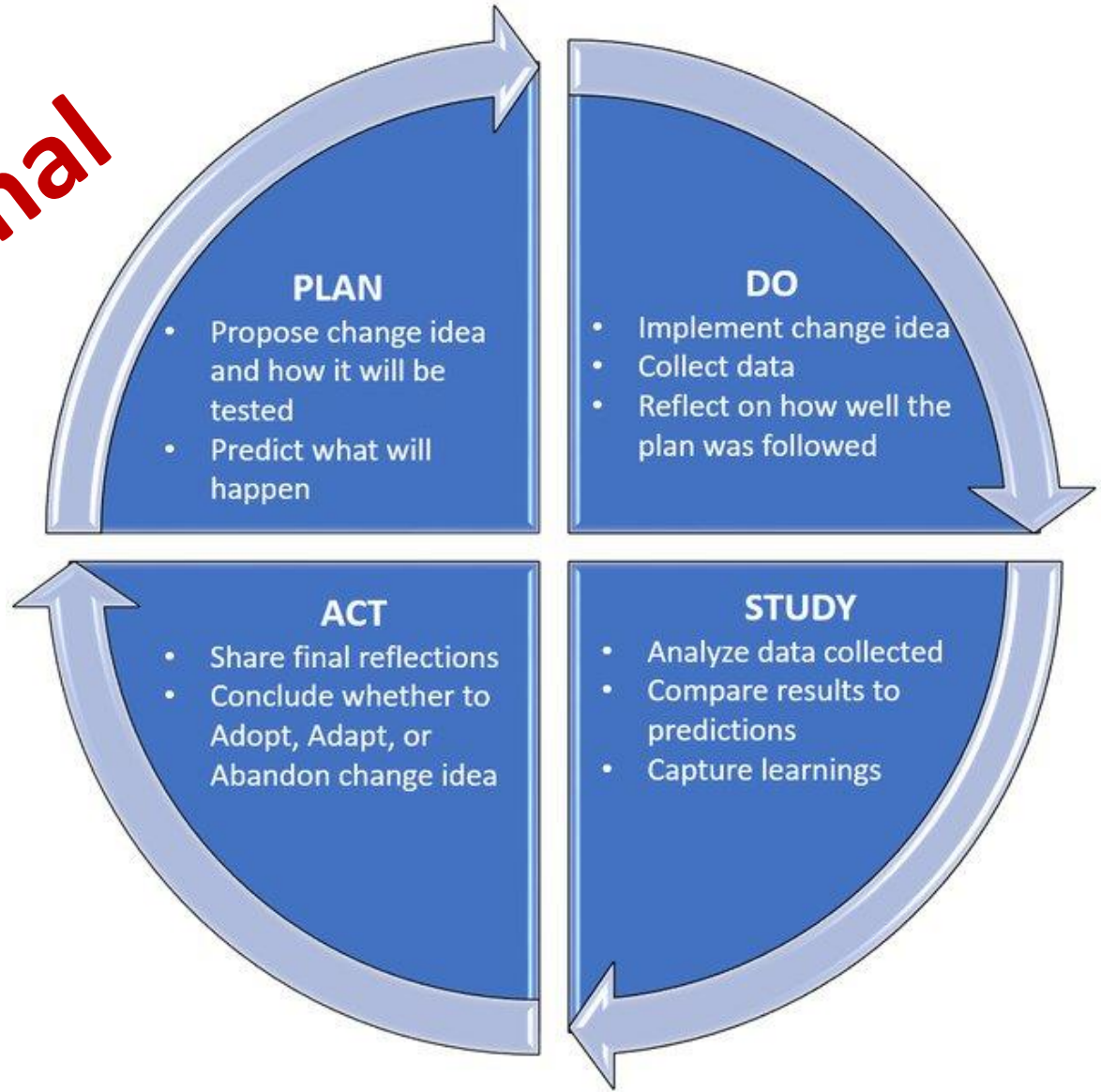
- Catchment area data:
  - Demographics
  - Racial/ethnic cancer disparities
  - Geographic cancer disparities
  - Behavioral risk and protective factors
- Community feedback on health priorities and strategies
- Identify needs, gaps, potentially effective strategies
- Respond to community-identified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



Adapted from slide by D. Friedman

Acting on the Identified Needs

#BeIntentional



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!!!

MEHARRY VANDERBILT Alliance SINCE 1999

Thank you!!

Questions?

www.drkarenwinkfield.com

3blackdocs.com

@DrWinkfield

@3BlackDocs

podcast

VANDERBILT-INGRAM CANCER CENTER

Creating an Equity Action Plan

Keli DeVries, LMSW


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


Achieve targets
Schedule site visit
MOQC Excellence in Quality
Collect PROs
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: MSHIELD Best Practices Guide

INTERPROFESSIONAL EDUCATION

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

Educational Opportunity

Target Audience

Planned Date of Completion

Educational Opportunity

Target Audience

Planned Date of Completion

Equity Action Plan

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.

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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

Resource: MSHIELD Best Practices Guide

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

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.

Contact MOQC
Meet with YesRx team
Provide training for all staff on YesRx

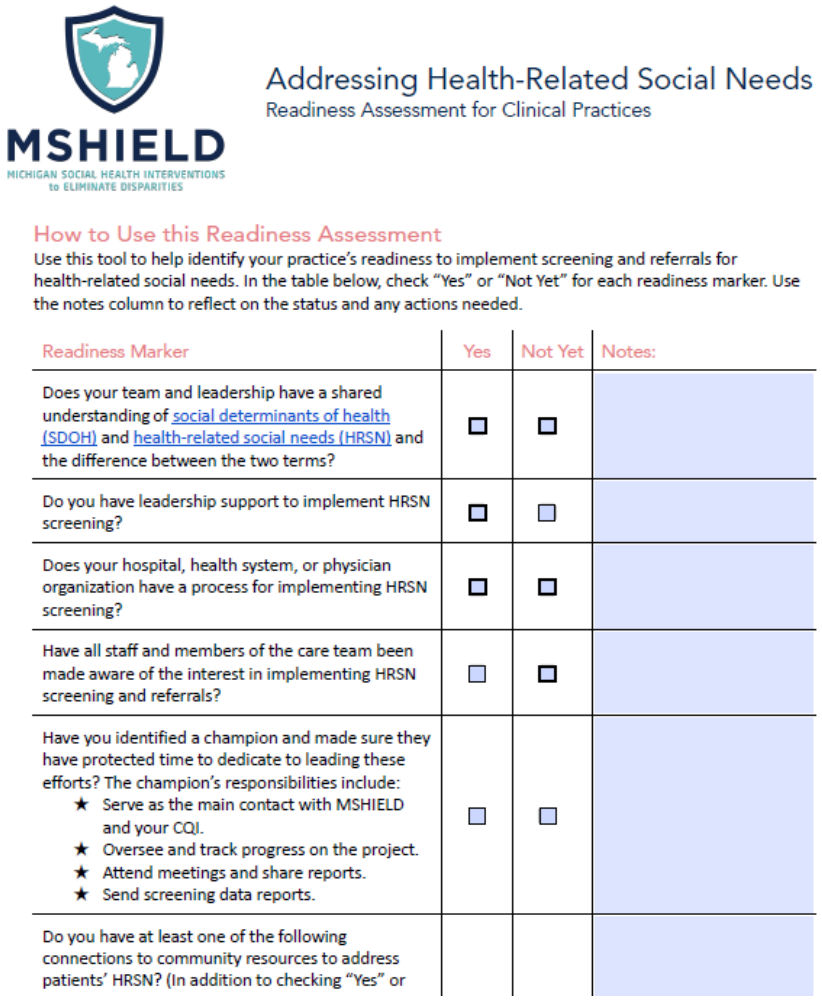
Questions?

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



MSHIELD
MICHIGAN SOCIAL HEALTH INTERVENTIONS to ELIMINATE DISPARITIES

Addressing Health-Related Social Needs
Readiness Assessment for Clinical Practices

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.

Readiness Marker	Yes	Not Yet	Notes:
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?	☐	☐	
Do you have leadership support to implement HRSN screening?	☐	☐	
Does your hospital, health system, or physician organization have a process for implementing HRSN screening?	☐	☐	
Have all staff and members of the care team been made aware of the interest in implementing HRSN screening and referrals?	☐	☐	
Have you identified a champion and made sure they have protected time to dedicate to leading these efforts? The champion's responsibilities include: ★ Serve as the main contact with MSHIELD and your CQI. ★ Oversee and track progress on the project. ★ Attend meetings and share reports. ★ Send screening data reports.	☐	☐	
Do you have at least one of the following connections to community resources to address patients' HRSN? (In addition to checking "Yes" or			

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

MOQC
MICHIGAN ONCOLOGY QUALITY CONSORTIUM

CBSSM

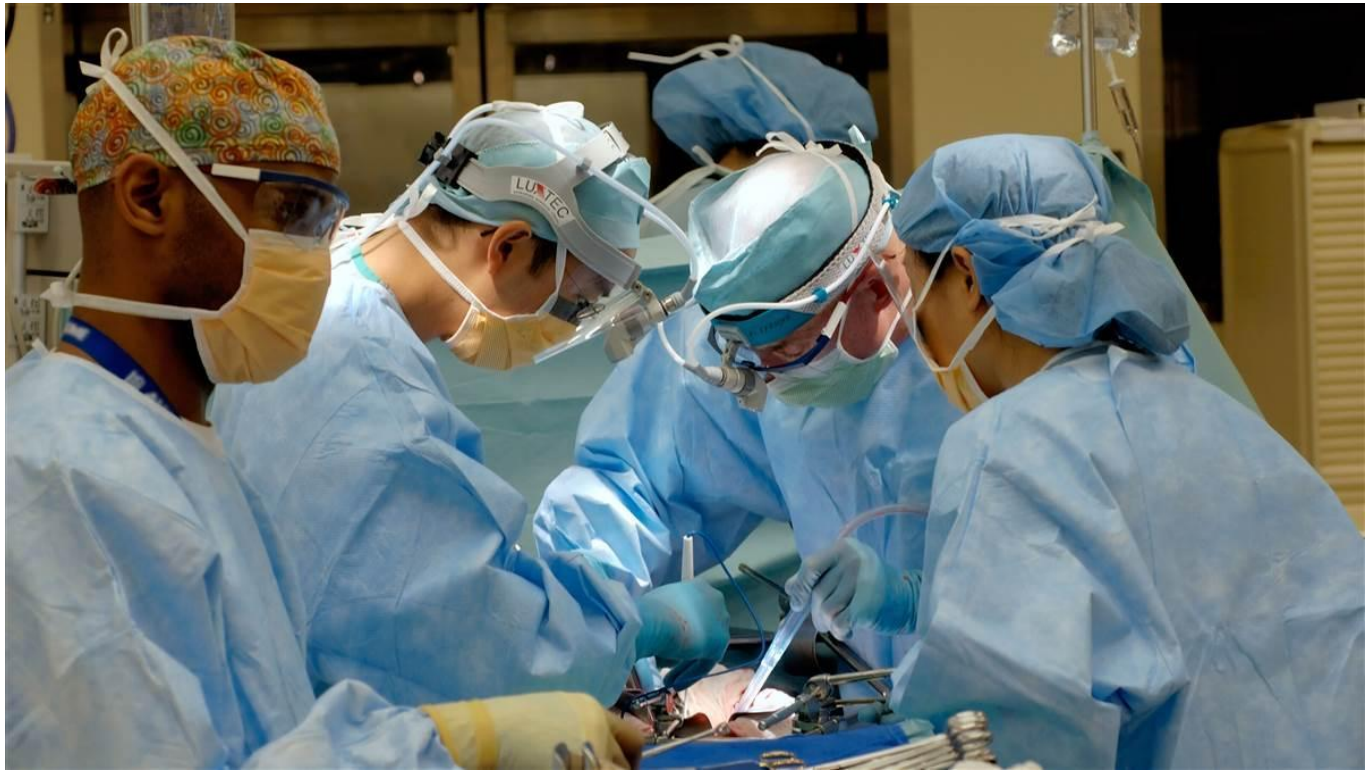
Disclosure

- 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


CISplatin
Injection
50 mg per 50 mL
(1 mg per mL)
CISplatin doses greater than 100 mg/m² once every 3 to 4 weeks are rarely used. See package insert.
Cytotoxic agent.
For intravenous use.
50 mL Multiple Dose Vial
Rx only
CISplatin
Injection
200 mg per 200 mL
(1 mg per mL)
CISplatin doses greater than 100 mg/m² once every 3 to 4 weeks are rarely used. See package insert.
Cytotoxic agent.
For intravenous use.
200 mL
Multiple Dose Vial
Rx only
CISplatin
Injection
100 mg per 100 mL
(1 mg per mL)
CISplatin doses greater than 100 mg/m² once every 3 to 4 weeks are rarely used. See package insert.
Cytotoxic agent.
For intravenous use.
100 mL Multiple Dose Vial
Rx only

Another 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

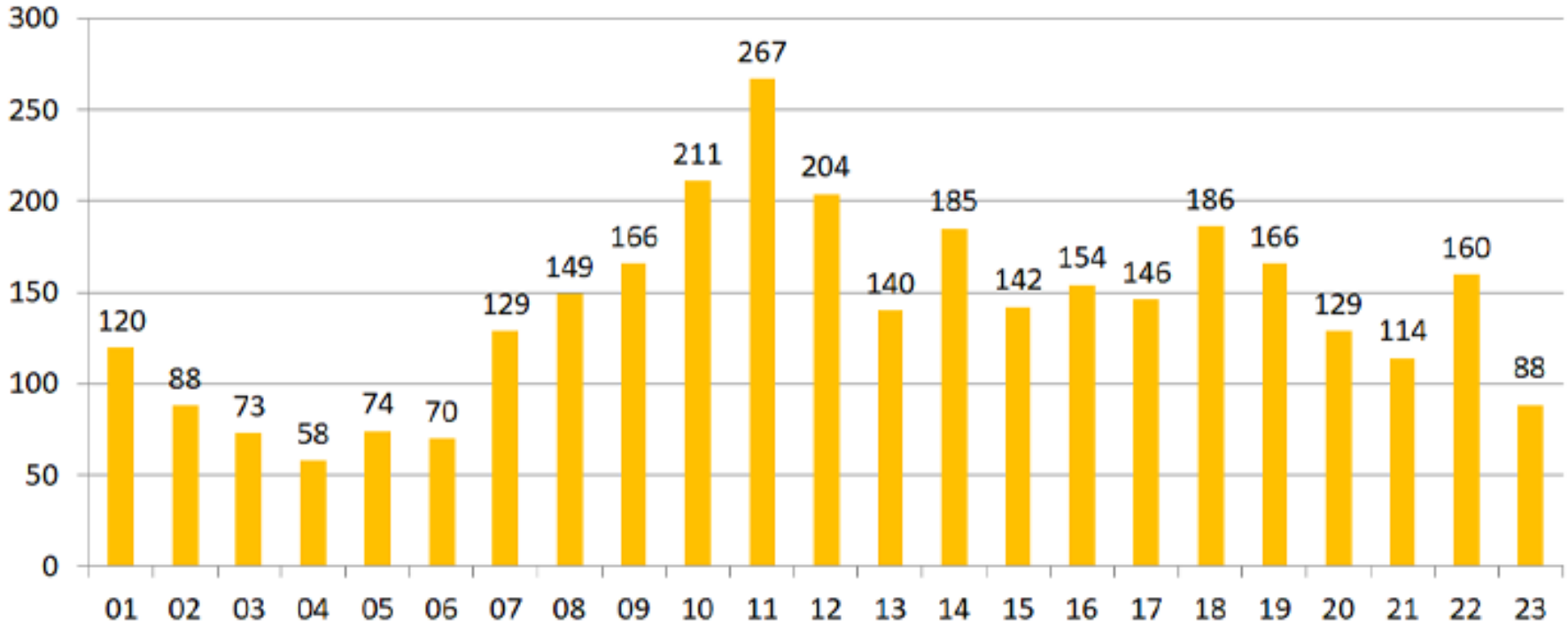
Outline

- Introduction to modern drug shortages
- Ethical assessment of the dilemma
- Policy implications and potential solutions

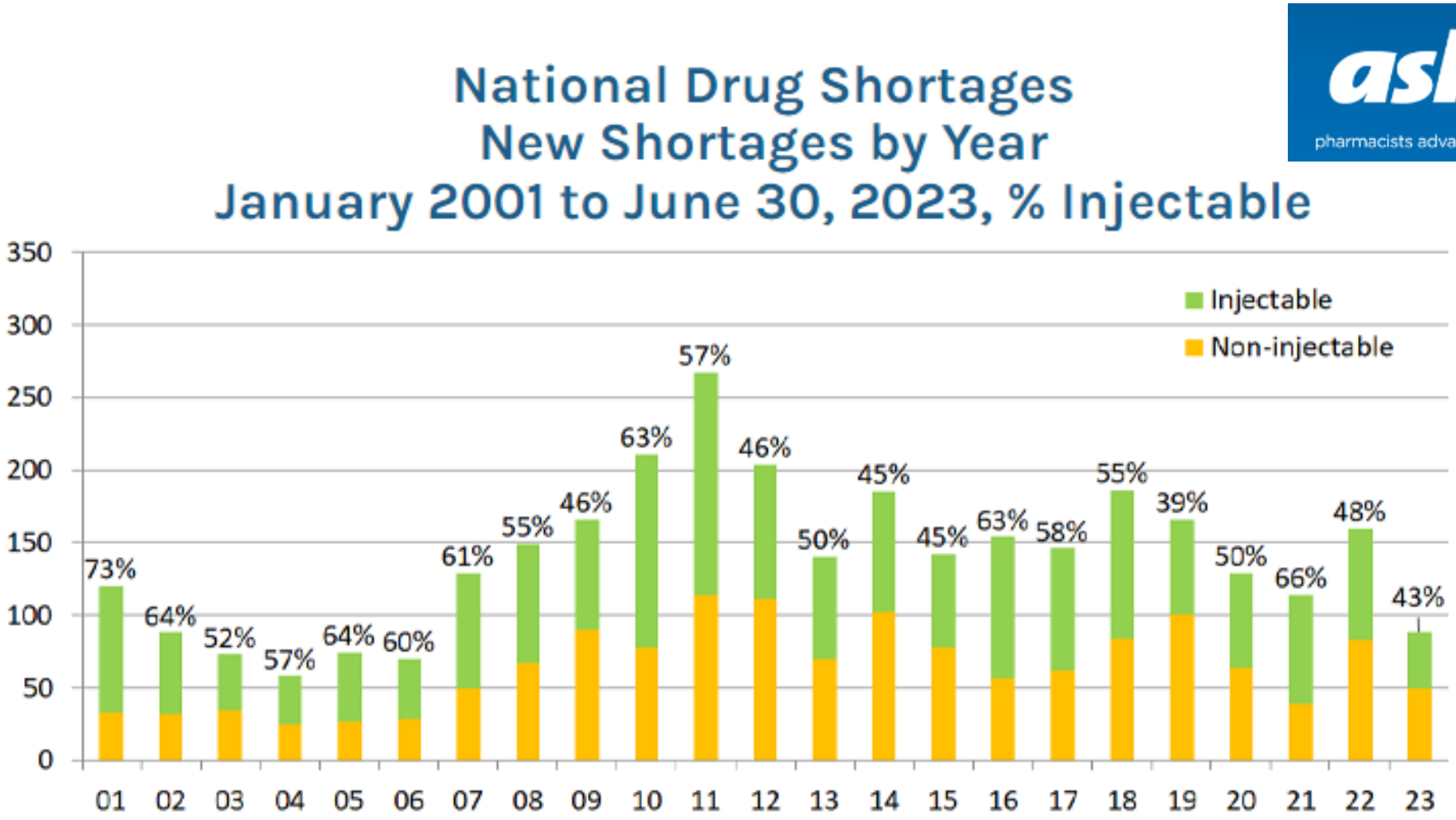
Introduction

- 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.

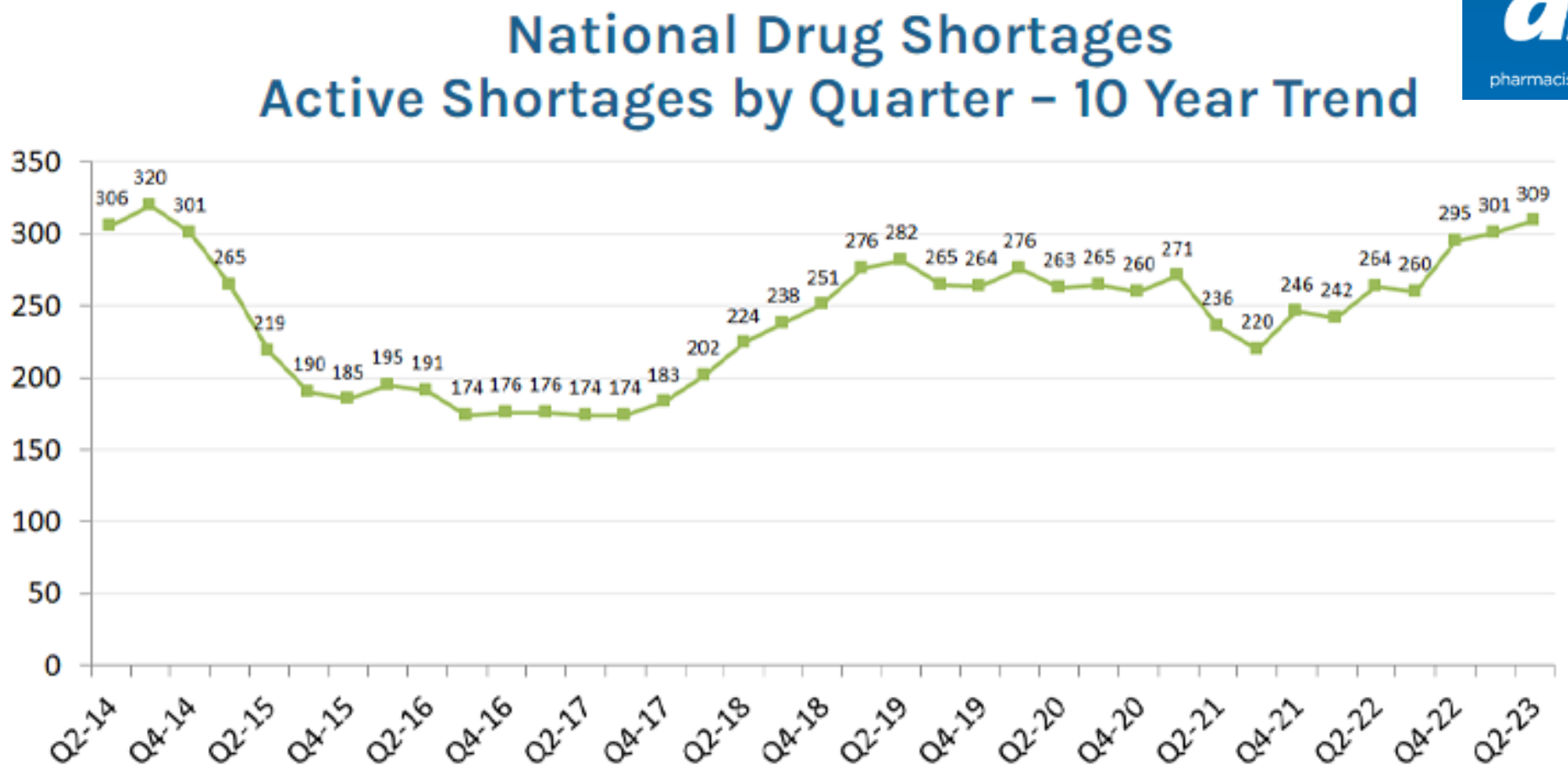
Drug Shortages Are an Ongoing Problem



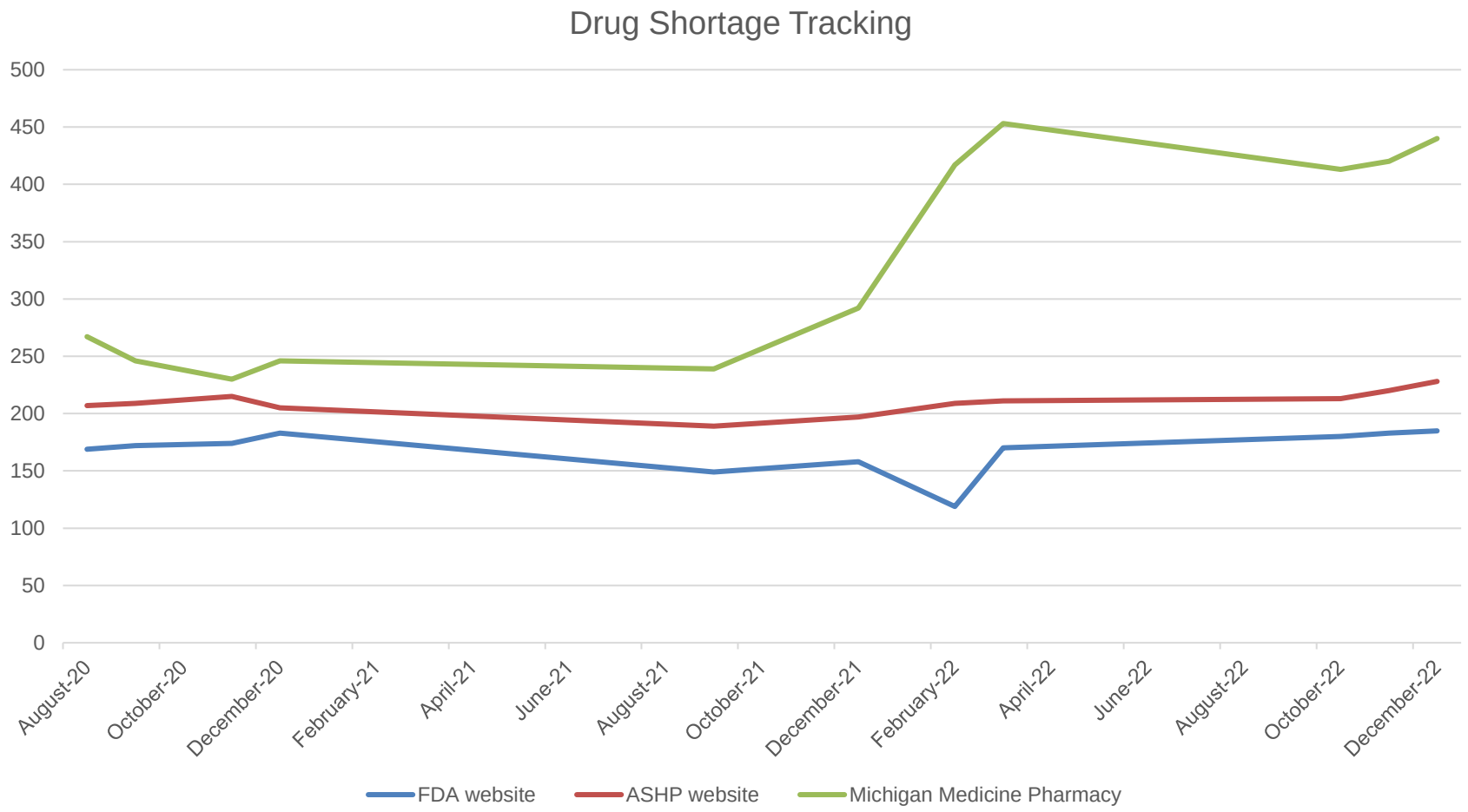
Drug Shortages Are an Ongoing Problem



Drug Shortages Are an Ongoing Problem



Michigan Medicine Data



VA | U.S. Department of Veterans Affairs

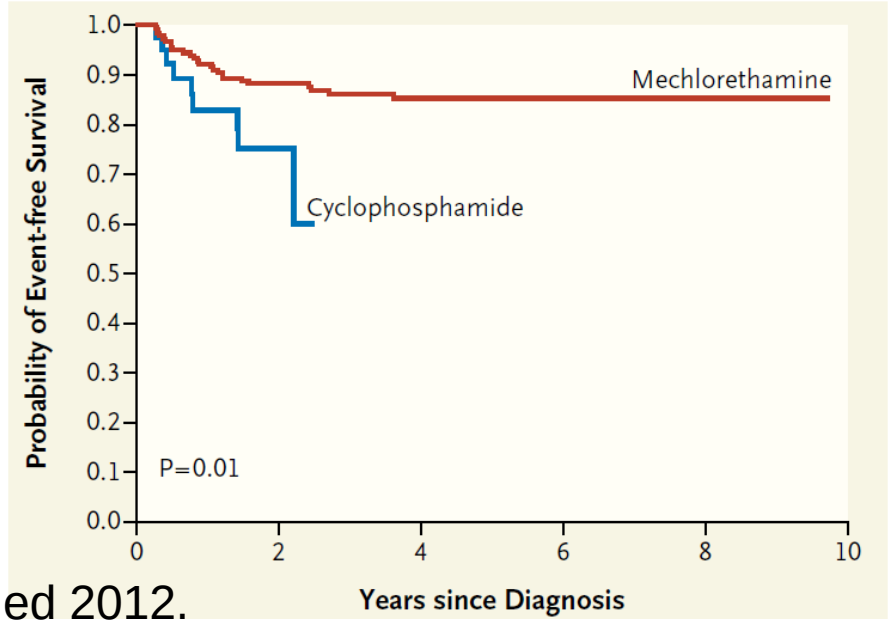
VA Ann Arbor Healthcare System

35 active shortages

Drug Shortages Affect Outcomes

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

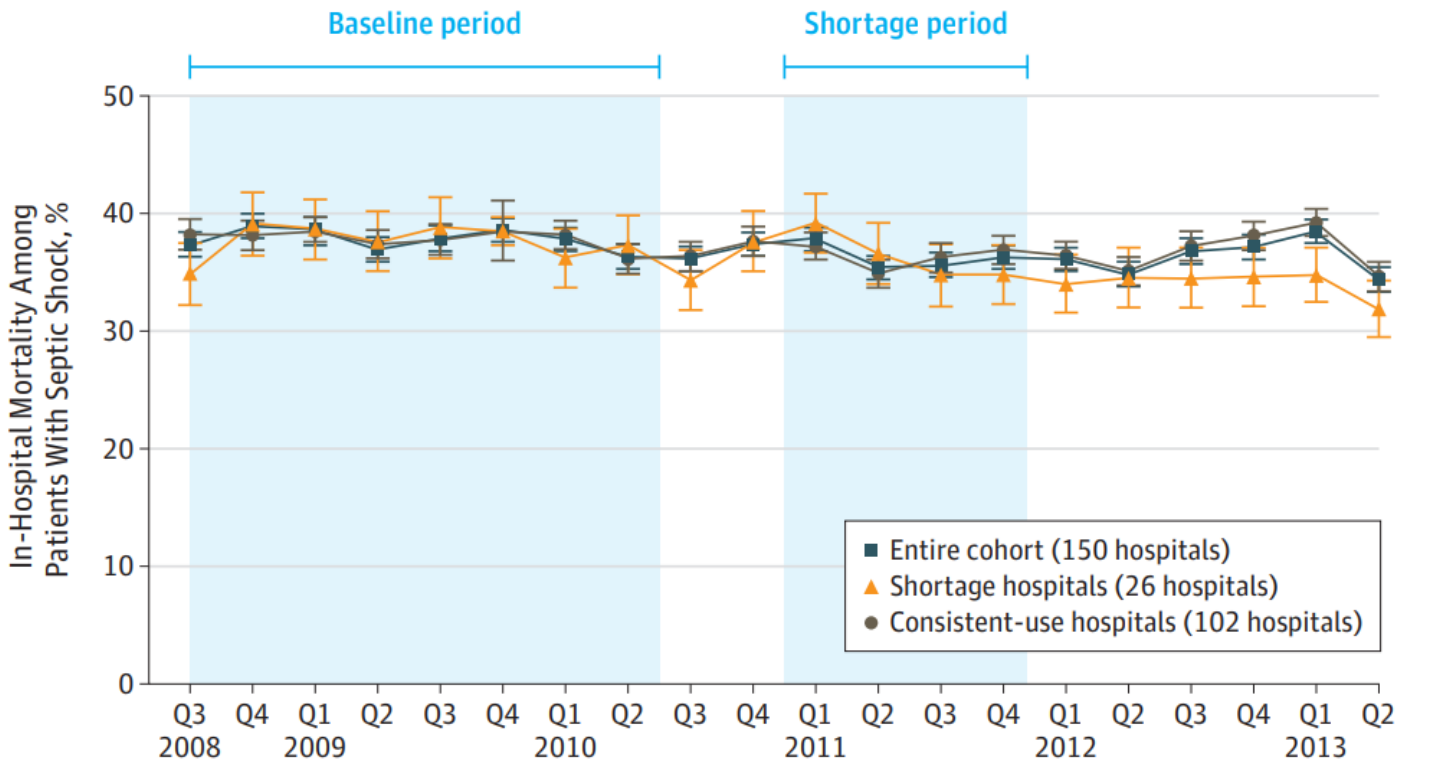
- Pediatric Hodgkin's Lymphoma Consortium assessed outcomes before/after mechlorethamine shortage



Metzger M. N Engl J Med 2012.

Drug Shortages Cause Preventable Deaths

Figure 3. Trends in In-Hospital Mortality Among the Entire Cohort, Shortage Hospitals, and Consistent-Use Hospitals



Vail E. JAMA. 2017;317(14):1433-1442.

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.

Mazer-Amirshahi M. J Grad Med Educ. 2020 Feb; 12(1): 44–45.

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

Vizient 2019; JMCP. 2013;19(9):783-788. AJHP. 2004;61(19):2015-2022.

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.

Goozner M. J Natl Cancer Inst. 2012;104 (12): 891-892.

The New York Times

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 FINK JAN. 29, 2016

The New York Times

"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

The New York Times

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.

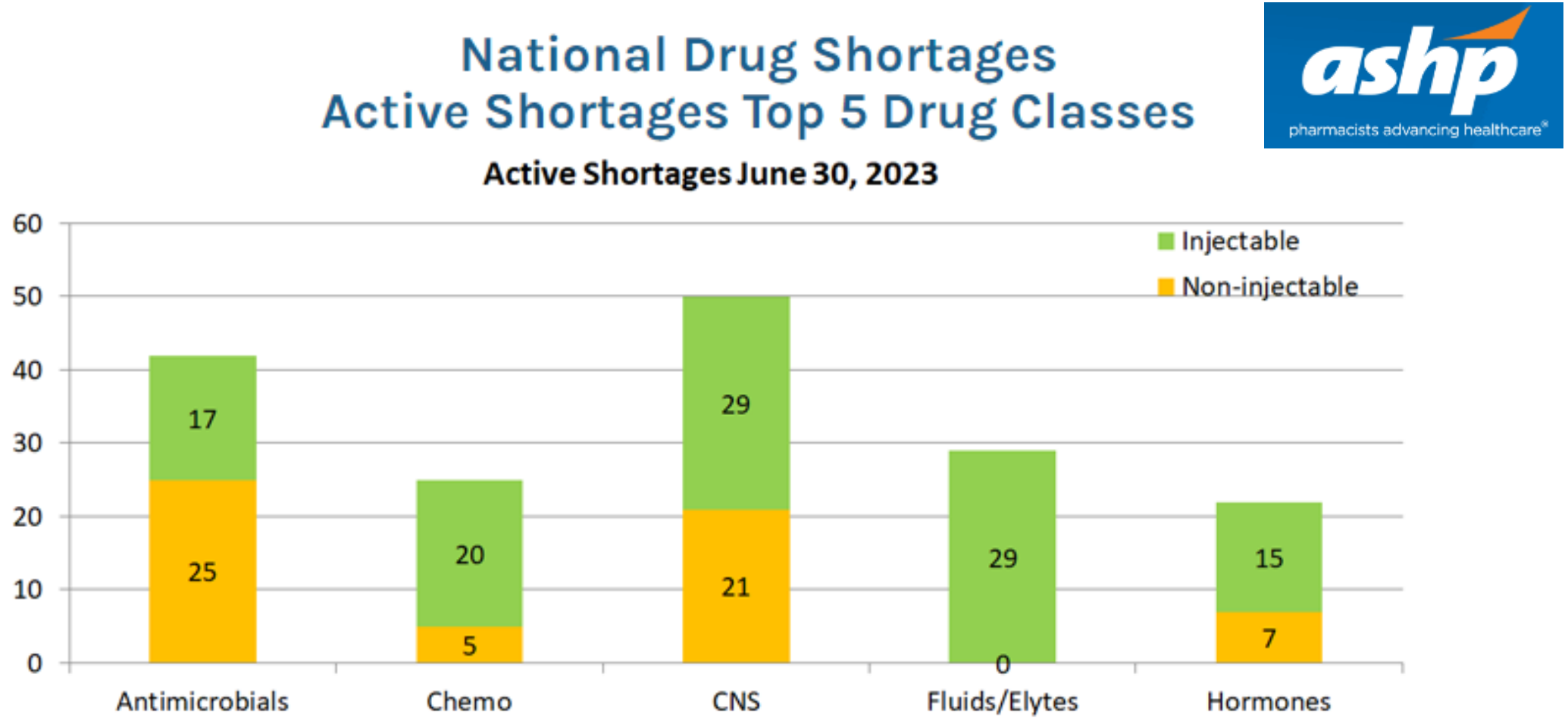
Give this article

Witnesses at a Senate hearing recommended diversifying the locations for drug

Which Drugs are Unavailable?

- Cancer drugs
- Antimicrobials
- Anesthesia medications
- Electrolyte solutions / vitamins

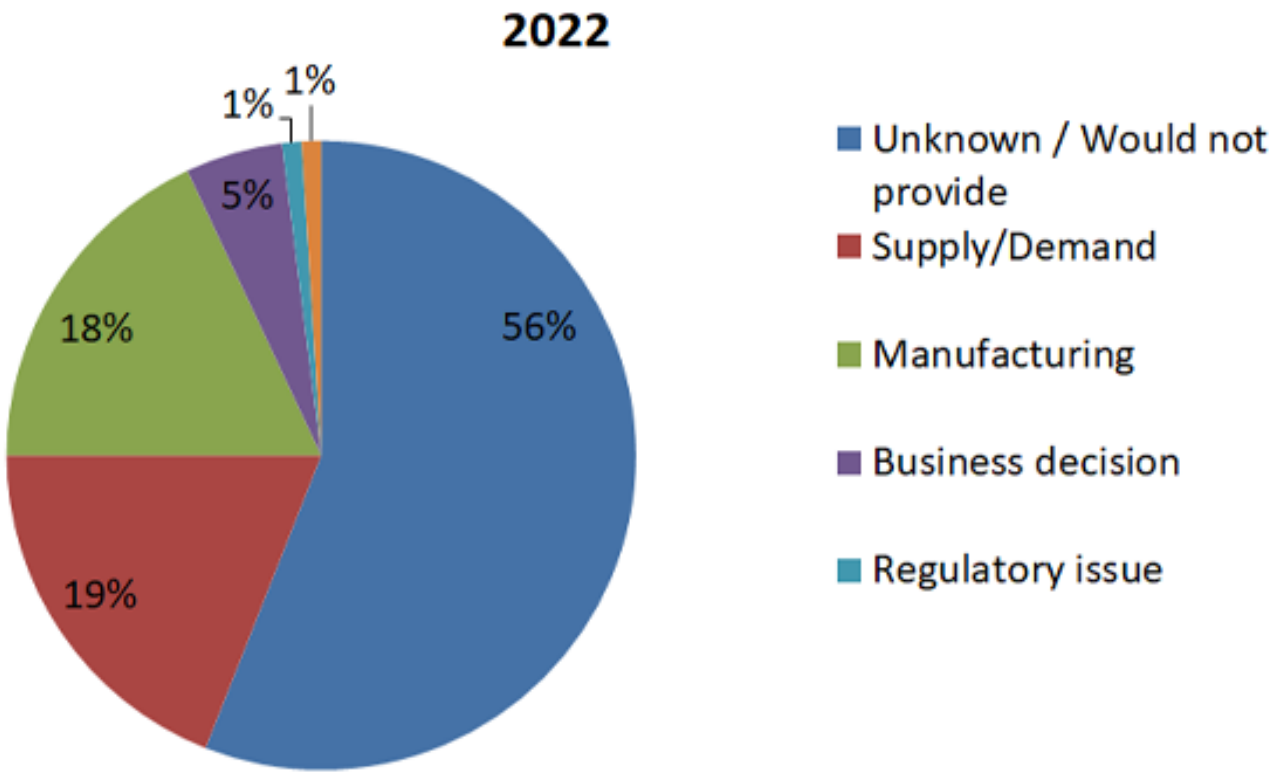
Types of Drugs Unavailable



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



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.

Chabner BA. N Engl J Med 2011;365:2147-2149.

Broadening the Discussion

- Not just “drugs” …
  - Blood products
  - Organs
  - Oxygen
  - Vaccines

Klein HG. N Engl J Med 2013;368:199-201.

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.[1] 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.[2]

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.[2] 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.[2,3] In ad-

Economics $101

Applying Ethical Principles

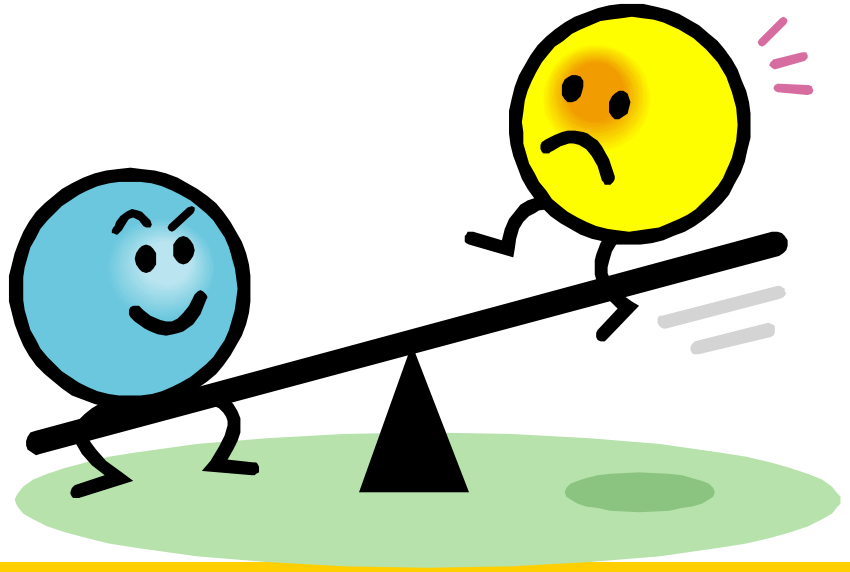
- Autonomy
- Beneficence
- Non-maleficence
- Justice

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.

Persad G. Lancet. 2009;373(9661):423-31.

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.

Ann Intern Med. 2005;142(7):560-82.

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

Rosoff PM. Am J Bioethics. 2012;12(1):1-9.

Establishing Rationing Criteria

- Evidence-based
- Transparent
- Universal
- Objective

Shuman AG. Hastings Cent Rep. 2012;42(2):12-3.

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)

Rosoff PM. Arch Intern Med. 2012;172(19):1494-9.

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

Duke's Approach

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.

Ethics in the Marketplace

- 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

Begun 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:

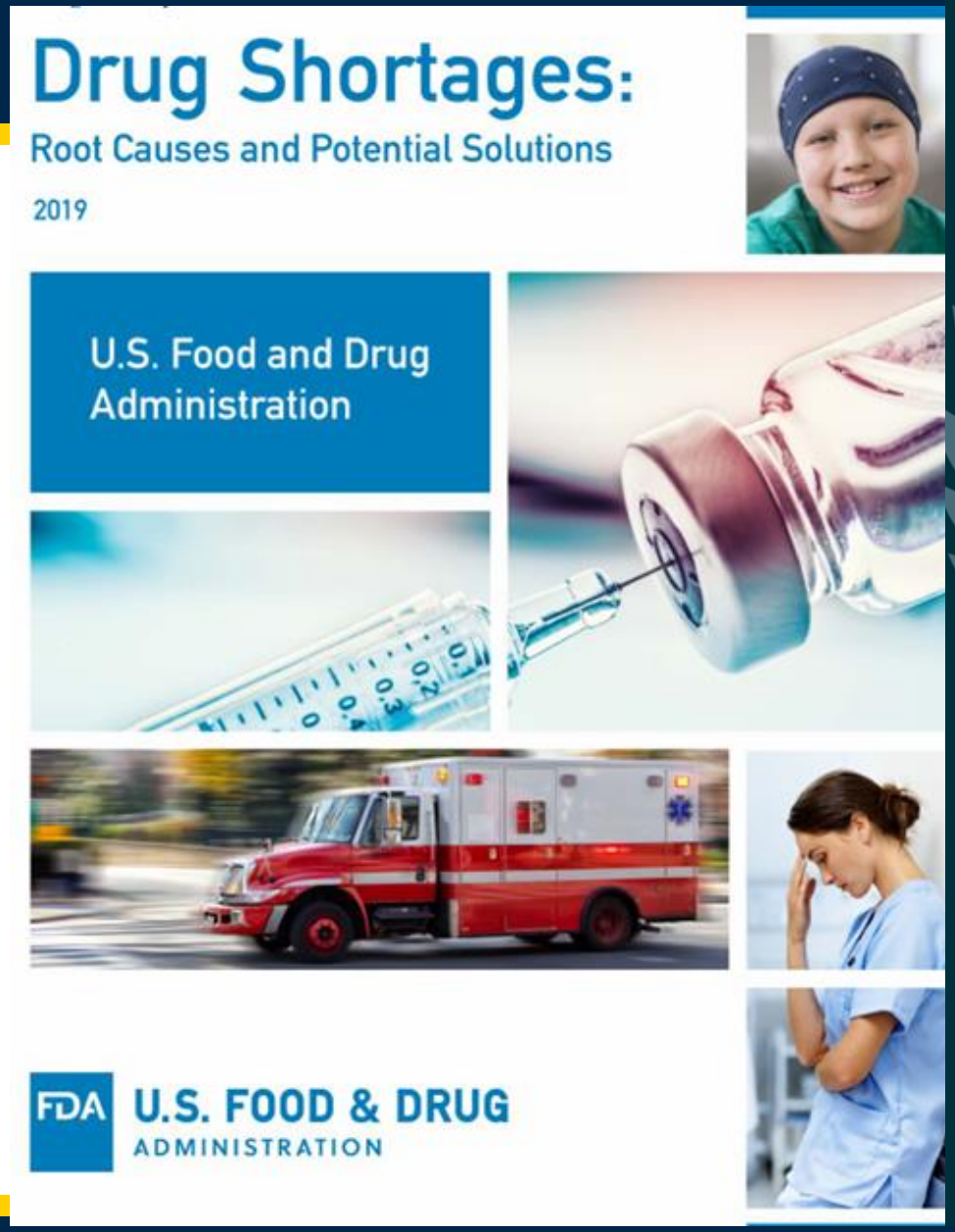
Essential Medicines

- 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.

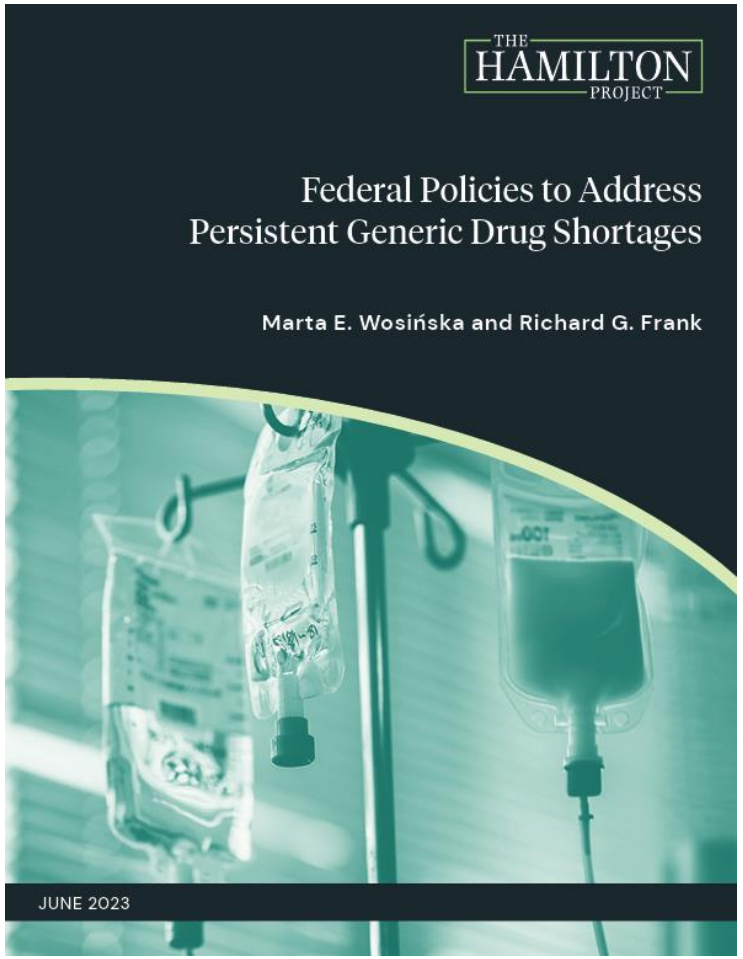
- Public-private agreements to strengthen manufacturing facilities and allow FDA to certify quality of generics, so that hospitals know that they are purchasing a reliable and safe drug.


Drug Shortages:
Root Causes and Potential Solutions
2019
U.S. Food and Drug Administration
FDA
U.S. FOOD & DRUG
ADMINISTRATION


United States Senate Committee On
HOMELAND SECURITY
& GOVERNMENTAL AFFAIRS
Chairman Gary Peters
SHORT SUPPLY
The Health and National Security Risks of Drug Shortages
HSGAC Majority Staff Report
March 2023

- 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.



CONGRESSWOMAN ELISSA SLOTKIN MICHIGAN'S 7TH DISTRICT

ABOUT CONTACT PRIORITIES SERVING YOU PRESS

Enter keywords Search

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

CBSSM

THURSDAY, MAY 25, 2023

PETERS, STABENOW & SLOTKIN CALL ON FDA TO TAKE ALL POSSIBLE ACTIONS TO MITIGATE CANCER DRUG SHORTAGES

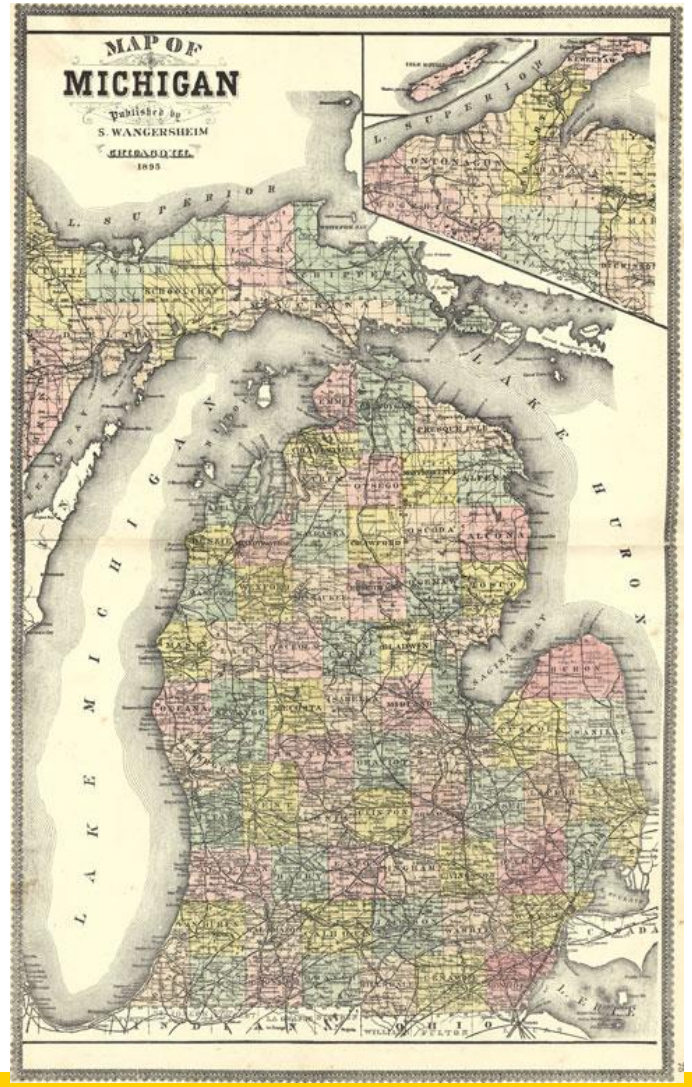
CBSSM

Michigan Statewide Research

- 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

Chen et al. PLoS One. 2021;16(4).

Inter-Institutional Collaboration



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.

POEM

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MICMT
Michigan Institute for Care Management & Transformation

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

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shumana@med.umich.edu

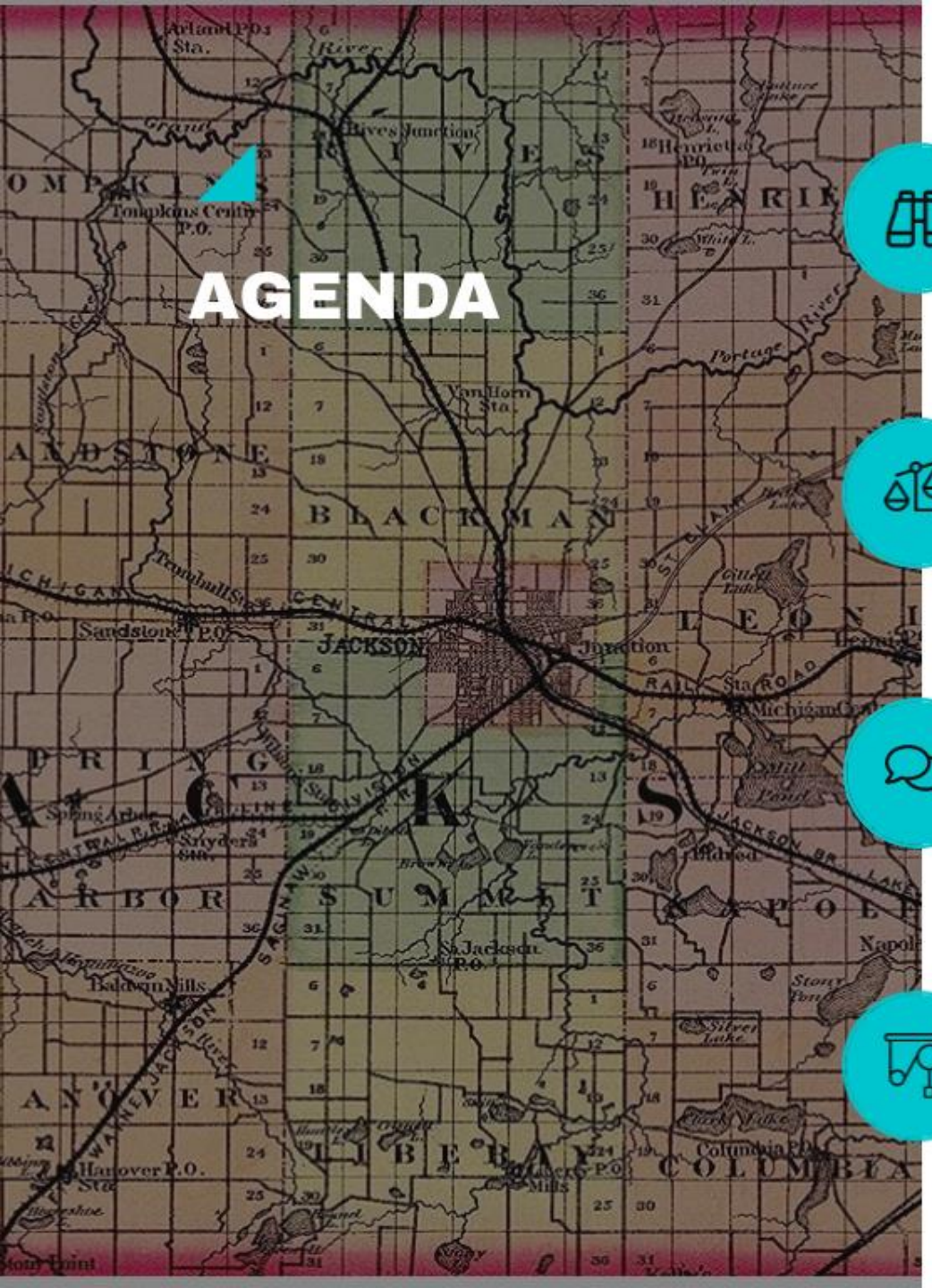
Justice in Healthcare

Megan Albertson, MPH

PRESENTED BY: MEGAN ALBERTSON, MPH

JUSTICE IN HEALTHCARE

FRIDAY, JANUARY 19, 2024



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

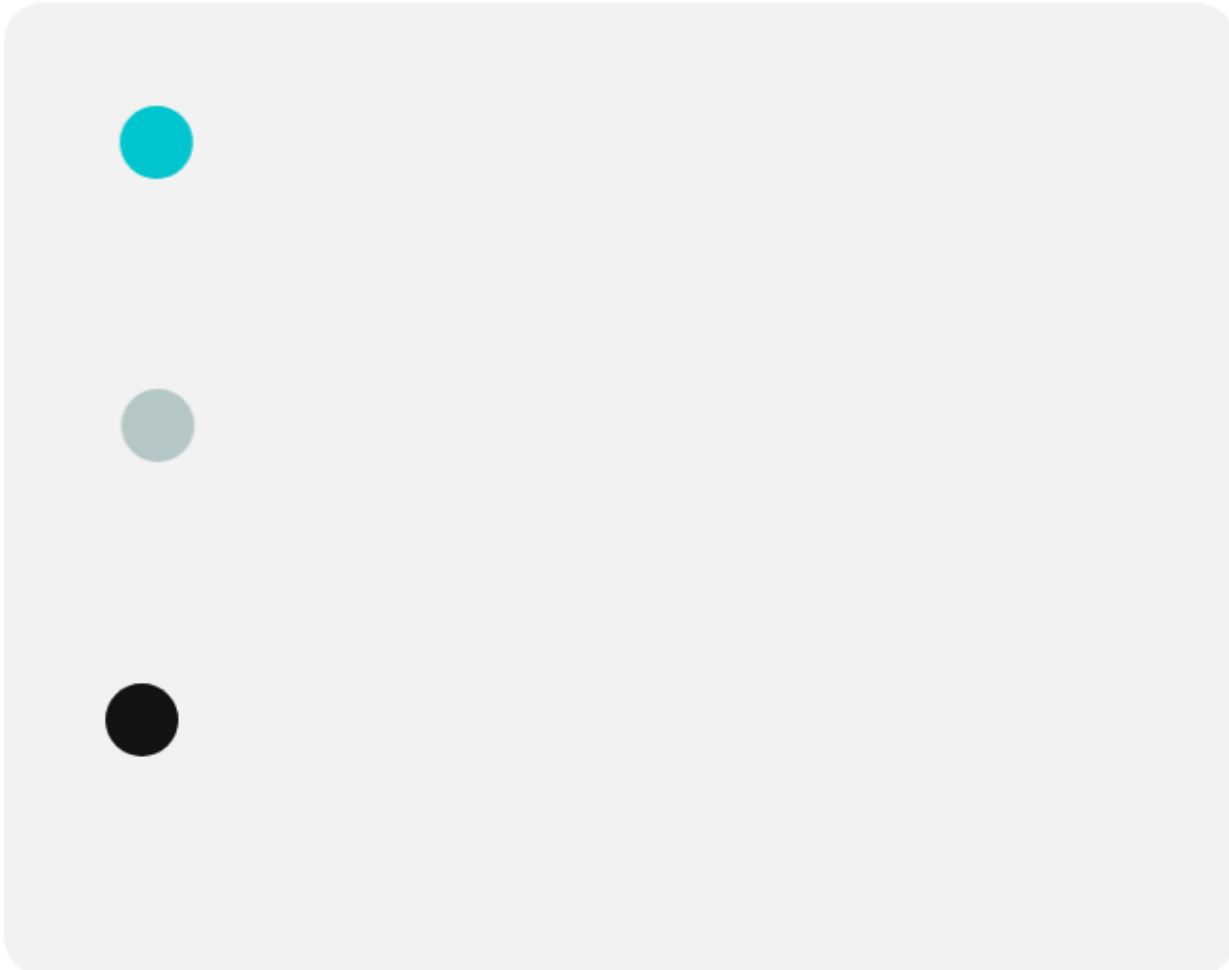
(she/they)

BIG TUNA

GOOSE

NICOLE

Perspectives



Perspectives

JACKSON HEALTH NETWORK

Clinically integrated network

Perspectives

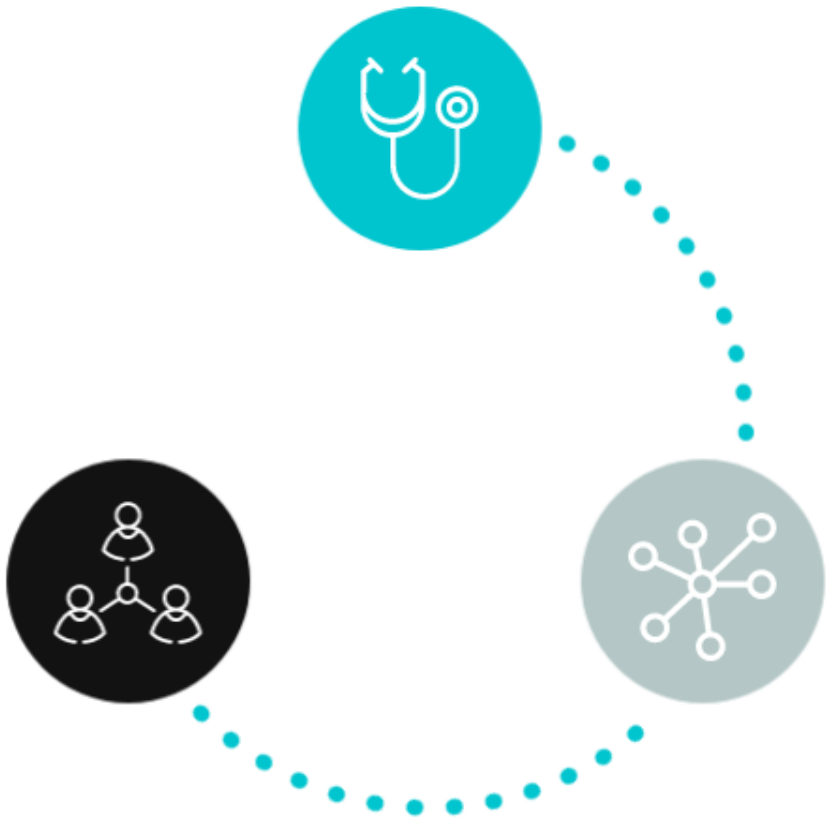
JACKSON HEALTH NETWORK

Clinically integrated network

JACKSON COLLABORATIVE NETWORK

Collective impact network

Perspectives



JACKSON HEALTH NETWORK

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Collective impact network

JACKSON CARE HUB

Community information exchange

Perspectives

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Community information exchange

Clinical Quality Scope of Need

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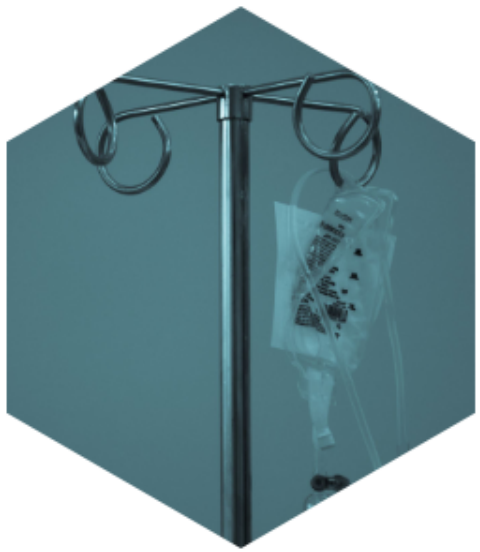
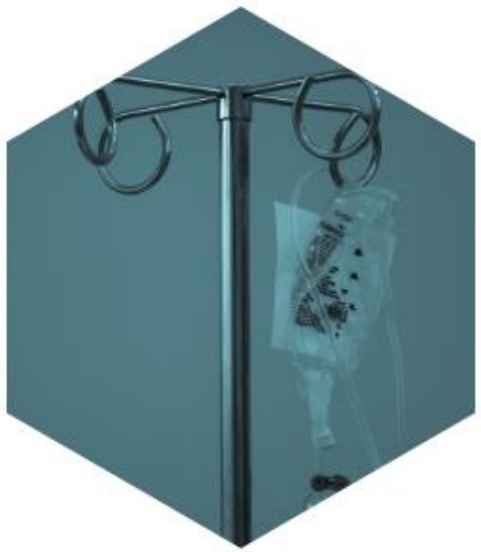


Healthcare

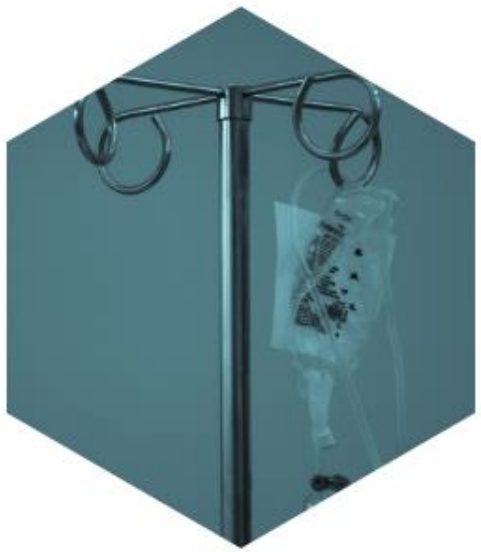
Clinical Quality Scope of Need



Healthcare

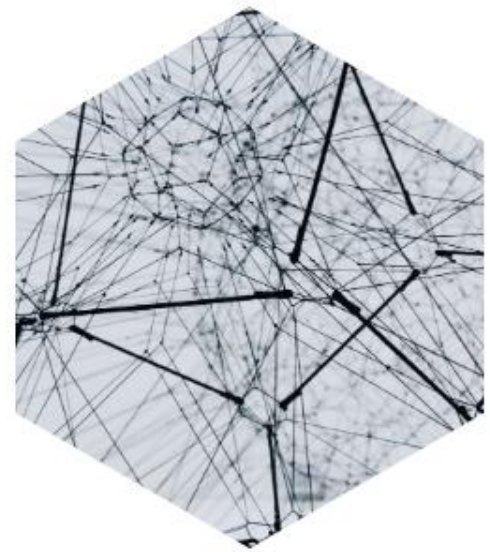
Social Support

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

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December 1, 2022 - November 30, 2023

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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

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

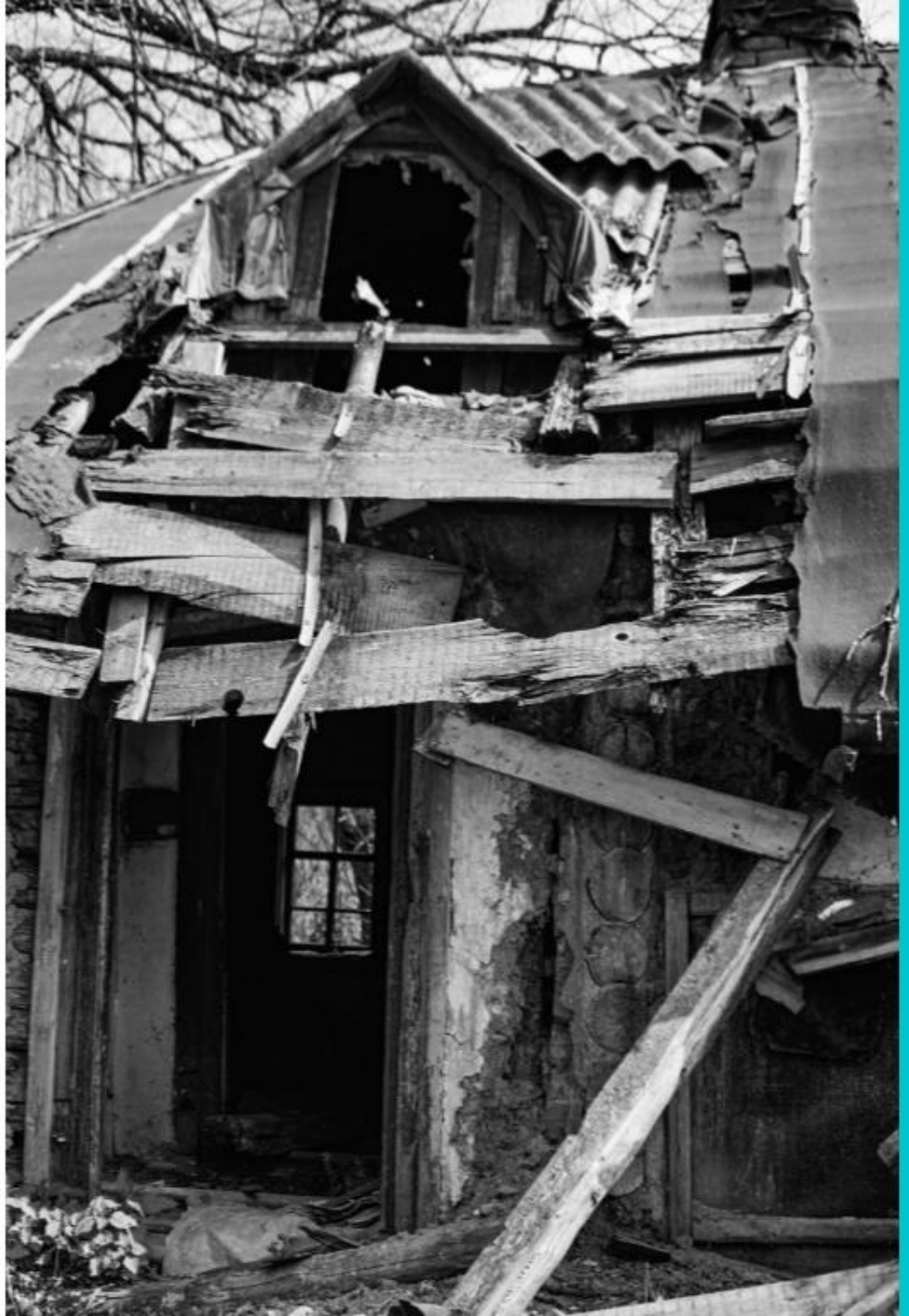
Margins

Healthcare

Community Capacity

Societal Compassion

Cancer Mortality



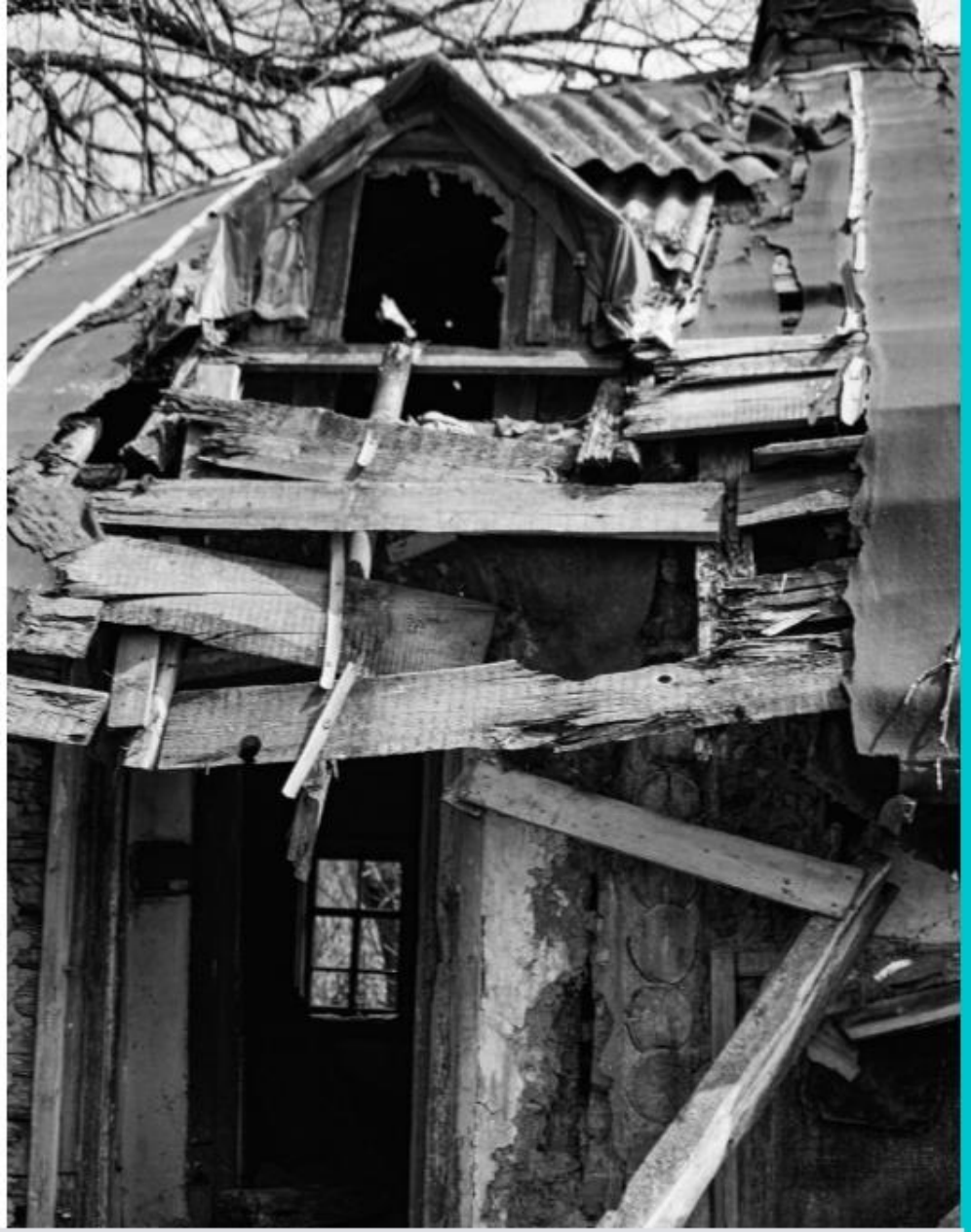
Cancer Mortality

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



Moss JL, Pinto CN, Srinivasan S, Cronin KA, Croyle RT. Persistent Poverty and Cancer Mortality Rates: An Analysis of County-Level Poverty Designations. Cancer Epidemiol Biomarkers Prev. 2020 Oct;29(10):1949-1954. doi: 10.1158/1055-9965.EPI-20-0007. PMID: 32998949; PMCID: PMC7534551.

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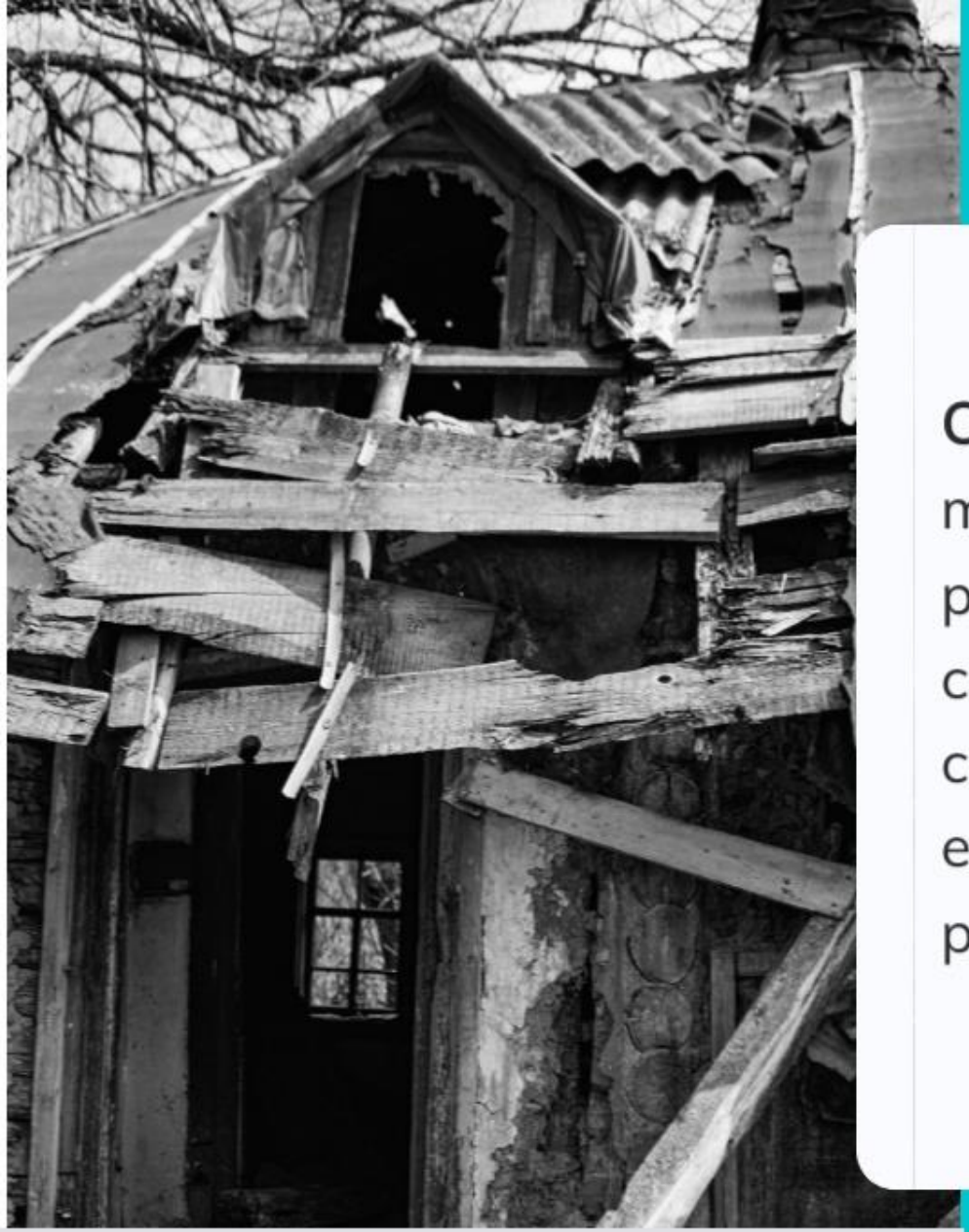


Conclusion: Cancer mortality was higher in persistent poverty counties than other counties, including those experiencing current poverty.

Moss JL, Pinto CN, Srinivasan S, Cronin KA, Croyle RT. Persistent Poverty and Cancer Mortality Rates: An Analysis of County-Level Poverty Designations. Cancer Epidemiol Biomarkers Prev. 2020 Oct;29(10):1949-1954. doi: 10.1158/1055-9965.EPI-20-0007. PMID: 32998949; PMCID: PMC7534551.

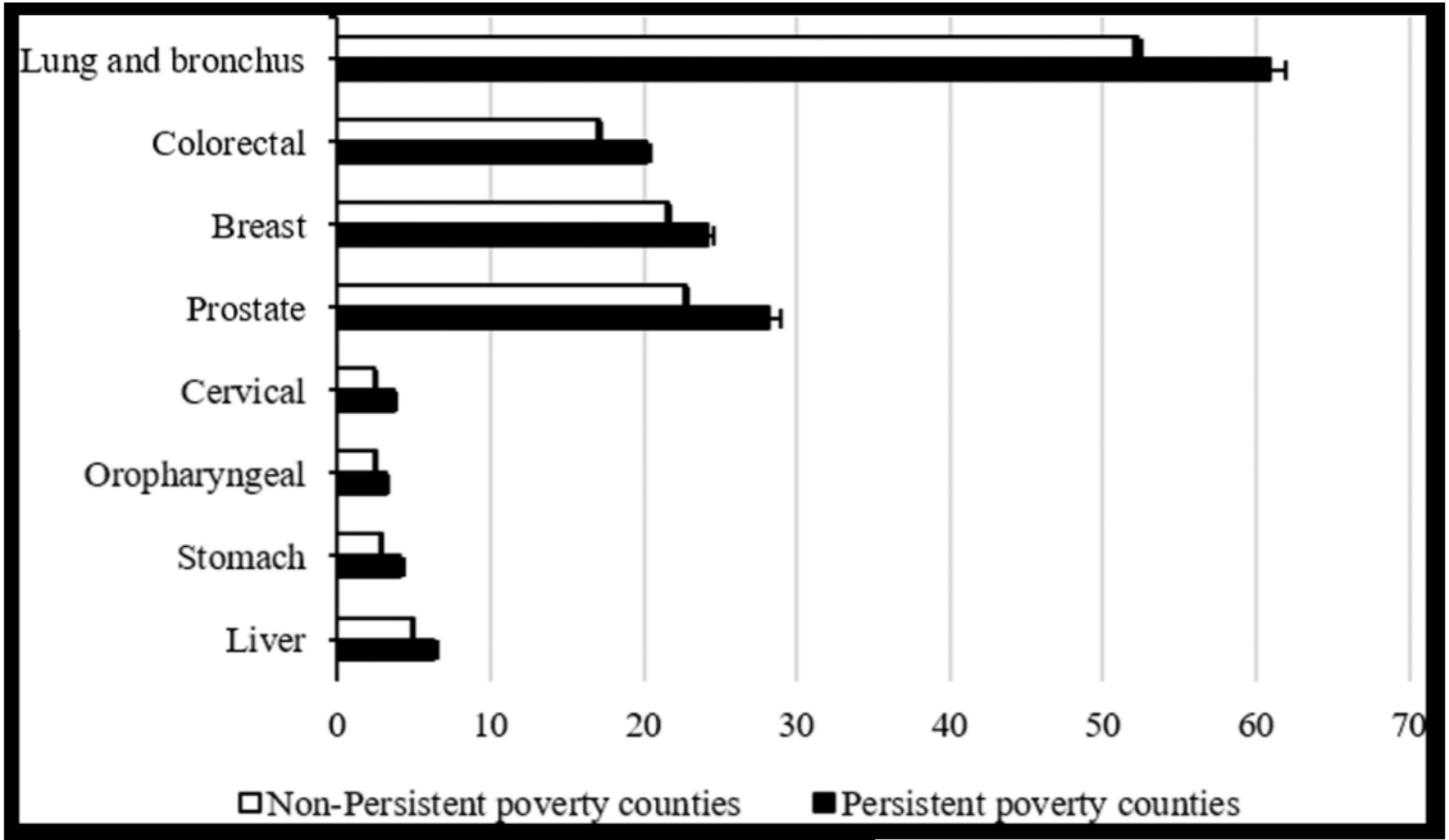


Figure 1. 2007–2011 age-adjusted cancer mortality rates for non-persistent poverty versus persistent poverty counties. Cancer mortality rates are expressed as deaths per 100,000 people per year, except breast and cervical cancers (deaths per 100,000 females per year) and prostate cancer (deaths per 100,000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

Cancer Diagnosis

Cost of Care

ED Visit

Jackson Care Hub

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

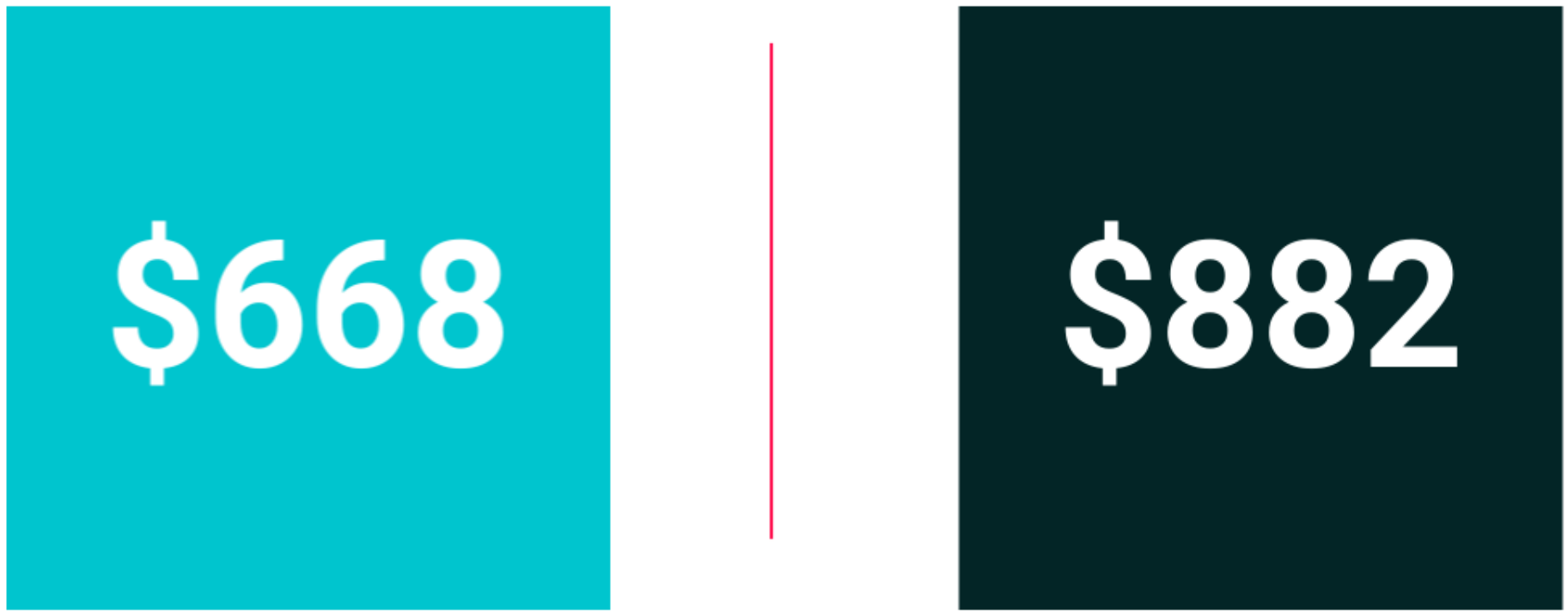
AVERAGE COST PER ED PATIENT: CANCER DIAGNOSIS WITH/OUT REPORTED TRANSPORTATION NEED

No Transportation Need

Transportation Need

Transportation

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



Utilities

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

Utilities

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

Housing

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

Housing

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

Safety

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

Safety

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

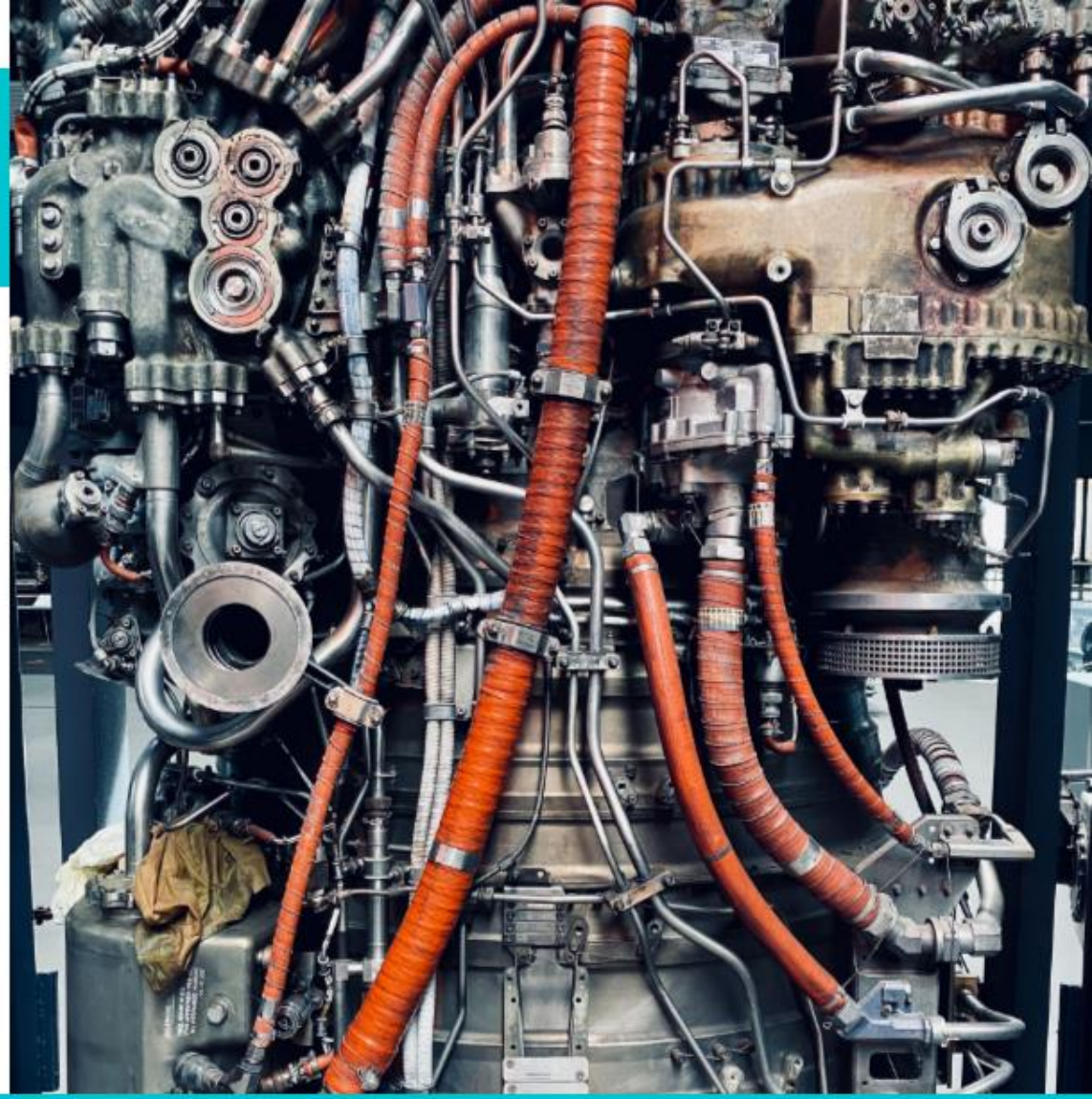
No Safety Need

Safety Need

STOP

Ally

Ally



Agent

Justice

equity

by

design

[pause]

What to do?


Jackson
COLLABORATIVE
NETWORK
HANDLE WITH CARE

Immunizations Birth - 2 years

Jackson Health Network

Gap Mapping

Jackson Care Hub

LITERACY AND LANGUAGE

Jackson District Library

THANK YOU!

DO YOU HAVE ANY QUESTIONS?

CONTACT

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

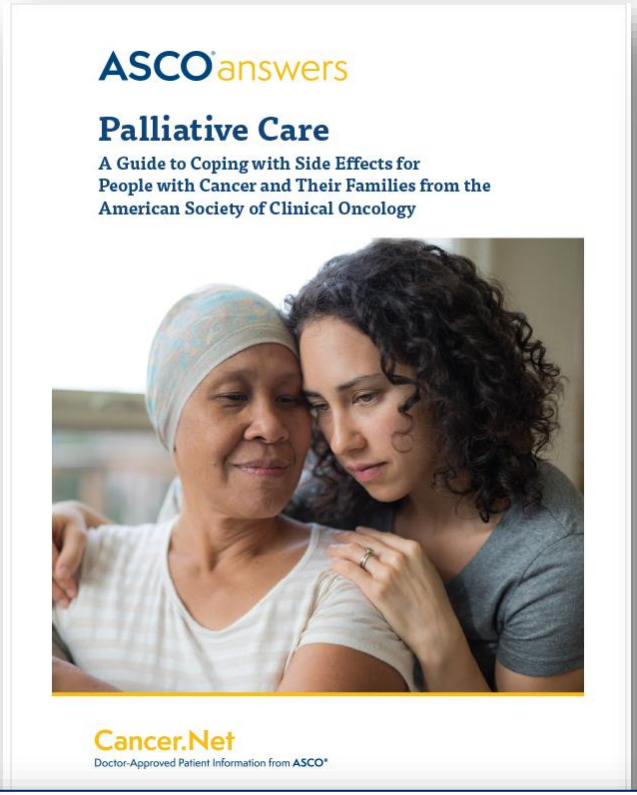
Questions? Please reach out to moqc@moqc.org

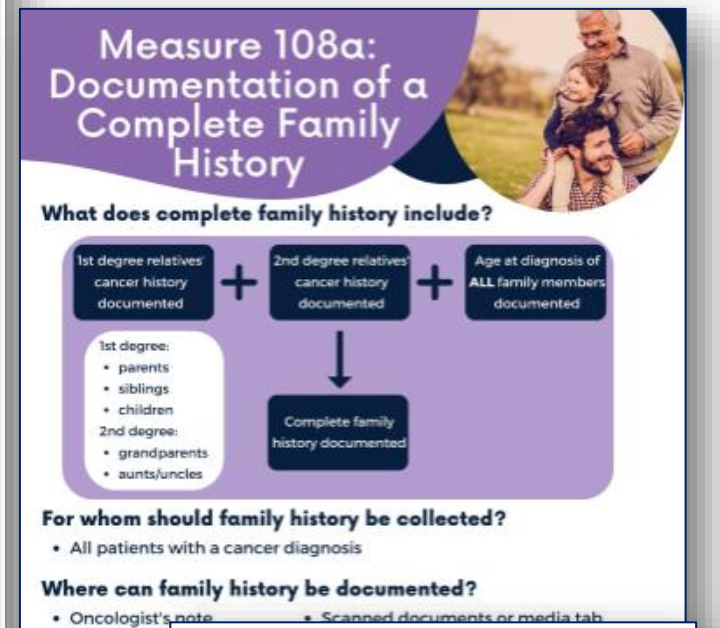
MOQC Resources

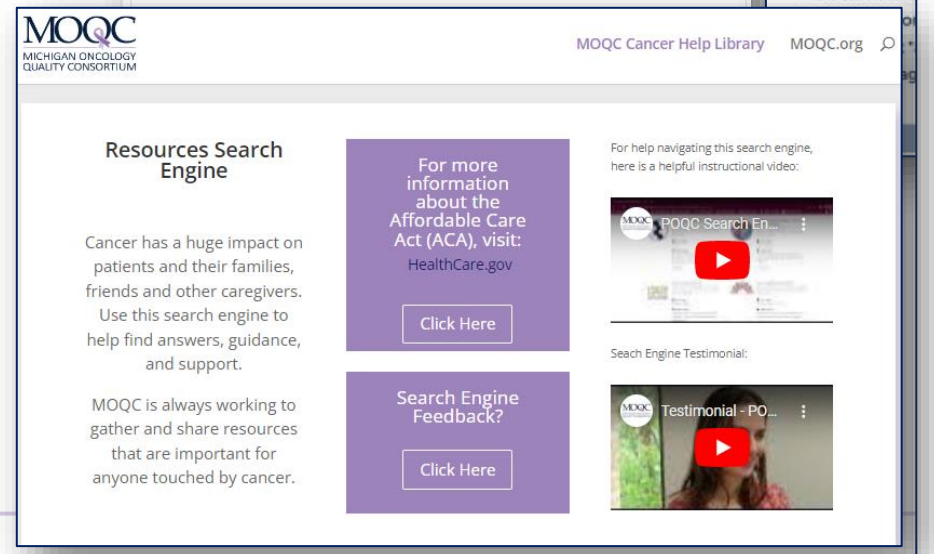
- MOQC has a variety of free resources for your **patients**, **caregivers**, and **clinicians**

- **Virtual** and **printed** formats available

www.moqc.org







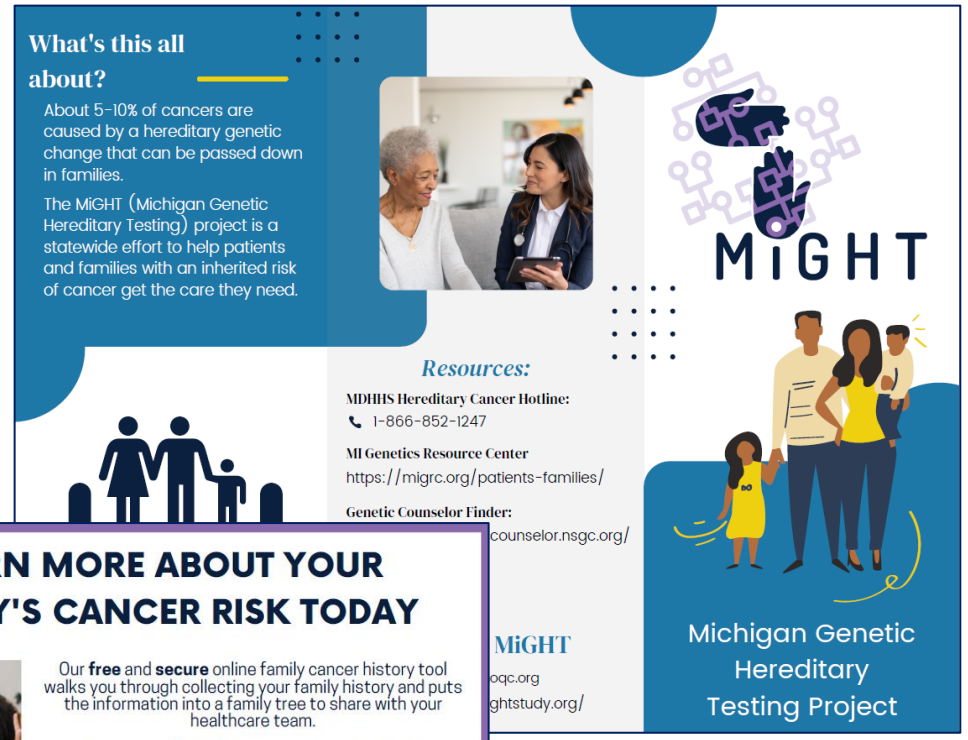
MOQC 15 CELEBRATING
MICHIGAN ONCOLOGY QUALITY CONSORTIUM

MiGHT Materials

Michigan **G**enetic **H**ereditary **T**esting

- 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

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

MOQC GynOnc Biannual Meeting	
Gyn Onc Biannual	Friday, May 3 (Plymouth)

MOQC MedOnc Biannual Meeting	
Med Onc Biannual	Friday, June 21 (Plymouth)

Register at: https://moqc.org/events/

THANK YOU!

Cancer care. Patients first.

The best care. Everywhere.