



# Endocrinology + Primary Care Practices Care Coordination Projects



## WHAT

The Michigan Collaborative for Type 2 Diabetes (MCT2D) is a state-wide collaborative quality initiative supported by Blue Cross Blue Shield of Michigan that aims to improve the treatment of type 2 diabetes.

The statewide collaborative is made up of over 1,400 physician members, representing 355 primary care practices (PCP), 26 endocrinology practices, and 14 nephrology practices from 24 of Michigan's 30 physician organizations.

MCT2D asked each participating endocrinology practice to work with their physician organization to choose a participating MCT2D primary care practice to partner with to address a care coordination issue between the two practices.

Each partnership group chose their own issue to work on, since MCT2D wanted to allow practices to focus on the specific factors that were impacting their shared patients. This resulted in a large range of projects including creating more diabetes friendly meal options for hospitalized patients, implementing a consult-lite approach for patients beginning a continuous glucose monitor (CGM), and developing specific plans to refer patients back to primary care after reaching treatment goals with endocrinology.

## WHY

One of MCT2D's primary goals is to enhance collaboration and communication between primary care and specialty practices in the treatment of patients with type 2 diabetes.

While both endocrinologists and primary care physicians have been involved in MCT2D since its launch, their primary interaction in MCT2D prior to this project was limited to endocrinologists providing education on CGM and diabetes medications.



This initiative marked the first time both specialties worked together on a meaningful, self-directed care coordination project—one that directly fostered collaboration and delivered mutual benefits.

MCT2D's 395 participating practices including primary care (blue ●), nephrology (teal ●), and endocrinology (orange ●) across the state.

## HOW

- 4/1/2024  
All endocrinology practices were required to identify their partnering primary care practice, ahead of our regional meetings so that the clinical champions could meet in person. Clinical champions were encouraged to meet with their partnering PCP practice and PO administrative leads to brainstorm potential areas for collaboration and determine the roles of the PCP practice and endocrinology practice for the proposed partnership.
  - 6/15/2024  
Project plans due. Partnering endocrinology and primary care practices submitted their plan to MCT2D including the focus of their work, the role of the PCP practice, the role of the endocrinology practice, their goals, and anticipated challenges. The project was intended to start following the submission of the project plan and continue throughout the value-based reimbursement year, ending in March 2025.
  - 11/21/2024  
At the Endocrinology Clinical Champion meeting, three endocrinologists gave a presentation of the work that they were doing and the progress that they had made.
- Spring 2025 regional meetings: Each endocrinology practice has created a poster to showcase the results of their work at each of the seven regional meetings across the state, giving attendees an opportunity to learn about these collaborations, including successes and lessons learned.

## HIGHLIGHTS

Collaboration between specialists is important for ensuring that type 2 diabetes patients receive the best care possible. There are numerous opportunities to improve patient care through collaboration, as demonstrated from the vast array of projects chosen by our participating practices.

This is especially important considering that across the state, the wait time to see an endocrinologist can be high, and many of these projects have supported the streamlining of care so that it is provided efficiently and effectively. Projects included revamping the meal options offered to hospitalized T2D patients, offering a consult-lite approach to patients who are just beginning on a CGM, and defining appropriate referrals.

### EXAMPLE PROJECT POSTERS



Example Project 1 - Expanding Continuous Glucose Monitoring Use in Primary Care

Example Project 2 - Type 2 Diabetes Menu: Improving Patient Food Choices in an Inpatient Setting

Example Project 3 - Endocrinology Access: Decreasing Wait Times



Example Project 4 - Supporting Patients Together: Increasing Utilization of Continuous Glucose Monitoring in Primary Care

## NEXT STEPS

- This project has provided a unique opportunity for primary care providers and endocrinologists to collaborate in ways that were previously uncommon. Each partnership group has specific next steps based on the focus of their collaboration, with most planning to build on the progress and advancements made throughout the year.
- The five new endocrinology practices that joined MCT2D this year will be working on PCP partnership projects in 2025, following a similar timeline to the one outlined above.
- Additionally, MCT2D will be introducing a performance measure for endocrinologists in 2025, aimed at optimizing billing for continuous glucose monitor (CGM) interpretations. This initiative ensures that patients receive the necessary guidance and support when using a CGM.

### LEARN MORE ABOUT MCT2D



Scan the QR or visit  
[MCT2D.ORG](https://mct2d.org)



Support for MCT2D is provided by Blue Cross and Blue Shield of Michigan as part of the BCBSM Value Partnerships program. Although Blue Cross Blue Shield of Michigan and MCT2D work collaboratively, the opinions, beliefs and viewpoints expressed by the author do not necessarily reflect the opinions, beliefs and viewpoints of BCBSM or any of its employees.



# ADVANCING SUICIDE PREVENTION: A PROGRESSIVE QUALITY IMPROVEMENT APPROACH IN PRIMARY CARE AND BEHAVIORAL HEALTH

This analysis presents the outcomes of PDSA project implementation from 2022 to 2024 within MI Mind, highlighting the evolving focus on strategically progressive topic selection within a structured, tiered curriculum.

## AUTHOR

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## AFFILIATIONS

**MIMIND** HENRY FORD HEALTH

## 01. INTRODUCTION

MI Mind is a state-wide CQI dedicated to improving suicide prevention efforts through collaborative partnerships between Primary Care and Behavioral Health providers. Participants engage in a structured curriculum that evolves annually, ensuring continuous skill development. The culmination of each year's curriculum is a strategically progressive Plan-Do-Study-Act (PDSA) project, selected by the practice to enhance screening processes, intervention strategies, or workflow efficiencies. These PDSA projects serve as a cornerstone for driving measurable improvements in suicide prevention across diverse clinical settings.

## 02. OBJECTIVE

This analysis examines how a structured, tiered curriculum in both clinical interventions and quality improvement impacts participants' topic selection of strategically progressively complex PDSA projects. The analysis assesses trends in project selection to determine whether participants demonstrate increasing mastery. This framework serves as a demonstration on how Clinical Quality Improvement initiatives can engage participants to make sustainable changes at the clinic level.

## 03. METHODOLOGY

For the two cohorts that completed Year 1 so far, participants were introduced to the PDSA framework. For the one cohort that completed Year 2 so far, introductory quality improvement techniques were incorporated. To assess trends in project focus, all PDSA submissions from 2022 to 2024 were analyzed. A qualitative analysis was conducted to categorize each project into one of four domains: introducing screening with PHQ-2 with #9 of PHQ-9 (PHQ-2+#9), introducing PHQ-9 screening, modifying workflow through varying means such as implementing order sets, or implementing interventions such as lethal means counseling. The data provide insight into whether the curriculum effectively supports an increasing complexity in project selection.

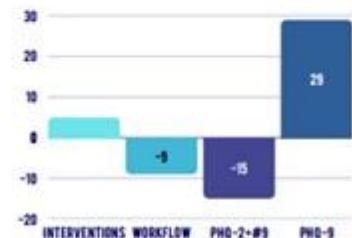
## 04. RESULTS/FINDINGS

In Year 1, PDSA topics were distributed as follows: 7% focused on interventions, 14% on workflow, 17% on PHQ-2+#9, and 62% on PHQ-9. In Year 2, project distribution shifted: 12% focused on interventions, 5% on workflow, 2% on PHQ-2+#9, and 81% on PHQ-9.



## Percent Change of PDSA Topic Selection in Year 2

When comparing Year 2 PDSA topic selection to Year 1, there was a 9% decline in clinics who selected to focus on improving their workflow, 15% decline in PHQ-2+#9 selection, 29% increase in PHQ-9 selection, and 5% increase in intervention selection.



**CLINICS ARE ABLE TO MAKE QUALITY IMPROVEMENT CHANGES AT THE CLINIC-LEVEL WITH A STRUCTURED, TIERED CURRICULUM.**

## 05. ANALYSIS

The reduction in PDSAs focused on PHQ-2+#9 and workflow in Year 2 is a positive indicator, as these introductory topics were heavily emphasized in Year 1. The increase in PHQ-9 and intervention-focused PDSAs in Year 2 reflects a strategic progression, with participants aligning their projects with more complex elements of the Primary Care and Behavioral Health Care Pathways. This shift supports the program's goal of fostering increasingly sophisticated quality improvement initiatives.

## 06. CONCLUSION

The structured, progressive nature of the MI Mind curriculum has facilitated a meaningful transition from introductory to advanced quality improvement initiatives. The data suggests that participants are building upon foundational skills and applying them to more complex suicide prevention strategies. Ongoing analysis will further clarify how these changes impact patient care and system-level outcomes.

## 07. FUTURE DEVELOPMENTS

Year 3 marks the first iteration of an advanced curriculum, introducing participants to higher-level quality improvement methodologies and individualized coaching. Current PDSA plans indicate a record-breaking shift toward intervention-based projects, reflecting increasing complexity and clinical impact. To further ensure high-quality outcomes, participants will be evaluated using an advanced PDSA rubric, setting a new standard for project assessment. These developments will provide deeper insight into how sustained quality improvement efforts can drive meaningful change in suicide prevention practices across Michigan.



# \$14 MILLION DOLLARS IN CANCER MEDICATION PROVIDED FOR FREE TO 900 PATIENTS

## DEVASTATING PROBLEM

- o >\$3 billion dollars in cancer medication thrown away annually in U.S.
- o 3 out of 4 patients worry about paying for their cancer treatment.
- o \$200K average cost annually for a single cancer medication.

## INNOVATIVE SOLUTION

- o Michigan House Bill 5672 passed in 2006, enacted the cancer drug repository (CDR) program allowing for safe redistribution of donated oral cancer medication and supportive cancer medication.
- o Founded June 2023, YesRx operates the YesRx Network, a statewide interconnected healthcare ecosystem working together to improve health equity and protect community health via CDR programming.

## LIFE-CHANGING OUTCOMES

### OVER A 20-MONTH PERIOD:

- o \$14 million in CDR medication provided to patients in Michigan, for free.
- o 900 patients experienced improved access to medication.
- o 10x healthcare participation increase in CDR program (>80 sites).
- o \$21 million in eligible CDR medication donated by individuals.



yesrx

yesrx Network

- o Partner Sites Across YesRx Network
- o Counties Served by YesRx Network



[www.yesrx.org](http://www.yesrx.org)

YesRx is a nonprofit charitable service organization © 2023

REFERENCES AND MORE

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The YesRx mission to improve cancer medication access for vulnerable people and communities while protecting Michigan land and water is supported by generous sponsor, private individuals, and Michigan grants. Financial donations are critical for YesRx to continue to help ease the lives of patients with cancer.



MICHIGAN HEALTH  
ENDOWMENT FUND

MSHO 40



" Thank you for this month's medication! I had a grant and now I don't qualify. I don't have \$3800 a month for my deductible, I only make \$2800 a month. "



"I was glad YesRx was able to provide a very important medication that I needed daily. I was worried I couldn't get it. I am thankful for the program being there in a time of need."





# Naloxone Distribution Across a Statewide Emergency Department Quality Improvement Collaborative



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**OPEN**  
Prevention. Treatment. Recovery.

## BACKGROUND

- Naloxone is an effective and lifesaving strategy to prevent opioid overdose deaths.
- Emergency departments (EDs) are important access points for people who use drugs to receive harm reduction supplies and education.
- OPEN and MEDIC collaborated to develop a statewide emergency department naloxone distribution program.

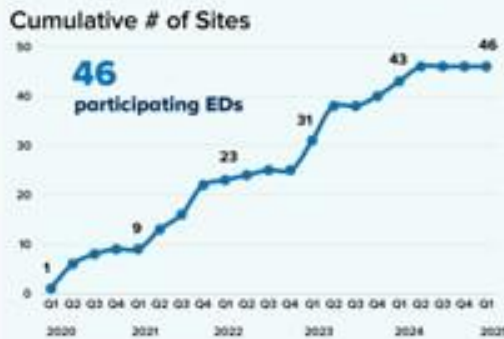
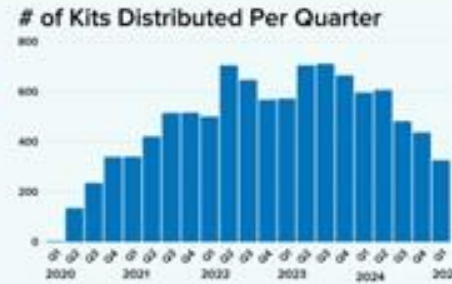
## OBJECTIVE

To demonstrate the feasibility of implementing a statewide ED quality improvement program for naloxone distribution to patients at high risk for future overdose.

## METHODS

- We applied a learning health system approach to quality improvement and implementation.
- Hospital sites were recruited into the program to represent an operationally and geographically diverse range of health systems in urban, suburban, and rural regions across Michigan.
- Naloxone kits were assembled by OPEN to contain 2 doses of intranasal naloxone, personal protective equipment (face shield & gloves), and educational materials.
- Each hospital designated 3 champions (physician, nurse, and pharmacist) to lead the program at their site and communicate with the program coordinating center.
- Provider education and technical support were provided to each participating hospital and quarterly site champion calls offer opportunities for discussion and support.
- Tallies of naloxone dispensed at each hospital were reported back to the coordinating center team monthly.

## RESULTS



### Patient and Provider Education



### Patient Testimonials

I'm very grateful for your products (thank you 🙏) — it's people and companies like you that actually care ❤️

Thank you for providing this lifesaving service! I was afraid I had lost my son forever ❤️



## CONCLUSIONS

- We have demonstrated the feasibility of ED take-home naloxone programs.
- We believe this program can provide a model for other states to make naloxone more accessible for communities.
- Further directions of the program include expansion to partner with hospitals in rural regions, especially considering areas with higher substance use burden and less access to harm reduction and treatment resources.

## ACKNOWLEDGEMENTS

Thank you to all our collaborators on this project, including all our partner hospitals, the Michigan Department of Health and Human Services, and Blue Cross Blue Shield of Michigan.

OPEN is partially funded by the Michigan Department of Health and Human Services

Support for MEDIC is provided by Blue Cross Blue Shield of Michigan (BCBSM) and Blue Care Network (BCN) as a part of the BCBSM Value Partnerships program. Although Blue Cross Blue Shield of Michigan and MEDIC work collaboratively, the opinions, beliefs, and viewpoints expressed by MEDIC do not necessarily reflect the opinions, beliefs, and viewpoints of BCBSM or any of its employees.



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# The Lived Experience of Completing the National Pediatric Readiness Project (NPRP) Assessment: The Case for a Multidisciplinary, Team-Based Approach



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## BACKGROUND & SIGNIFICANCE

- The National Pediatric Readiness Project (NPRP) is a national initiative aimed at ensuring all Emergency Departments (EDs) are equipped to provide effective and timely care to children
- The NPRP Assessment is available via a free, web-based tool that can be used by EDs to gauge pediatric resources and capabilities.
- NPRP self-assessments can provide data for evaluation and identification of areas for quality improvement (QI) at local, state, and national levels.
- The process and overall experience of completing the assessment at the local ED level has not previously been studied.

## OBJECTIVES

- To gain real-time insight on the experience of completing the NPRP assessment in general EDs.
- To identify opportunities to better support successful and accurate NPRP assessment completion in the future.

## METHODS

**RECRUITMENT:** Six general EDs were recruited through the Michigan Emergency Department Improvement Collaborative (MEDIC) to participate in a pilot project focused on understanding and improving the current state of site pediatric readiness.



**PRE-SURVEY:** Participating sites were asked to review NPRP Assessment questions and identify key informants, their "pediatric readiness team", to be present or contribute to assessment completion.



**SITE VISITS:** In-person, on-site, observed assessment events were conducted with each of the 6 participating sites.



During the events, teams completed the NPRP online assessment by answering questions to the best of the team's ability through consensus. Concurrently, study team members recorded observations.



After assessment completion, the team participated in an audio recorded debriefing.

## ANALYSIS

Qualitative content analysis was conducted on debriefing session transcripts. Descriptive coding was used to categorize the data into meaningful segments, with at least two independent coders ensuring reliability through consensus discussions. From this process, key themes were identified and refined through iterative discussions among the research team.

## RESULTS

Table 1. Descriptive data for enrolled hospital sites.

Hospital Type	Trauma Designation	Annual Patient Volume (est)	Pediatric Volume	Pediatric Readiness Team - Identified Key Stakeholders
Site 1 General Hospital with GED*	Adult Trauma Level II	45,000	Medium	Critical Care Nursing Quality Care Manager ED Nurse Manager ED Associate Medical Director Physician ED Physician Group Administrator Trauma Program Manager
Site 2 Critical Access Hospital with GED*	Adult Trauma Level IV	29,000	Medium-High	ED Medical Director ED Nurse Manager Trauma Program Manager Physician Group Pediatric Consultant
Site 3 General Hospital with GED*	Adult Trauma Level II	60,000	Medium	ED Clinical Nurse Leader ED Bedside Nurse ED Physician ED Nurse Manager ED Pharmacist Trauma Program Manager
Site 4 General Hospital with GED*	Adult Trauma Level II	60,000	Medium-High	Trauma Surgeon/Director of Trauma Trauma Registrars Trauma Process Improvement Coordinator Peds and EM Physician ED Clinical Nurse Specialist Trauma Program Manager ED Clinical Pharmacist Specialist ED Medical Director ED Nurse Manager
Site 5 General Hospital with GED*	Adult Trauma Level II	50,000	Medium	ED Physician ED Physician Quality Director ED Medical Director Trauma Program Manager ED Nurse Manager
Site 6 General Hospital with GED*	Adult Trauma Level IV	28,000	Medium	ED Medical Director ED Bedside Nurse ED Nurse Manager Trauma Program Manager Physician Group Pediatric Consultant Hospital Quality Manager ED Physician

\*GED = general emergency department. Bolded text in color indicates key informant roles identified by each of the 6 sites.

### Key stakeholders identified at each site include:

- ED Nurse Manager
- ED Physician Representative – leadership role OR pediatric interest
- Trauma Program Manager

## RESULTS CONTINUED

Table 2. Key themes from debrief transcripts and recorded observations.

Main Theme	Sub-Theme	Quotes
Multidisciplinary involvement during NPRP assessment completion	Increases accuracy	"I think when I last did the (assessment) ... especially when it comes to the quality improvement aspects of it, I scored us lower because we didn't have anything specific at that time. But then during our discussions today, we talked through some of the various quality metrics that are being done nested within several different committees and programs that are already in place, and that those qualified. Which I think is what helped get our score from 72, when I did it. Compared to 86.5 today. So recognizing that a lot of this work is being done, even if it's not being done within specifically a pediatric readiness committee."
	Encourages collaborative approach to QI	"Where are our deficits? What do we need to work on and get the right people at the table to do some of these things?"
	Reliant on purpose and intent	"I think it was very good to have a lot of people here ... because I think the last time, like I said, I went through and I did it to get it done"
Perceptions surrounding NPRP assessment	Positive perceptions on data it provides	"I love data metrics, so having a benchmark to compare I think was really good. And then just having some way to compare us with what we should be at from a state or regional level. It was really exciting for me."
	Desire for question clarification	"... (when completing NPRP assessment in the past) I felt a little daunting being the person filling it out just because you're not really sure. The questions seemed pretty black and white, but yet at the same perspective it's like am I actually answering what they're asking?"
Emerging role of the trauma team in ED pediatric readiness		"...my exposure (to the NPRP assessment) was done by self-study based on information given to me by my trauma coordinator"

## CONCLUSIONS



Completing the assessment with key stakeholders present increased confidence in accurate result reporting.



There is a desire for more guidance and clarification on assessment questions.



Completing the pediatric readiness assessment as a multidisciplinary team established the importance of collaborative QI efforts and provided space to determine action steps.

## ACKNOWLEDGEMENTS

We would like to recognize the six EDs that participated in the pediatric readiness pilot program for their contributions and valuable insights during the debriefing sessions. We would also like to acknowledge our collaborators on this project including the Michigan Trauma Quality Improvement Program (MTQIP), the Michigan Pediatric Readiness Improvement Project (MI PRIP), and the Michigan Emergency Medical Services for Children (EMSC) teams for their support in recruitment, initial site visits, and provision of resources to participating sites.



# Continuous Quality Improvement in Social Needs Screening: Evaluation of Two Social Needs Linkage Programs

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## BACKGROUND

Growing evidence demonstrates that interventions addressing patients' unmet health-related social needs—such as food insecurity, housing instability, and transportation— are associated with better health outcomes and frequently lower healthcare costs. We highlight two key components of social needs interventions identified in the emerging literature:

- (1) Community Health Workers (CHWs)
- (2) Digital platforms to connect health care and social care partners

## OBJECTIVES

MSHIELD aims to facilitate and evaluate two social needs linkage programs:

- (1) **High-touch Approach:** Partnership with the Southeastern Michigan Health Association (SEMHA) to engage community health workers (CHWs) to conduct outreach and connect patients at the Michigan Bariatric Surgery Collaborative (MBSC) with community resources.
- (2) **Low-touch Approach:** Partnership with the Michigan Oncology Quality Consortium (MOQC) to integrate their Patient-Reported Outcome (PRO) surveys with Michigan 2-1-1 (Mi211)'s bidirectional referral program.

## CQI PARTNERS



**Michigan Bariatric Surgery Collaborative (MBSC):** A regional group of hospitals and surgeons that perform bariatric surgery in Michigan. MBSC aims to innovate the science and practice of metabolic and bariatric surgery through comprehensive, lifelong, patient-centered obesity care-in Michigan.



**Michigan Oncology Quality Consortium (MOQC):** A voluntary collaborative of medical and gynecologic oncologists. MOQC's purpose is to further the success of interdisciplinary teams improving the quality and value of cancer care.

## REGIONAL PARTNERS



**Southeastern Michigan Health Association (SEMHA):** A nonprofit organization assisting local agencies with health programs in southeast Michigan, including training, hiring, and engaging community health workers



**Michigan 2-1-1 (Mi211):** A statewide resource directory and referral platform that connects Michigan residents to resources right in their communities leveraging social care navigators and a curated resource database of over 27,000 programs statewide.

## METHODS

MSHIELD will use **quantitative analysis of referral, utilization, and resource linkage metrics, along with demographic variables**, to assess the implementation and feasibility of each approach. These findings will be critical to evaluate how successful the two different approaches are in ensuring high-quality equitable access to social care resources.

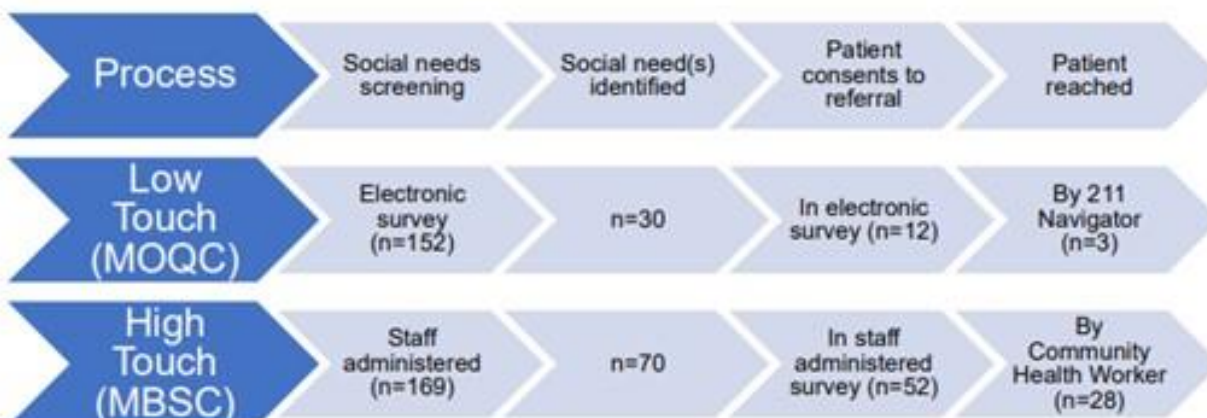
MSHIELD will utilize **patient satisfaction surveys and qualitative interviews with staff and clinicians** to inform improvements within the two existing programs and to formulate recommendations for the implementation of future social needs screening and linkage for additional CQIs in the state of Michigan.

## NEXT STEPS

This evaluation of a "high-touch" and a "low touch" approach to social needs linkages will continue through December 2025 and will inform:

- The development of more comprehensive programs for regions of the state without a current community hub.
- Recommendations for future expansion of social needs screening/linkage including which team members are most critical in which settings, and which approach best meets the needs of different CQIs, health systems, and communities.

### Comparison of a Low-Touch and High-Touch Approach to Social Needs Linkages: Processes and Preliminary Results (November 2024 – March 2025)





# MOQC Oncology Stewardship

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## Background

### The Michigan Oncology Quality Consortium

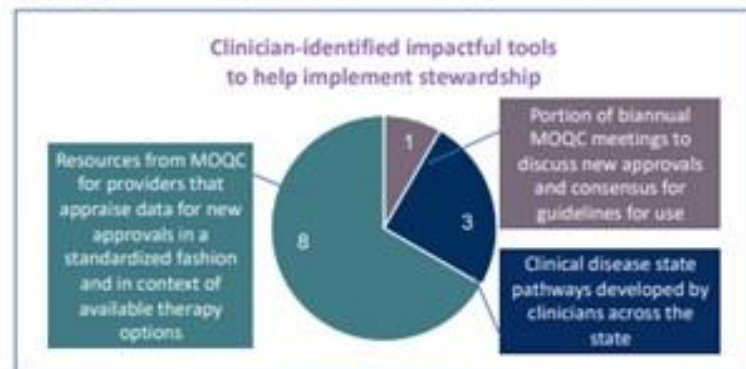
(MOQC, www.moqc.org) is a statewide collaborative of hematologist-oncologists and gynecologic oncologists. In 2023, MOQC launched an oncology stewardship initiative to address challenges like drug shortages, rising costs, and care disparities. Backed by its Patient and Caregiver Oncology Quality Council (POQC), the project supports MOQC's goals of centering equity, maximizing value, and fostering professional development.

### Oncology Stewardship

A set of coordinated strategies to improve the use of systemic anticancer therapy with the goal of enhancing patient health outcomes while reducing financial toxicity.

## Methods

Clinicians expressed the need for tools that offer guidance while also incorporating current treatment options. Such tools were identified as particularly valuable in supporting the effective implementation of stewardship practices.



MOQC sought feedback on impact and feasibility of three clinical scenarios for the initial stewardship adoption. Based on the survey results received from the collaborative, the topic of "Improving biomarker testing for metastatic non-small cell lung cancer (NSCLC)" was selected.



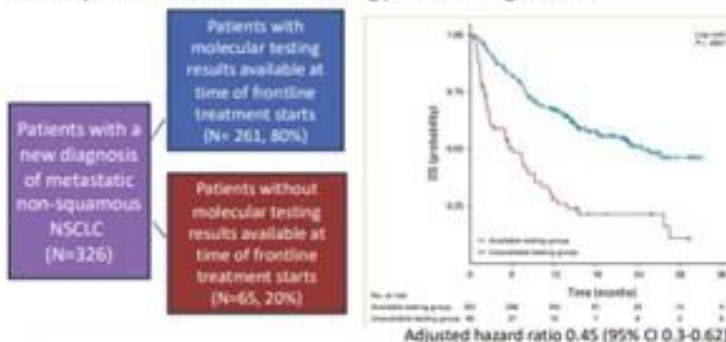
MOQC recommends that large-panel next-generation sequencing (LG-NGS) be covered for all patients with metastatic or incurable NSCLC. These comprehensive panels, which analyze over 50 genes, are necessary to capture all guideline-recommended biomarkers. As the number of actionable mutations continues to grow, relying on single-gene or limited panels risks missing critical treatment opportunities. To ensure timely and effective care, coverage for LG-NGS should be available in both inpatient and outpatient settings.

### New Approvals through Oncology Stewardship Lens

01. Efficacy	If there is a <b>clear winner</b> , then this should become the <b>standard of care</b> .
02. Toxicity	Efficacy is comparable thus we choose the treatment with <b>less toxicity</b> to improve quality of life and decrease unplanned hospitalizations.
03. Cost	<b>ONLY</b> if efficacy and toxicities are comparable, choose the <b>lowest cost</b> treatment to the payer/patient.

## Research and evidence

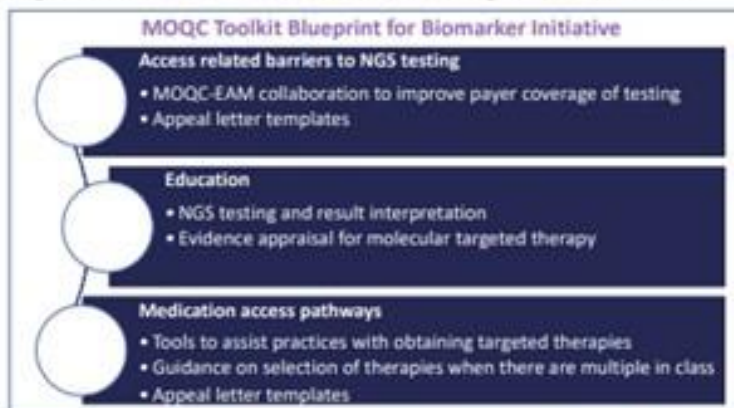
Real-world evidence supports this initiative and recommendations. A non-randomized retrospective study using electronic health records of 326 patients newly diagnosed with non-squamous non-small cell lung cancer examined the relationship between the timing of molecular testing results and overall survival. The study compared outcomes between patients who had molecular genotyping results available before initiating frontline therapy (~80%) and those who did not (~20%). The findings confirmed that patients with genotyping results available prior to starting treatment had significantly longer overall survival compared to those without results at treatment initiation. Risk of death at any point in time was 55% lower in patients who had molecular testing prior to starting treatment.



Risk of death at any point in time was **55% lower** in patients who had molecular testing prior to starting treatment

## Results and Future Direction

MOQC is currently conducting its own data collection initiative to evaluate molecular testing practices within the collaborative. This includes evaluating test types used (e.g., NGS, point mutation, or no testing), turnaround times, and treatment decisions relative to test results. The study also tracks therapy changes within three months and use of non-targeted treatments in patients with actionable mutations. Findings will guide evidence-based recommendations shared through a collaborative toolkit.



In parallel, MOQC is partnering with the Economic Alliance for Michigan (EAM) to advocate for insurance coverage of molecular testing in both outpatient and inpatient settings, promoting broader and more equitable access.

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