T1D Exchange

QI Collaborative Call, Adults

1/24/23

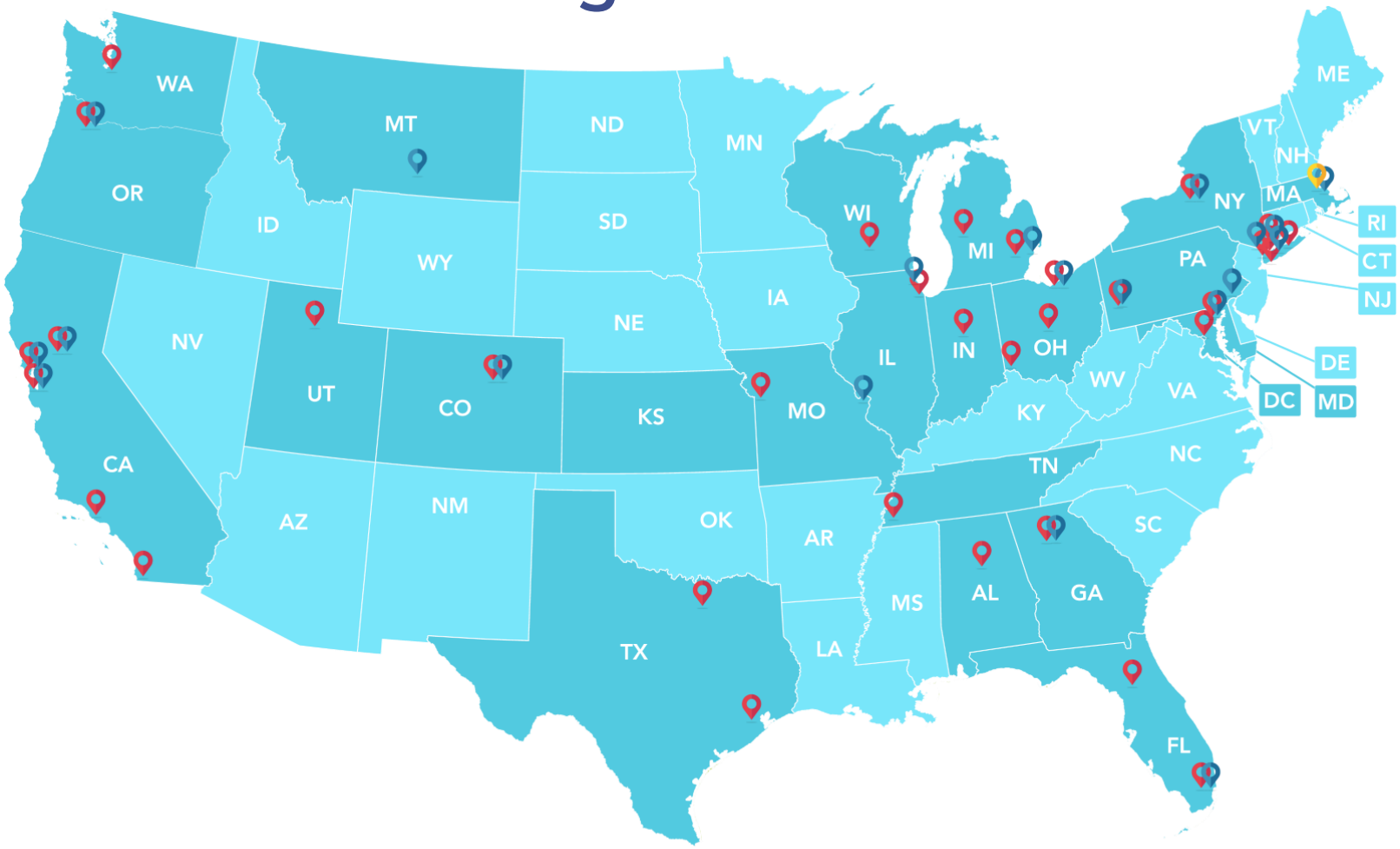
Welcome & introductions

Agenda

- Collaborative updates
  - New clinics joining the Collaborative
  - Reporting Measures
  - T2D program
- January Collaborative presentations
  - Ruth S. Weinstock, MD, PhD SUNY
  - Ann Mungmode, MPH, CPHQ, T1DX-QI

T1D Exchange Updates

T1DX-QI network of 54 centers, caring for 85,000+ T1D patients across 21 states and Washington D.C.



Priya Prahalad, Nicole Rioles et al. T1D Exchange Quality Improvement Collaborative: Accelerating Change through Benchmarking and Improvement Science for People with Type 1 Diabetes. Journal of Diabetes. Nov. 2021

20 adult clinics – caring for 28,000 patients with T1D

20 participating adult clinics

Albert Einstein Shivani Agarwal MD MPH	Mount Sinai Carol Levy MD
Billings Clinic Haleigh James MD	NYU Langone Lauren Golden MD
Boston Medical Center Devin Steenkamp MD	Oregon Health & Science University Andrew Ahmann MD
Grady Memorial Hospital Sonya Haw MD	Stanford University Marina Basina MD
Northwestern Medicine Grazia Aleppo MD	SUNY Ruth Weinstock MD PhD
Penn Medicine Ilona Lorincz MD	UC Davis Prasanth Surampudi MD
Washington University Alexis McKee MD	UCSF Umesh Masharani MD
Barbara Davis Center Halis Akturk MD	UPMC Jason Ng MD
Cleveland Clinic, Pratibha Rao, MD, MPH & Mary Vouyiouklis, MD	University of Miami Francesco Vendrame, MD PhD
Johns Hopkins Nestoras Mathioudakis MD MHS	

T1D Exchange

Welcome Johns Hopkins and UC Davis!

Nestoras Mathioudakis, MD, MHS
JHM Diabetes Prevention & Education Program. Division of Endocrinology, Diabetes & Metabolism. Division of Biomedical Informatics & Data Science

JOHNS HOPKINS
MEDICINE

Prasanth N Surampudi, MD
Associate Professor, Endocrinology, Diabetes, and Metabolism, UC Davis

UCDAVIS
HEALTH

T1D Exchange

Collaborative Clinic Profile: Adult Diabetes Center at Johns Hopkins

Center and Providers	Multidisciplinary Team Members	Volume and Demographics	Contact Names
Johns Hopkins Comprehensive Diabetes Center (Johns Hopkins Outpatient Center, Bayview Medical Center, Green Spring Station)	**Adult Endo MD:** 9 **APP:** 4 **Adult Endo Fellows:** 7 **CDCES:** 5 (1 RD, 3 RN, 1 PharmD)	1,343 patients with T1D seen in last 1 year **Insurance:** **Medicare:** 13% **Medicaid:** 1.3% **Race:** White: 74% Black: 20% Other: 6%	**Site PI:** Nestoras Mathioudakis, MD MHS nmathio1@jh.edu **Site coordinator:** Mohammed Abusamaan, MD MPH mabusamaan@jhmi.edu

Learning Session

Reminder: T1D Exchange will not accept reimbursements for the 2022 learning session after Jan 30, 2023. Please share your flight receipts to QI@t1dexchange.org this week!

Quarterly invoices for 2022 deliverables are due by Jan 31, 2023 to close our books on 2022.

2023-2025 reporting

- Q4 2022 data reporting are due now and use the previous Smartsheet table definitions for numerators and denominators.

- Reminder: reporting for the 2023-2025 period, which began 1/1/2023.

- Expectations: centers should report monthly data for the Jan 1-31, 2023 period by 3/1/2023.

- You can find Reporting Measures on the "New Clinics" page of the T1DX-QI member website.

- Questions about reporting or the Smartsheet access? Ask your QI coach and/or email qi@t1dexchange.org

T2D Program

2020-2022 — Pre-Launch Pilot

- Stanford
- SUNY

2023-2024 — Expansion Phase

- Boston Medical Center
- Grady Memorial
- University of Pittsburgh

2023-2024 — Demonstration

- Opportunity to contribute T2D data in Smartsheet
- Co-authorship opportunities for all clinics sharing data
- Demonstration: no funding now but will be prioritized for future expansion

2024- — Goal: engage as many T2D sites as possible

- Seek sponsorship for funding support

T1D Exchange

Clinical Presentation:

Screening for SDOH

January 24, 2023

SDOH QI Project Team Members

Emilie Hess, MS
Beth Wells, MSN, RN
Hollie Cartini, LMSW
Melissa Reed, MSW
Melissa Stacy, AS
Marisa Desimone, MD
Shabnam Dhillon MBBS
Rachel Hopkins, MD
Roberto Izquierdo, MD
Jessica Reis, MSN, RN
Ruth S. Weinstock, MD, PHD

About Us: Adult Clinic

Time-Frame: **1/17/22 to 1/16/23**

1,650 people with T1D
3,200 people with T2D
3,760 people with endocrine disorders

75 % seen in-person vs. 25 % telemedicine

T1D using CGM: 80.3 %
T2D using CGM: 30.5%
T1D using insulin pump: 52.2 %
T2D using insulin pump: 1.8 %

Staff: Clinical FTE

- 4.3 Endocrinologists
- 6.3 APPs (NP/PAs)
- 1.0 Podiatrist
- 4.5 Nurse DCES
- 4.4 Dietitians*
- 1.0 Social Worker
- 1.0 Pharmacist*
- 1.0 QI Coordinator*
- 1.0 Data Coordinator*
- 13.3 LPNs / MOAs

*shared with Pediatric Clinic

Adult and Pediatric Clinics are adjacent with some shared spaces

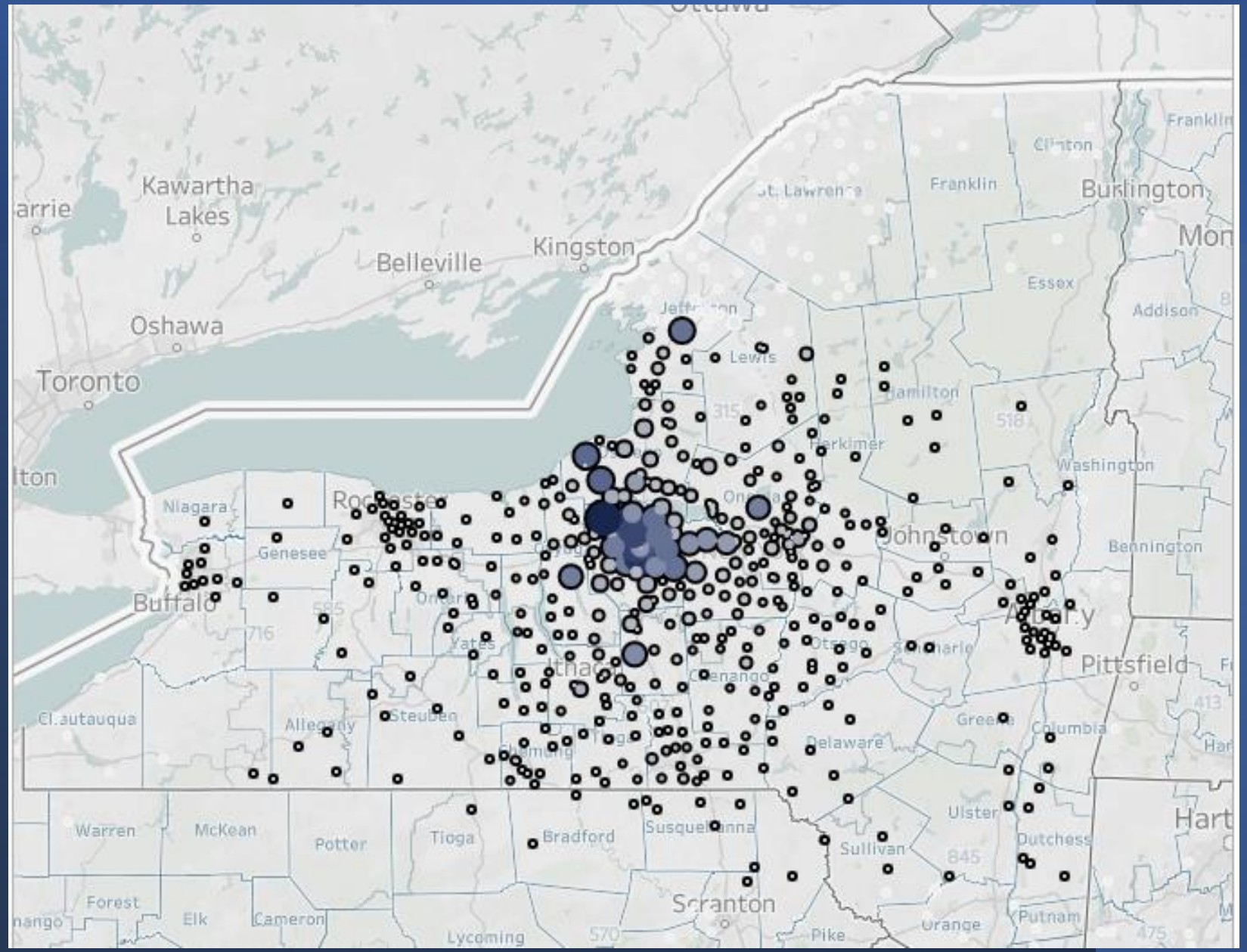
Insurance: Adult Clinic

T1D

- Private: 55.4 %
- Medicare: 23%
- Medicaid: 20%
- Uninsured: 0.25%

T2D

- Private: 30.3%
- Medicare: 56.1%
- Medicaid: 12.7%
- Uninsured: 0.22%


Kawartha
Lakes
Belleville
Kingston
Oshawa
Toronto
Niagara
Buffalo
Genesee
Franklin
Burlington
Essex
Addison
Washington
Bennington
Johnstown
Pittsfield
Albany
Ithaca
Chautauqua
Allegany
Steuben
Delaware
Columbia
Ulster
Dutchess
Sullivan
Warren
McKean
Potter
Tioga
Bradford
Susquehanna
Forest
Elk
Cameron
Lycoming
Scranton
Pike
Orange
Putnam

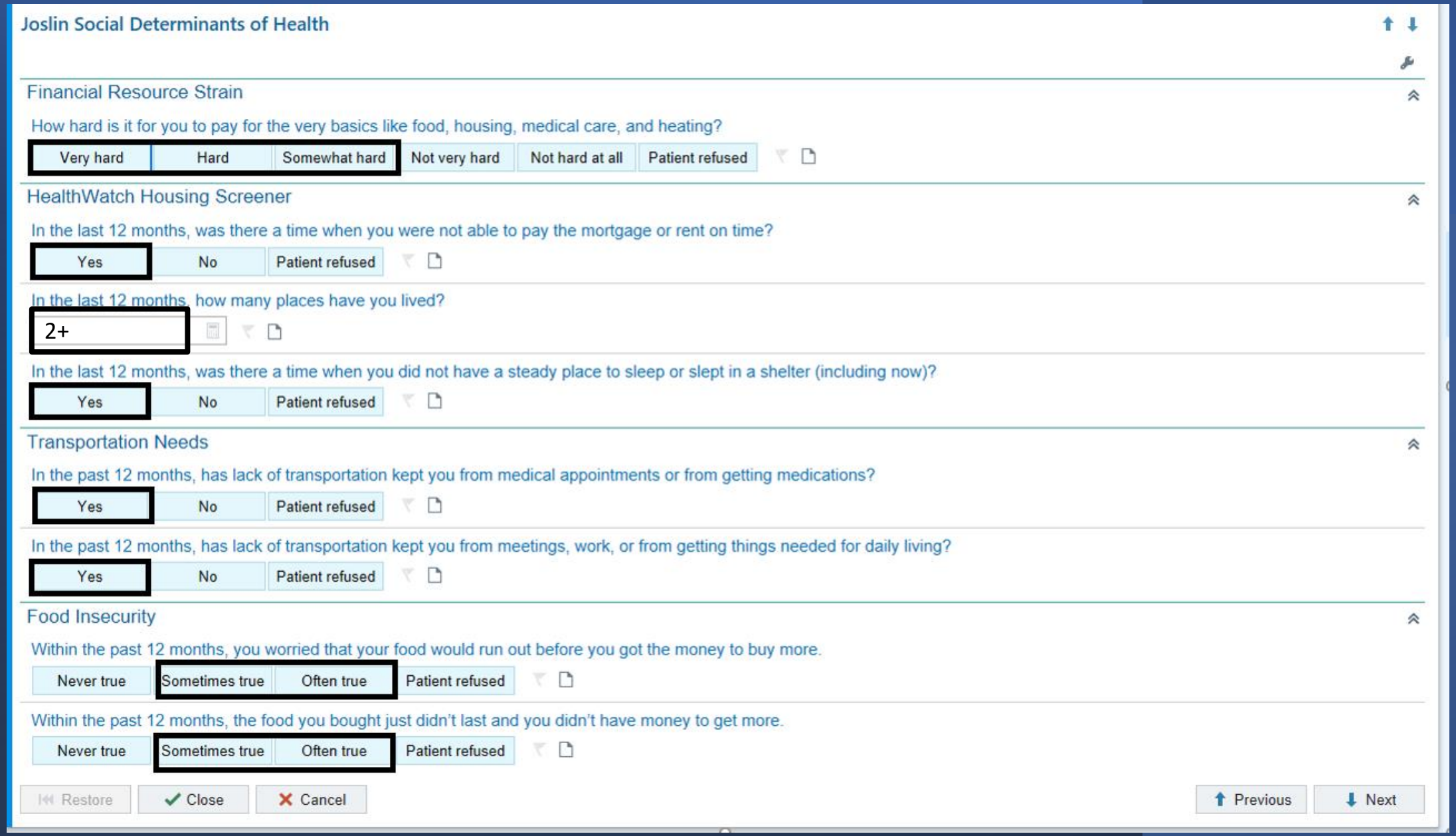
Social Determinants of Health

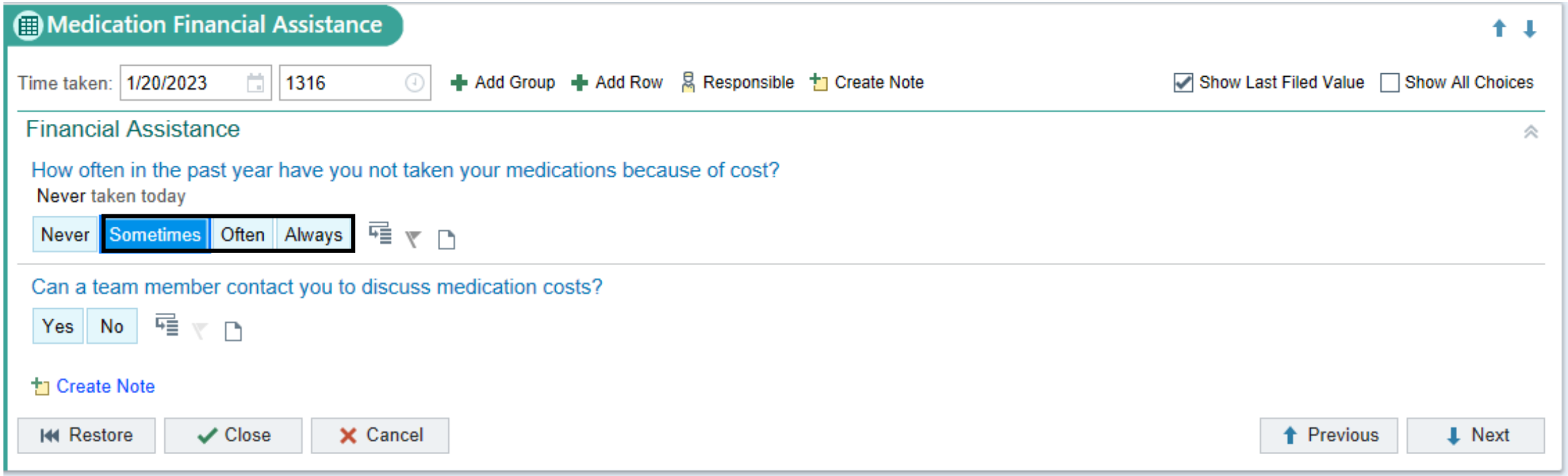
Background:

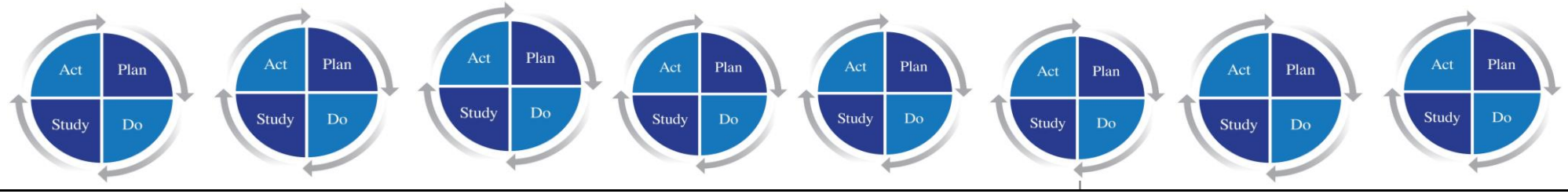
August 2021: screening for Social Determinants of Health (SDOH) 0%

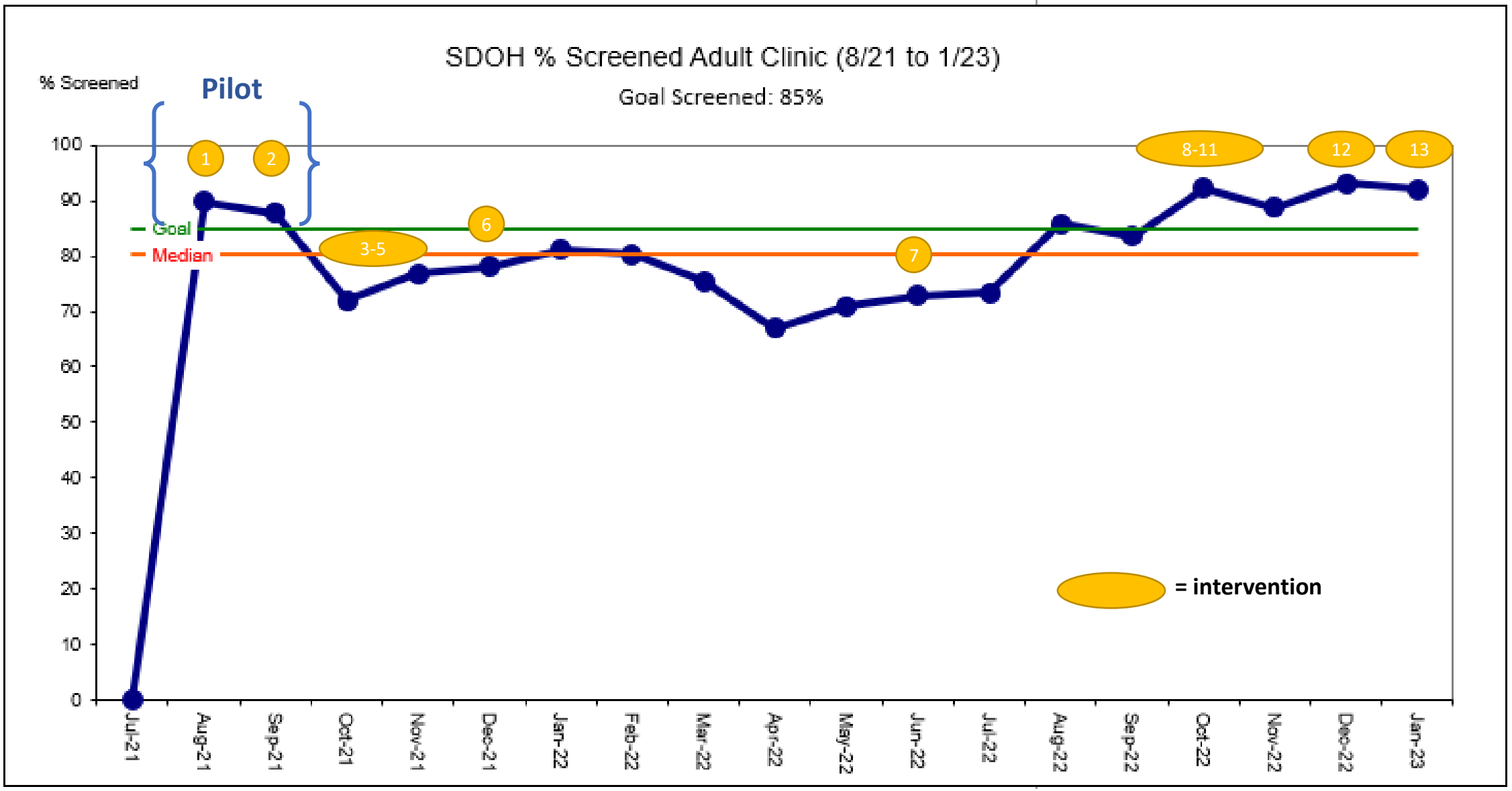
AIMS:

- **To begin screening for SDOH**
- **To increase screening with goal of 85%**


Joslin Social Determinants of Health
Financial Resource Strain
How hard is it for you to pay for the very basics like food, housing, medical care, and heating?
Very hard
Hard
Somewhat hard
Not very hard
Not hard at all
Patient refused
HealthWatch Housing Screener
In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?
Yes
No
Patient refused
In the last 12 months, how many places have you lived?
2+
In the last 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter (including now)?
Yes
No
Patient refused
Transportation Needs
In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?
Yes
No
Patient refused
In the past 12 months, has lack of transportation kept you from meetings, work, or from getting things needed for daily living?
Yes
No
Patient refused
Food Insecurity
Within the past 12 months, you worried that your food would run out before you got the money to buy more.
Never true
Sometimes true
Often true
Patient refused
Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.
Never true
Sometimes true
Often true
Patient refused
Restore
Close
Cancel
Previous
Next


Medication Financial Assistance
Time taken: 1/20/2023 1316
Add Group
Add Row
Responsible
Create Note
Show Last Filed Value
Show All Choices
Financial Assistance
How often in the past year have you not taken your medications because of cost?
Never taken today
Never
Sometimes
Often
Always
Can a team member contact you to discuss medication costs?
Yes
No
Create Note
Restore
Close
Cancel
Previous
Next


Act
Plan
Study
Do


SDOH % Screened Adult Clinic (8/21 to 1/23)
Goal Screened: 85%
% Screened
Pilot
1
2
3-5
6
7
8-11
12
13
Goal
Median
100
90
80
70
60
50
40
30
20
10
0
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
= intervention

Pilot

1. Aug. 2021: During rooming process, LPNs screened (verbally asked SDOH questions) patients of one endocrinologist doing televisits and one seeing patients in-person
2. Sept. 2021: Created an Epic smart phrase (.jossdoh) to improve LPN documentation and enable generation of reports in Epic (answers to SDOH questions; track SW referrals and reasons SW referral declined)

Patient was asked Joslin SDOH questions and screened:
{JOSSDOH:26129}

- [ ] Patient declined to answer Social Determinants of Health questions
- [ ] Positive SDOH screening, social work referral made, provider notified via Qliq/Vocera/in-person
- [ ] Positive SDOH screening, social work referral declined by patient, provider notified via Qliq/Vocera/in-person
- [ ] Reason patient declined referral - The situation is temporary
- [ ] Reason patient declined referral - Already receiving Resources elsewhere
- [ ] Reason patient declined referral - Too personal

3-5

Oct. 2021:

- **Roll Out of SDOH Screening to All in Adult and Pediatric Clinics**
- Started a formal referral process: referrals sent to SW via Epic (instead of only using Vocera; referrals in Epic can be tracked).
- After observing LPNs, SW created a script to improve referral rate (*instead of LPNs asking patients if they want to see SW, asking if they would like to receive additional support*)

Referral to Social Work – Positive Only

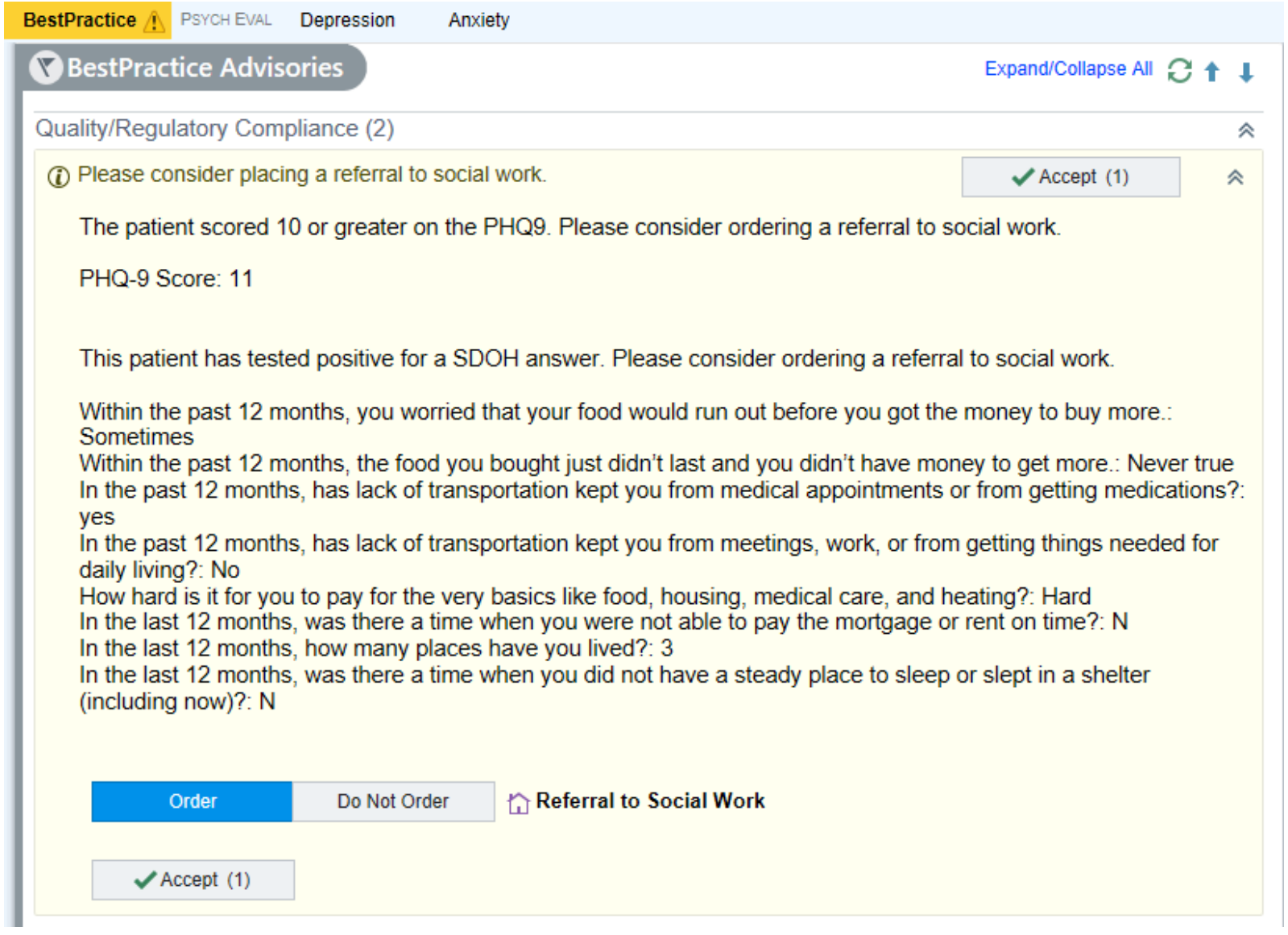
May I reach out to our support team to see if there are any additional resources to help you with?

(**yes**) great! I am going to connect you with Hollie or Melissa, our Social Workers

(**no**) ok! May I ask if:

a.) The situation is temporary
b.) Already receiving resources elsewhere
c.) Privacy Concerns
d.) Other (document reason)

6 Dec. 2021: Reminded LPNs to ask “would you like additional support”; Revised our BPA (added positive SDOH screen)



Adult Clinic

8/10/2021-6/16/2022	
Total patients seen (n, %) T1D T2D	 1,655 2,439
Total patients screened for SDOH (n, %) T1D T2D	 1,324/1,655 = 80% 2,305/2,439 = 92%
Total patients at risk (n,%) T1D T2D	 **229**/ 1,324 = 17.2 % **436**/2,305 = 18.9%
SW referrals for positive screening (n, %) T1D T2D	 **72**/229 = 31.4% **189**/436 = 43.3%

From Epic: SDOH encounter level reports (responses to SDOH questions), BPA reports, SW referral report

7 June 2022: Added our Clinical Trainer to help retrain staff and document mastery of SDOH screening / SW referral processes

Added to LPN Core Competencies

positive screening or declined to answer.			
For all patients; Complete SDOH screening. Do not ask questions if the patient has already completed them within 30 days prior to their visit			
1. Select Joslin SDOH in rooming tab to complete questions. **2.** Notify provider of a positive screening by indicating this on the rooming sheet. **3.** Document in a nursing note using ".jossdoh" smartphrase for positive screening or declined to answer. 4. If positive, a BPA will automatically populate to offer patient access to social work services. If patient accepts, follow prompts to pend a social work referral to the provider for review and signature. If patient declines, follow prompts to select appropriate option.			
For all patients: Verify all necessary documentation is completed under			

8-11

Oct, 2022:

Provided the SDOH questions (on paper) at check-in (instead of LPNs verbally asking questions).

LPNs put answers into Epic, if document blank the LPNs verbally ask SDOH questions.

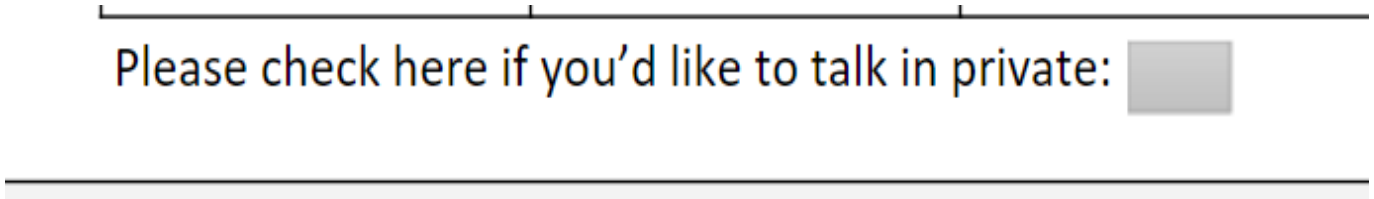
Expanded language access of SDOH question sheets (Spanish, Nepali, Arabic, Russian, Bosnian, and Somali, our most common languages).

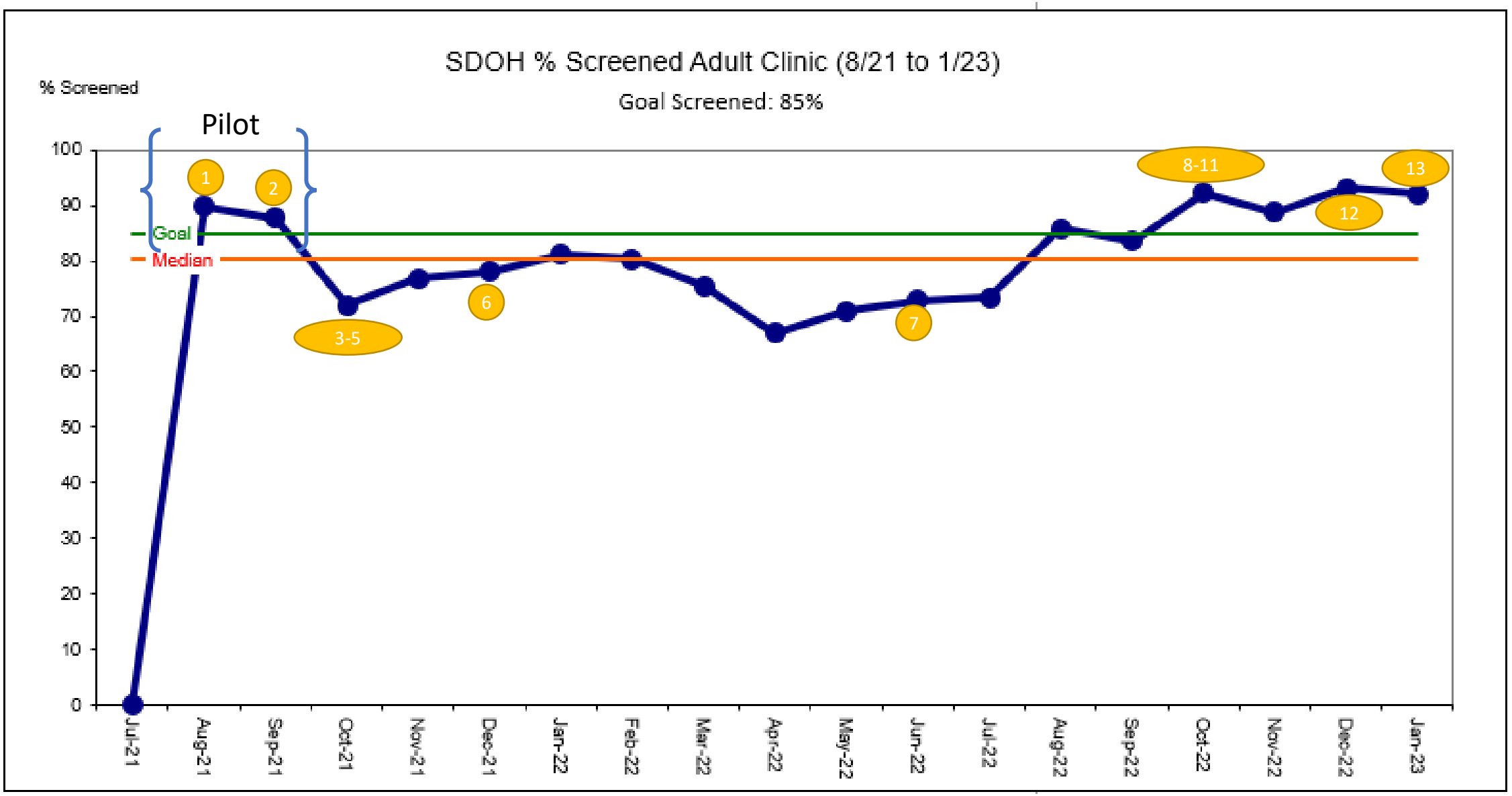
Started screening for every clinic visit except “Lab Only”.

Note: SDOH screen available for patients to complete via MyChart throughout institution since Sept 2021 (24 questions vs our 8 questions); only 7-8 MyChart responses received to date

12 Nov., 2022: Change SDOH screening from every visit, to SDOH screening every 30 days to reduce workload/burn-out

13 Dec., 2022: Patients given option to complete sheet in private

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Pilot
Goal
Median
1
2
3-5
6
7
8-11
12
13
100
90
80
70
60
50
40
30
20
10
0
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
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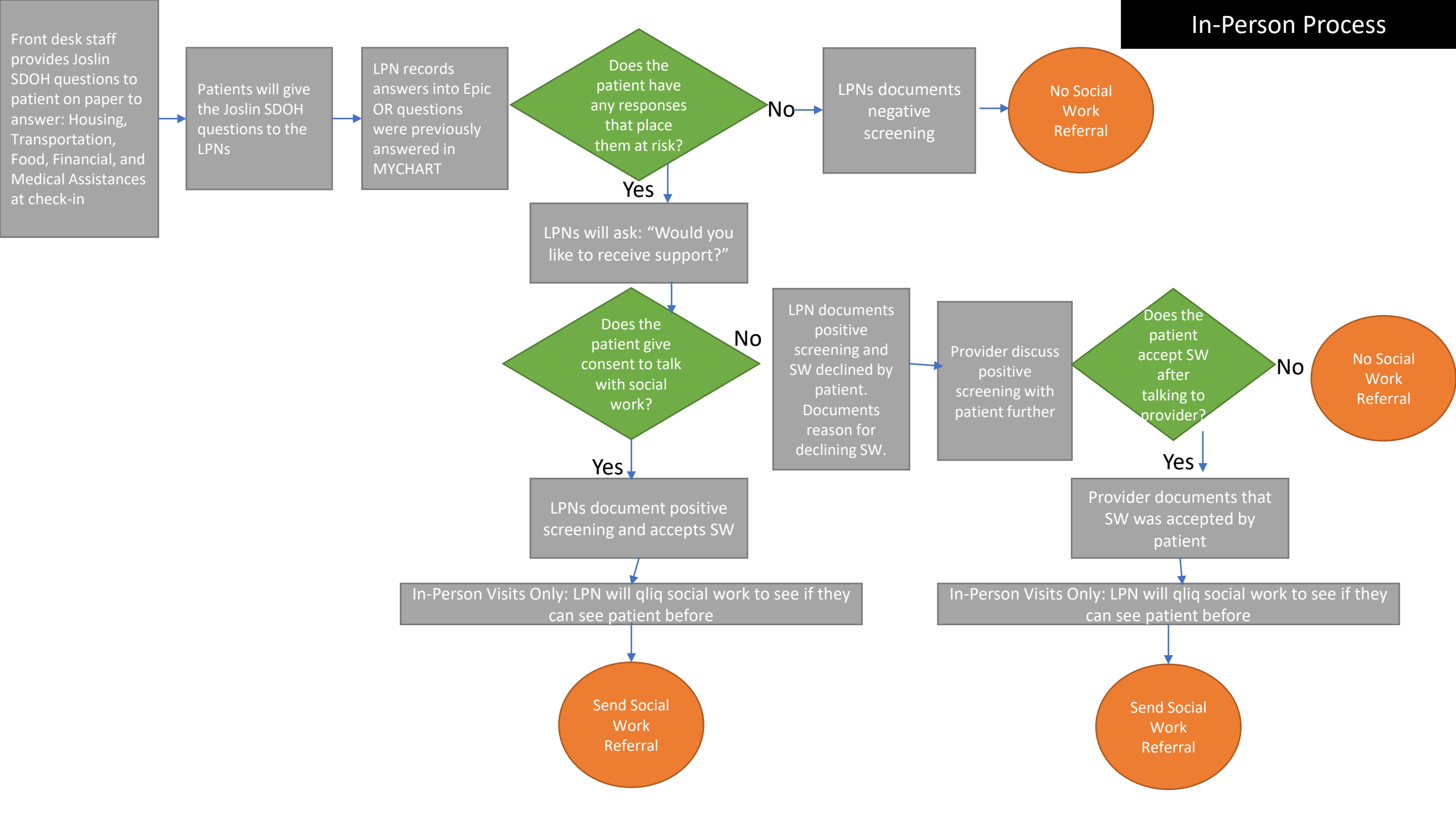
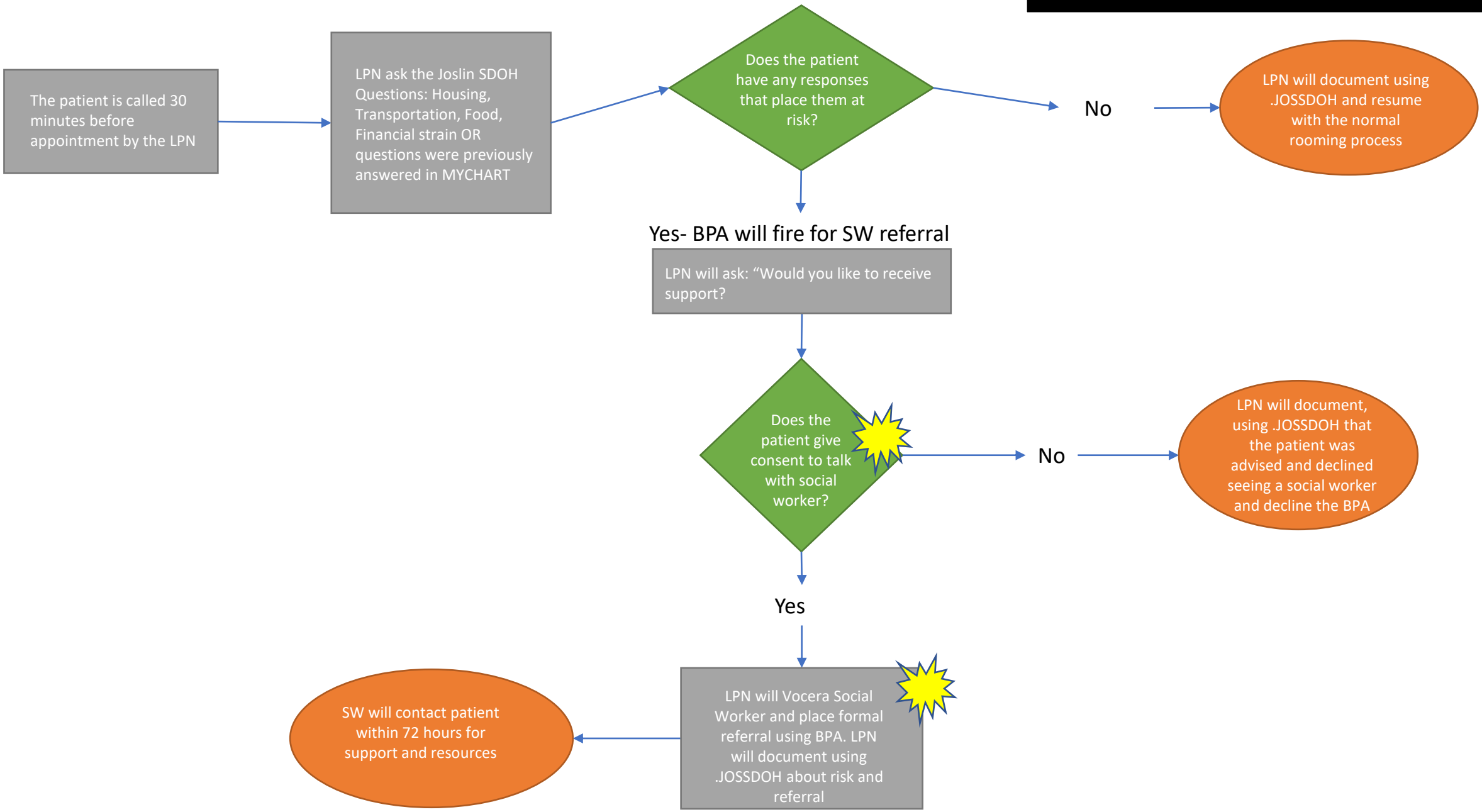
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23

In-Person Process



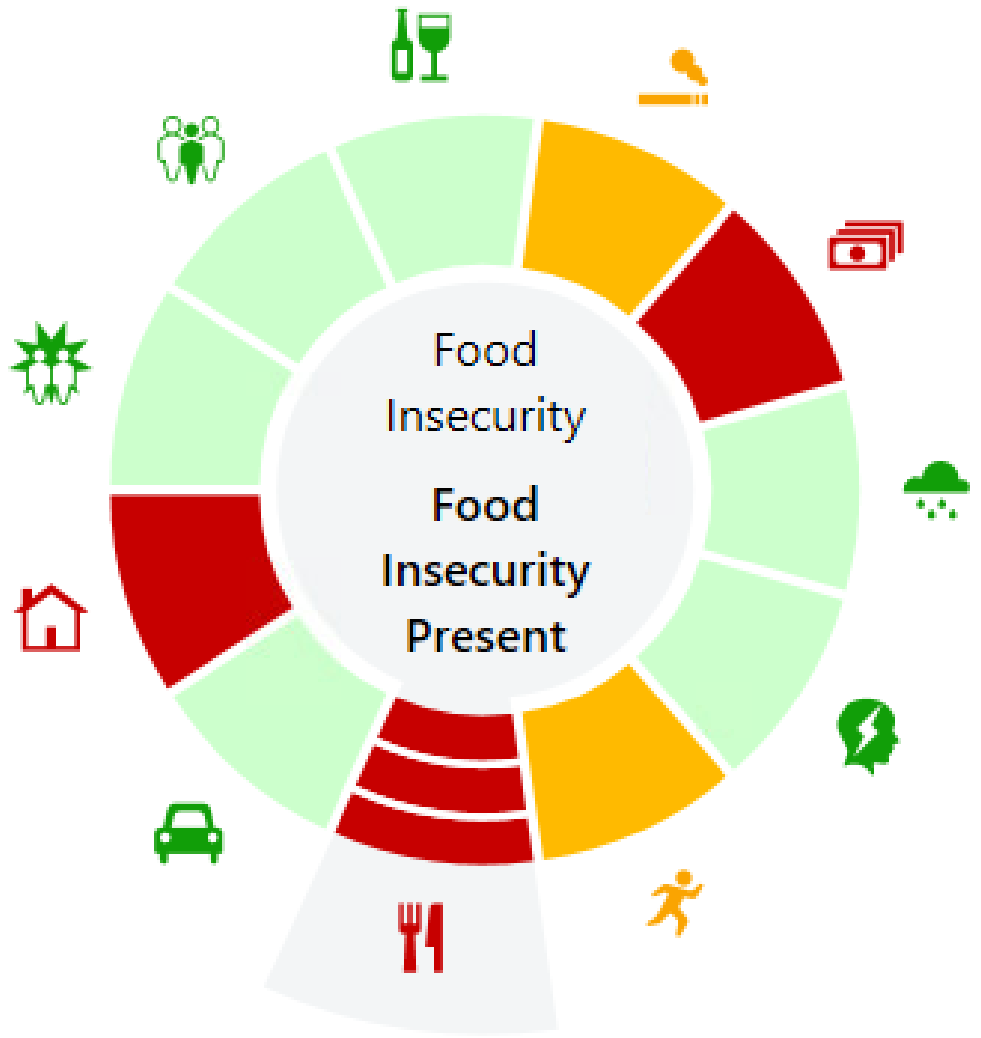
Telemedicine Process



SnapShot

Social Determinants of Health

Alcohol use
Tobacco use
Financial resource strain
Depression (PHQ9)
Stress
Physical activity
Food insecurity
Transportation needs
Housing stability
Intimate partner violence
Social connections



Next Steps/Future Directions

- Increase referrals to SW for positive screening
- Examine SW referrals by age, race and ethnicity
- Assess impact for those referred to SW e.g successful access of resources
- Assess outcomes such as A1c, No Show rate, depression, SDOH after 6 to 12 months post SW referral

THANK YOU!

Adult Clinic: Positive SDOH Screening (n)

8/10/2021-6/16/2022

Financial:

- How hard is it for you to pay for the very basics likes food, housing, medical care and heating? 241 T1D; 240 T2D

Food:

- You worried that your food would run out before you got the money to buy more. 81 T1D; 82 T2D
- The food you bought just didn't last and you didn't have money to get more. 79 T1D; 82 T2D

Housing:

- Was there a time when you were not able to pay the mortgage or rent on time? 99 T1D; 75 T2D
- How many places have you lived? (2+) 181 T1D; 66 T2D
- Was there a time when you did not have a steady place to sleep or slept in a shelter? 8 T1D; 12 T2D

Transportation:

- Has lack of transportation kept you from medical appointments or from getting medications? 68 T1D; 65 T2D
- Has lack of transportation kept you from meetings, work, or from getting things needed for daily living? 57 T1D; 62 T2D

Pre/Post learning

QI Adult Centers Network Performance

Monthly Collaborative Call
1/24/23

Adult T1D Glycemia Targets KDD 2020-2022

Aim

Among people with T1D,* increase proportion of patients achieving glycemic targets:

- **At least 25% with A1c <8%, OR**
- **Increase proportion of patients <8% by 5%, OR**
- **Increase TIR among CGM users by 5%**

from baseline in 2 years

*Duration > 1 year, ages 18-75, with at least one in-person or telemedicine visit in the last year

Primary Drivers

- Health Literacy/ Education and Support
- Use of Data
- Social Determinant of Health
- Diabetes comorbidities and complications
- Medication management and device use
- Access to care
- Psychosocial Support

Change Ideas

Health Literacy/ Education and Support

- ~~Patient Education on diet, exercise and device use~~
- Support "emerging adults" (18-26) with continued "transition" education for disease management
- ~~Education to reduce DKA events/admission,~~ ~~4X glucose check education~~
- **Set small patient- and provider-selected goals with clear action step**
- **Peer support groups, new onset classes, technology literacy**

Use of Data

- Use data registries to support population health
- Use EMR templates
- Incorporate QI measures or flow sheets

Social Determinant of Health

- Culturally Competent Care (offering education/materials in appropriate languages, etc.
- Catalogue of community resources, Train staff about SDOH
- Documenting barriers to care (housing, transportation, food etc.)

Diabetes comorbidities and complications

- Case management, follow up for patients not reaching target goals for BG, LDL, BP
- Self-management
- Health education for diabetes complications
- Screening for diabetes complications and comorbidities and referring to subspecialists/care as appropriate

Medication management and device use

- Insulin monitoring/nutrition interactions
- Coach >4 checks/day (for non CGM patients)
- Test new workflows to improve device use/device documentation
- Device data reviews, staff troubleshoot device
- Advertise CGM in waiting rooms, etc.
- Provide contact information for device reps/patient support

Access to care

- Follow up with LTFU patients (not seen for > 180 days); regular follow up (phone/email/text/televisit)
- Improve scheduling process
- Preparing patients for telehealth visits ("pre-visit visit")

Psychosocial Support

- **Conduct mental health screening and referrals (i.e. depression, FOH, diabetes distress)**
- Improve psychosocial support
- MyChart message for questionnaires, PROs, high-risk patients
- Create workflow for positive patients who needs referral
- Screen for QOL (compare control of people using CGM vs no CGM)

Data and T1D Exchange

Data and the T1D Exchange

Data Mapping

- Typically led by IT team, process to map against T1Dx data specifications resulting in access to the full QI portal and contribution to population health research.

Smartsheets

- Temporary data sharing solution (prior to site completing data mapping) where site shares aggregate data to produce dashboards; allows sites the benefit of benchmarking and identifying shifts and trends over time.

Special Initiatives

- Modify/use an existing data collection tool to support a temporary project (i.e. COVID-19 or telemedicine)

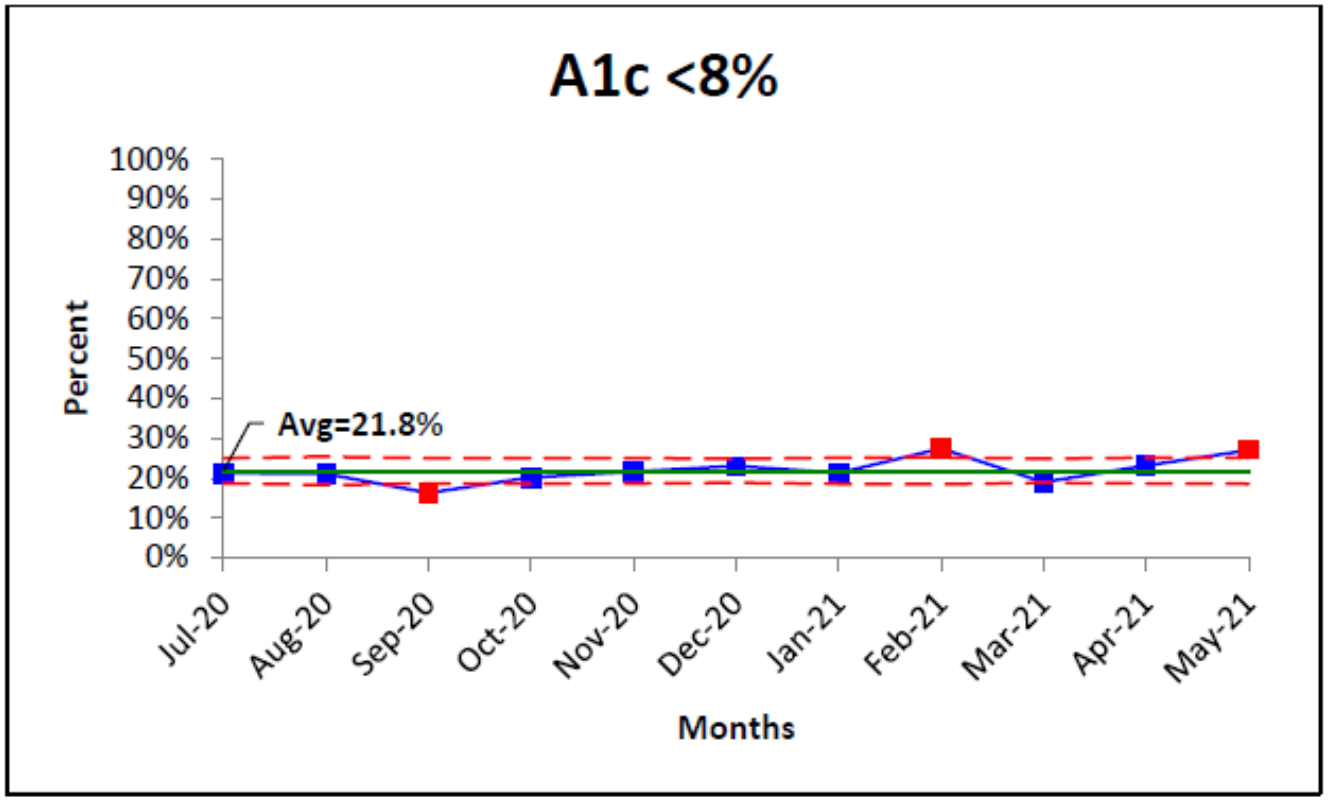
Smartsheets

Primary Column	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020
All Denominators (A): The number of patients with T1D (all ages) at your center with a minimum duration of diabetes ≥ 12 months with 1 or more HbA1c values in the preceding 12 months, of which the last visit (either in-person or telehealth visit) was from the reporting month.						
Phase 1 (Priority Measures to be completely reported by December 2020)						
(1) The number of patients in (Denominator - A) with HbA1c <8(Most recent A1C)						
(2) Median A1c of all patients from (A): of the unique type 1 diabetes patients ages 1-85, what was the median of the most recent hemoglobin A1c value from all patients in this reported month						
(3) The number of patients in (A) who reported using a sensor/CGM during the month being reported on						
(4) Number of patients in (A), excluding CGM users, who check their FSBG > or = to 4x/day						
(5) The number of patients in (A) who are active pump users						
(6a) Number of patients in (A), ages 12 and older, who met eligibility criteria* for depression screening for reporting month						
(6b) Number of patients in 6a that were screened						
Phase 2 (Measure reporting due before March 2021)						
(7a) The number of patients in (3) who wear CGM at minimum 14 days OR 70% of wear in reporting month.						
(7b) The number of patients in (7a) who reported using a CGM during the month reported with Time in Range (70-180) > 50%						
(7c) The number of patients in (7a) who reported using a CGM during the month reported with time in hypoglycemia (<70)						
(7d) The number of patients in (7a) who reported using a CGM during the month reported in time in severe hypoglycemia (<54)						
(8) The number of patients in (A) with a diagnosis of hypertension and BP < 140/90mm Hg who are prescribed ACE-I or ARBs in the measurement year						
(9) The number of DKA events that occurred during the reporting month among all patients in (A)						
(10) The number of patients in (A) with a diagnosis of hyperlipidemia or an LDL > 130 mg/Dl who is prescribed a statin for cholesterol.						
(11) The number of patients in (A) who have SDOH documented in their chart (related to food security, transportation needs, education, housing security, or employment status.)						
Phase 3 (Measure reporting due before June 2021)						

Clinic-specific Dashboards

Example T1Dx Dashboard

(Higher rankings indicate desired direction; e.g. 1st of 10 indicates your sites is performing most ideally compared to other T1Dx QIC adult sites)



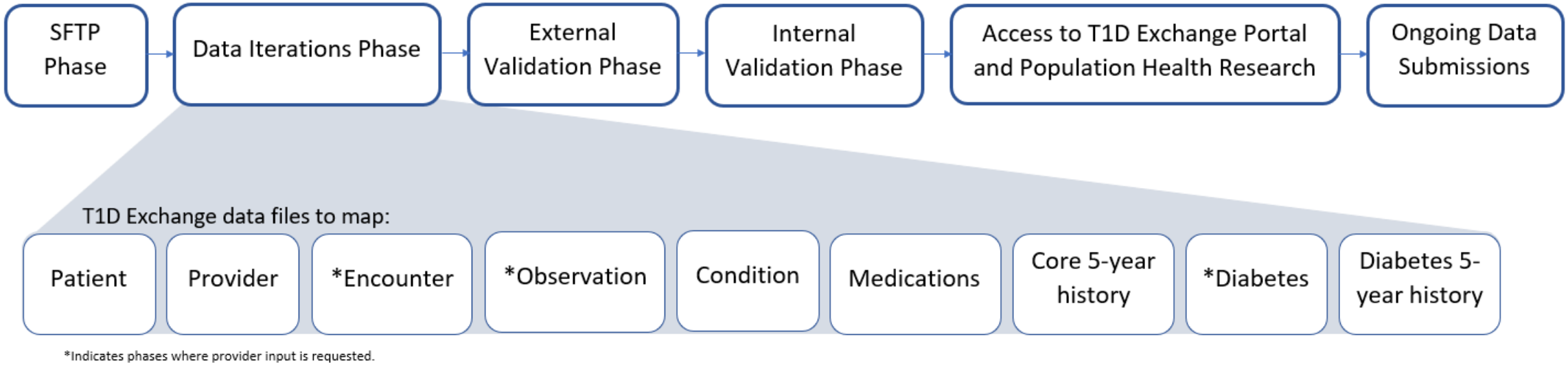
Desired Direction

P-chart

Jul-20	Aug-20	Sept-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
212	166	209	213	204	234	197	186	237	199	196
45	35	34	43	44	54	42	51	45	46	53

ABC clinic is ranked 4th among 8 T1Dx QIC adult clinics on A1c <8%. The T1Dx QIC goal is 50%.

Data Mapping Process



*Indicates phases where provider input is requested.

Data Mapping Progress – adult clinics as of 1/18/22

Site	Data Mapping Orientation	SFTP Established	Patient File	Provider File	Encounter File	Observation File	Condition File	Medication File	Diabetes File	5-Year History	External Validation	Internal Validation	Post Data Mapping/ Ongoing Validation
BDC Adult													
SUNY Adult													
Grady													
U of Miami Adults													
Mt. Sinai Adult													
NYU Langone Adults													
WashU													
Albert Einstein													
Northwestern													
UCSF Adults													
CCF Adults													
OHSU Adults													
Penn													
Stanford Adults													
BMC													
UPMC Adults													
Billings													
Johns Hopkins Adults													
Wayne													

Key	
	Completed
	In Progress

T1D Exchange

2020-2022 Data Overview

Core QI Measures – Adult clinics

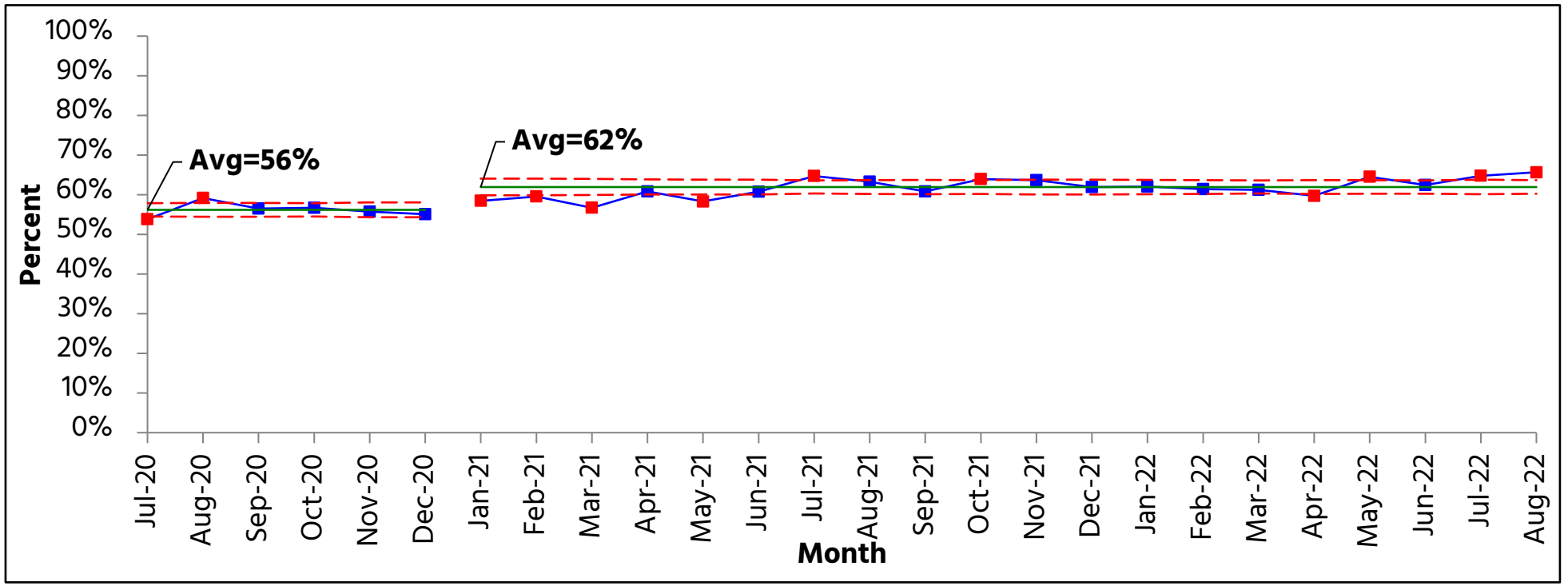
July 2020 – Aug 2022

Measures reported as of Nov 2022	Measure	# of adult clinics reporting
Outcome Measures	HbA1c < 8%	**8** (44%)
	Median A1c	**7** (39%)
Process Measures	CGM use	**8** (44%)
	Pump use	**7** (39%)
	Depression screening	**5** (28%)
	DKA events	**5** (28%)
	Time in Range	**1** (6%)
	Social Determinants of Health screening	**4** (22%)

T1D Exchange

Adult Clinics Improvement Scorecard November 2022 (data from Jul 2020 - Aug 2022)						
Metric	**A1c < 8%**	**CGM use**	**Pump use**	**Dep Scrn**	**DKA Events**	**SDOH**
T1DX-QI Goal	Greater than 50%	Greater than 70%	Greater than 65%	Greater than 80%	Less than 6.3%	Greater than 10%
T1DX-QI Status	**62% [6% increase]**	**69% [13% increase]**	**55% [7% increase]**	**69% [17% increase]**	**5.2% [1% increase]**	**56% [53% increase]**
1	BDC - 75% [+3%]	NYU - 87%	NYU - 79%	SUNY - 74%	NYU Adult - 0.7% [-1.5%]	NYU Adult - 72% [+65]
2	Northwestern - 74%	Penn - 84%	BDC - 67% [+17%]	NYU Adult - 61% [+56%]	BDC - 1.2%	SUNY - 61% [+53%]
3	SUNY - 55%	BMC - 80%	Penn - 59%	Grady - 25%	Penn - 3.7%	BMC - 45%
4	BMC - 46%	SUNY - 71% [+26%]	Wayne State - 56%	BDC - 0%	Grady - 11.5%	Grady - 27%
5	Wayne State - 38% [+22%]	BDC - 67% [+10%]	SUNY - 48% [+18%]	BMC - 0%	SUNY - 15.0%	
6	NYU - 38%	Montefiore - 65% [+10%]	BMC - 26% [+9%]			
7	Penn - 35%	Grady - 46% [+24%]	Montefiore - 19% [+3%]			
8	Grady - 22%	Wayne - 38% [+20%]				
Legend	Favorable Change and/or Above T1DX-QI Goal			No Change and/or Below T1DX-QI Goal		

Adult Clinics - HbA1c < 8% increased by 6%



Lahey-P chart favorable direction

	2020						2021												2022							
	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
T1D Population	1074	1014	1012	1109	890	909	720	717	767	876	890	912	1174	1036	990	1026	889	888	954	1036	1171	1060	1091	1146	937	1092
A1c >8%	578	600	572	629	496	501	421	433	435	533	519	554	760	656	602	656	566	550	592	636	717	633	704	716	607	717

Adult Clinics - HbA1c < 8% Summary

- **QI Collaborative Goal:** 50%
- **QI Collaborative Average:** 62%

- **Sites that meet goal:** 3/8
- **Top performers:**

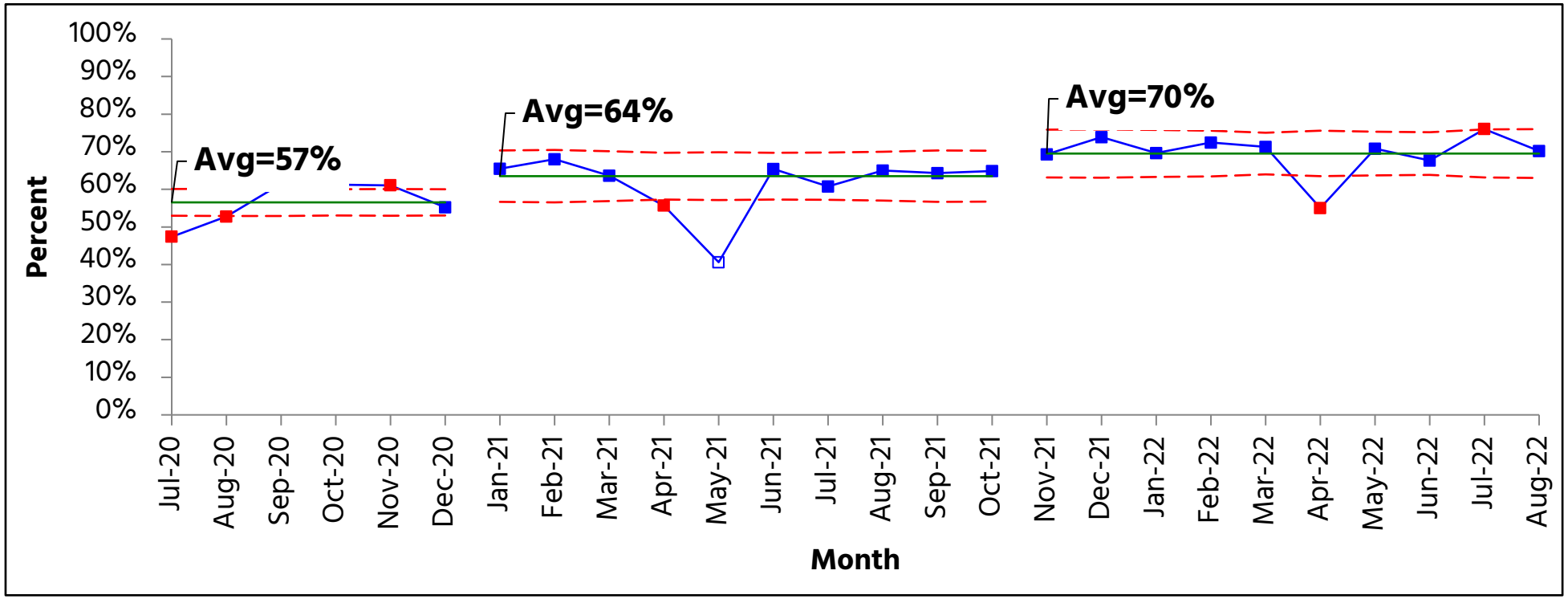
(1) BDC, 75%;
(2) Northwestern, 74%
(3) SUNY, 55%

- **Improvement Range:** 3-22%

Available data*	No data*
BDC	Albert Einstein
BMC	Billings
Grady	Cleveland
NYU	Mt. Sinai
Penn	OHSU
Northwestern	Stanford
SUNY	UCSF
Wayne	U of Miami
	UPMC
	WashU

*As of August 2022

Adult Clinics - CGM Use increased by 13%



Lahey-P chart favorable direction

	2020						2021												2022							
	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
T1D Population	1074	1014	1012	1109	1071	1093	912	882	974	1098	1062	1097	1088	1017	922	939	877	859	899	958	1154	967	1039	1090	860	833
CGM users	509	535	622	679	654	604	597	600	620	611	431	718	661	661	593	609	908	635	626	694	823	532	736	738	654	585

Adult Clinics – CGM Use Summary

- **QI Collaborative Goal:** 70%
- **QI Collaborative Average:** 70%

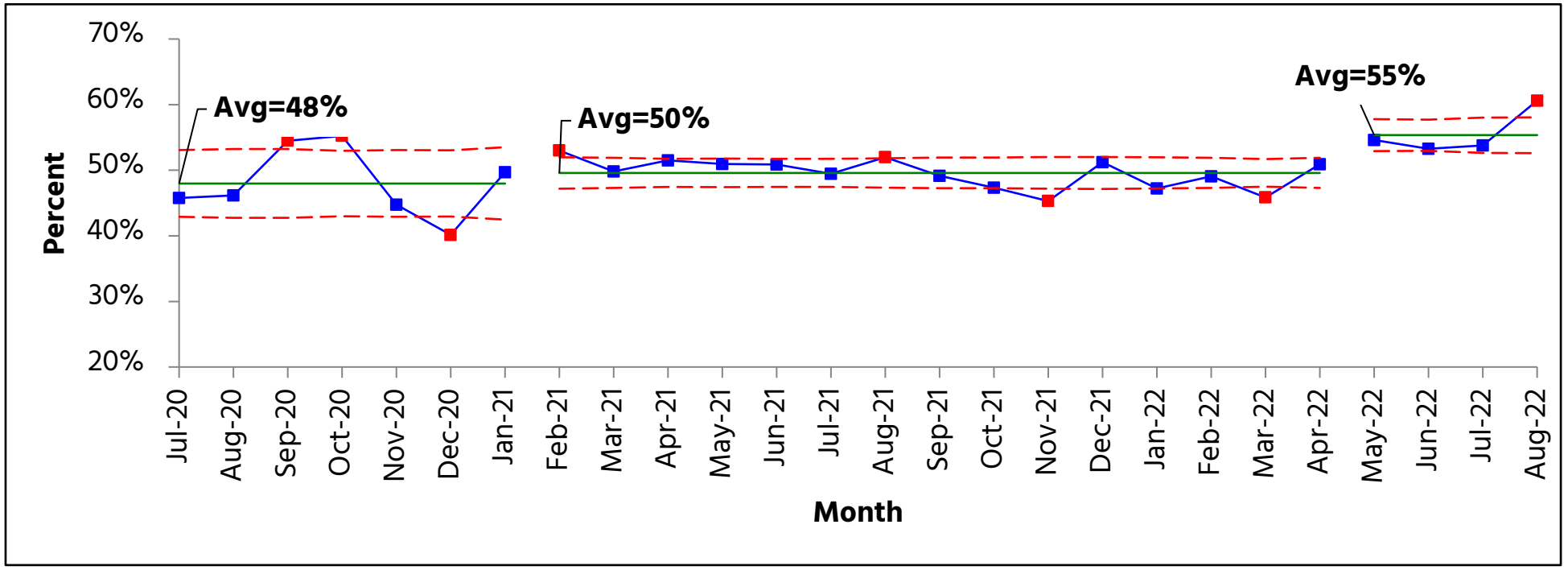
- **Sites that meet goal:** 4/8
- **Top performers:**

(1) NYU, 87%
(2) Penn State, 84%;
(3) BMC, 80%;
(4) SUNY, 71%

- **Improvement Range:** 10%-26%

Available data*	No data*
Albert Einstein	Billings
BDC	Cleveland
BMC	Northwestern
Grady	Mt. Sinai
NYU	OHSU
Penn	Stanford
SUNY	UCSF
Wayne	U of Miami
*As of August 2022	UPMC
	WashU

Adult Clinics - Pump Use increased by 7%



Lahey-P chart favorable direction

	2020						2021												2022							
	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
T1D Population	1031	962	965	1068	1030	1046	875	832	913	1039	999	1042	1037	960	875	881	823	814	145	903	1090	913	987	1042	816	787
Pump users	472	444	526	590	461	420	435	441	455	535	509	530	513	499	430	417	373	417	399	443	500	465	539	5555	439	477

Adult Clinics – Pump Use Summary

- **QI Collaborative Goal:** 65%
- **QI Collaborative Average:** 55%

- **Sites that meet goal:** 2/7
- **Top performers:**

(1) NYU, 79%;

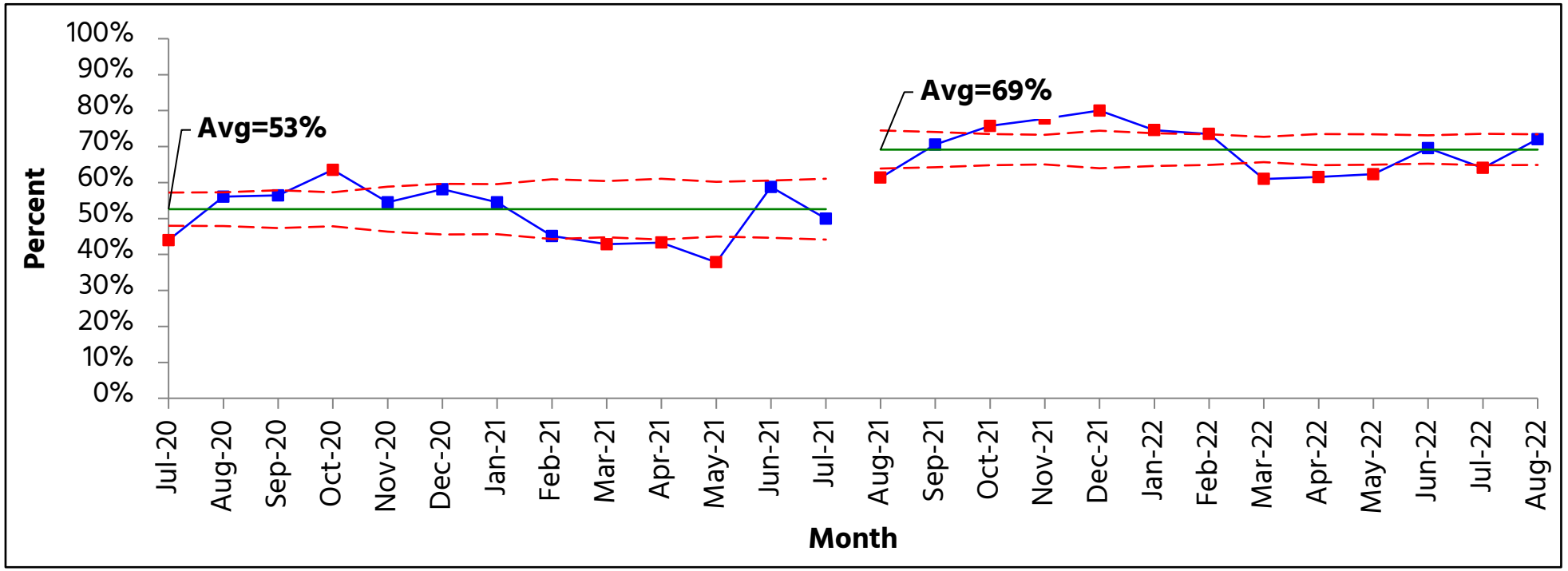
(2) BDC, 67%;

Available data*	No data*
Albert Einstein	Billings
BDC	Cleveland
BMC	Grady
NYU	Northwestern
Penn	Mt. Sinai
SUNY	OHSU
Wayne	Stanford
	UCSF
	U of Miami
	UPMC
	WashU

*As of August 2022

T1D Exchange

Adult Clinics – Depression Screening increased by 16%



Lahey-P chart favorable direction

	2020						2021												2022							
	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Eligible for screening	100	98	78	96	55	43	44	31	35	30	37	34	30	44	51	66	72	45	59	68	100	65	69	79	64	68
Received screening	44	55	44	61	30	25	24	14	15	13	14	20	15	27	36	50	56	36	44	50	61	40	43	55	41	49

Adult Clinics – Depression Screening Summary

- **QI Collaborative Goal:** 80%
- **QI Collaborative Average:** 69%

- **Sites that meet goal:** 0/5
- **Top performers:**

(1) SUNY, 74%

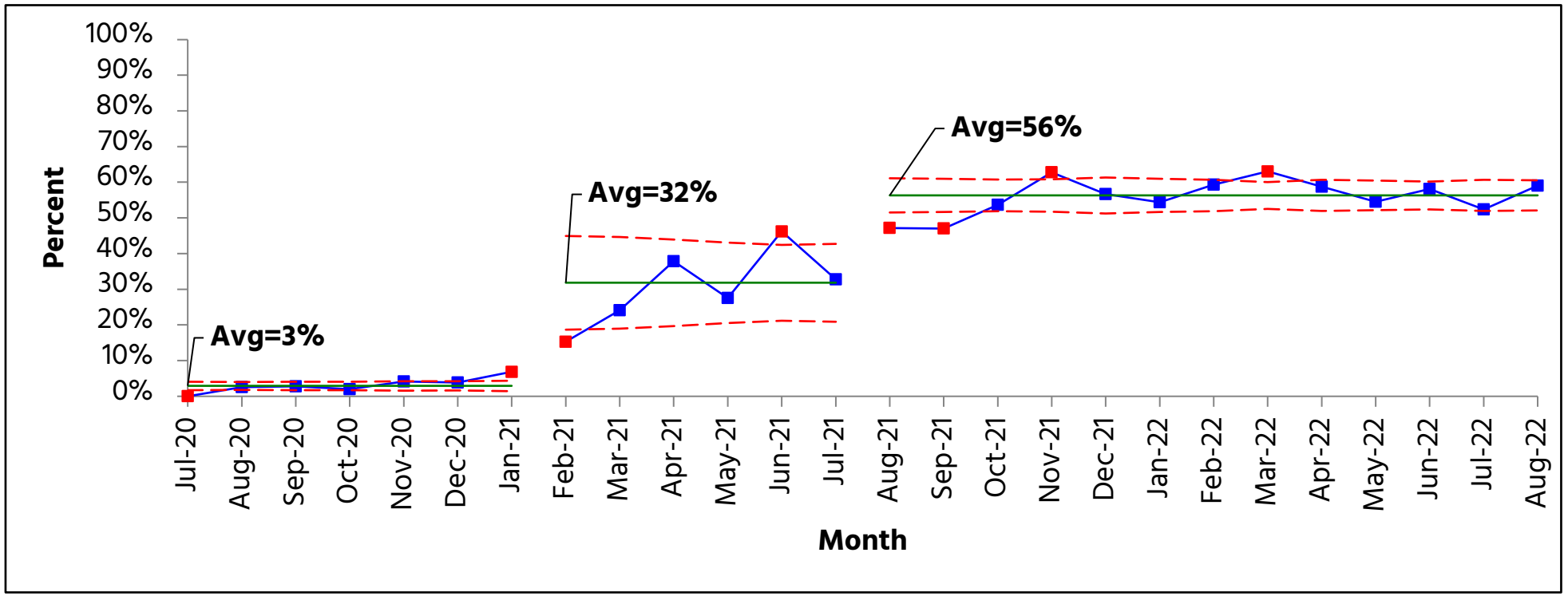
(2) NYU, 61%

- **Improvement Range:** 56%

Available data*	No data*
BDC	Albert Einstein
BMC	Billings
Grady	Cleveland
NYU	Mt. Sinai
SUNY	Northwestern
	OHSU
	Penn
	Stanford
	UCSF
	U of Miami
	UPMC
	WashU
	Wayne

*As of August 2022

Adult Clinics – SDOH Screening increased by 53%



Lahey-P chart favorable direction

	2020						2021												2022							
	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
T1D Population	408	427	399	401	314	336	249	190	199	222	258	290	275	318	334	369	352	284	333	349	511	383	418	499	382	403
Received screening	0	11	11	8	13	13	17	29	48	84	71	134	90	150	157	198	221	161	181	223	322	225	228	277	200	238

Adult Clinics – SDOH Screening Summary

- **QI Collaborative Goal:** 10%
- **QI Collaborative Average:** 56%

- **Sites that meet goal:** 4/4
- **Top performers:**

(1) NYU, 72%
(2) SUNY, 61%;
(3) BMC, 45%;
(4) Grady, 27%

- **Improvement Range:** 53-65%

Available data*	No data*
BMC	Albert Einstein
Grady	BDC
NYU	Mt. Sinai
SUNY	Northwestern
	Penn
	Stanford
	UCSF
	U of Miami
	Wayne

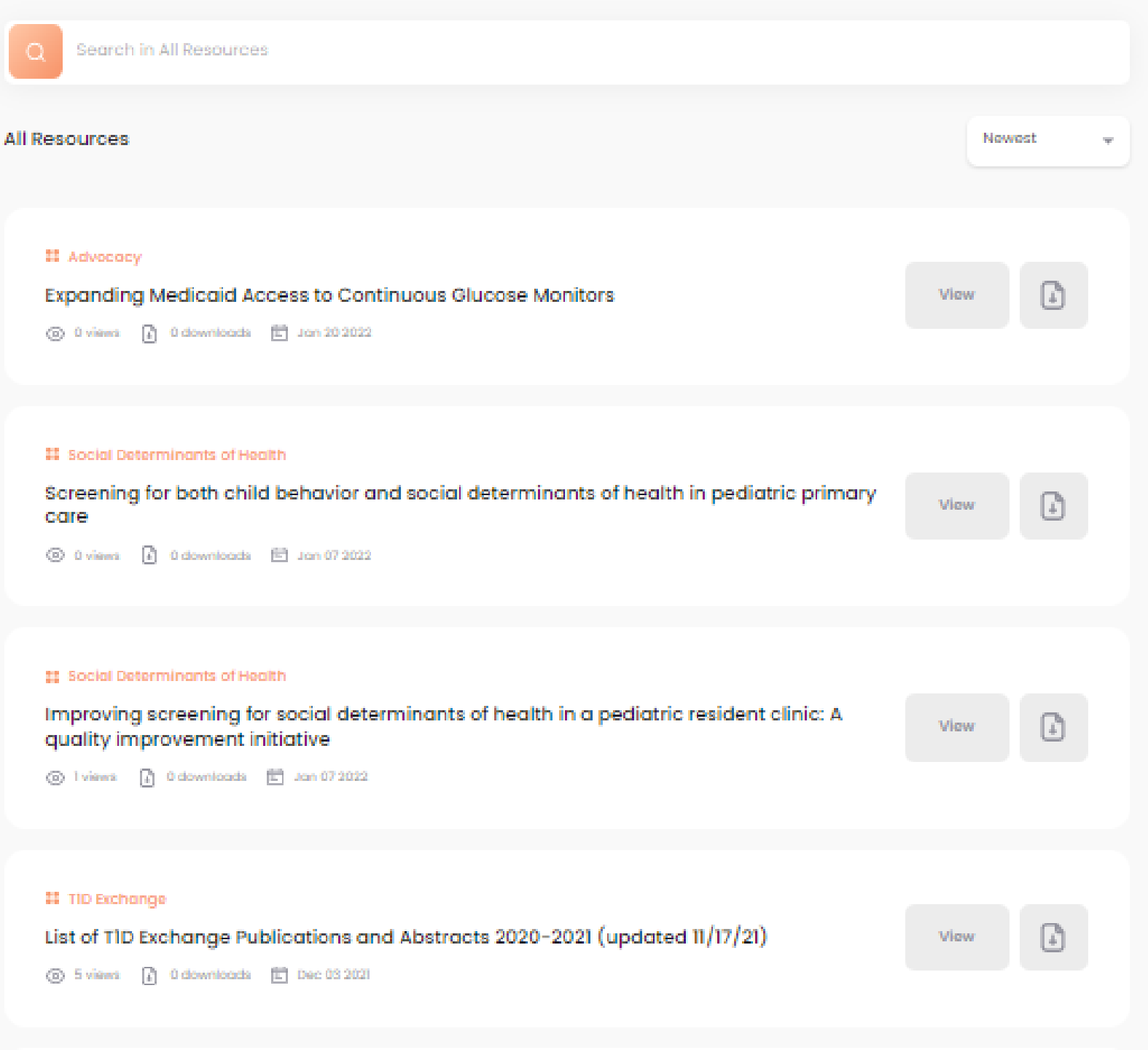
*As of August 2022

Utilizing Data

QI Portal

- Available for ALL clinics

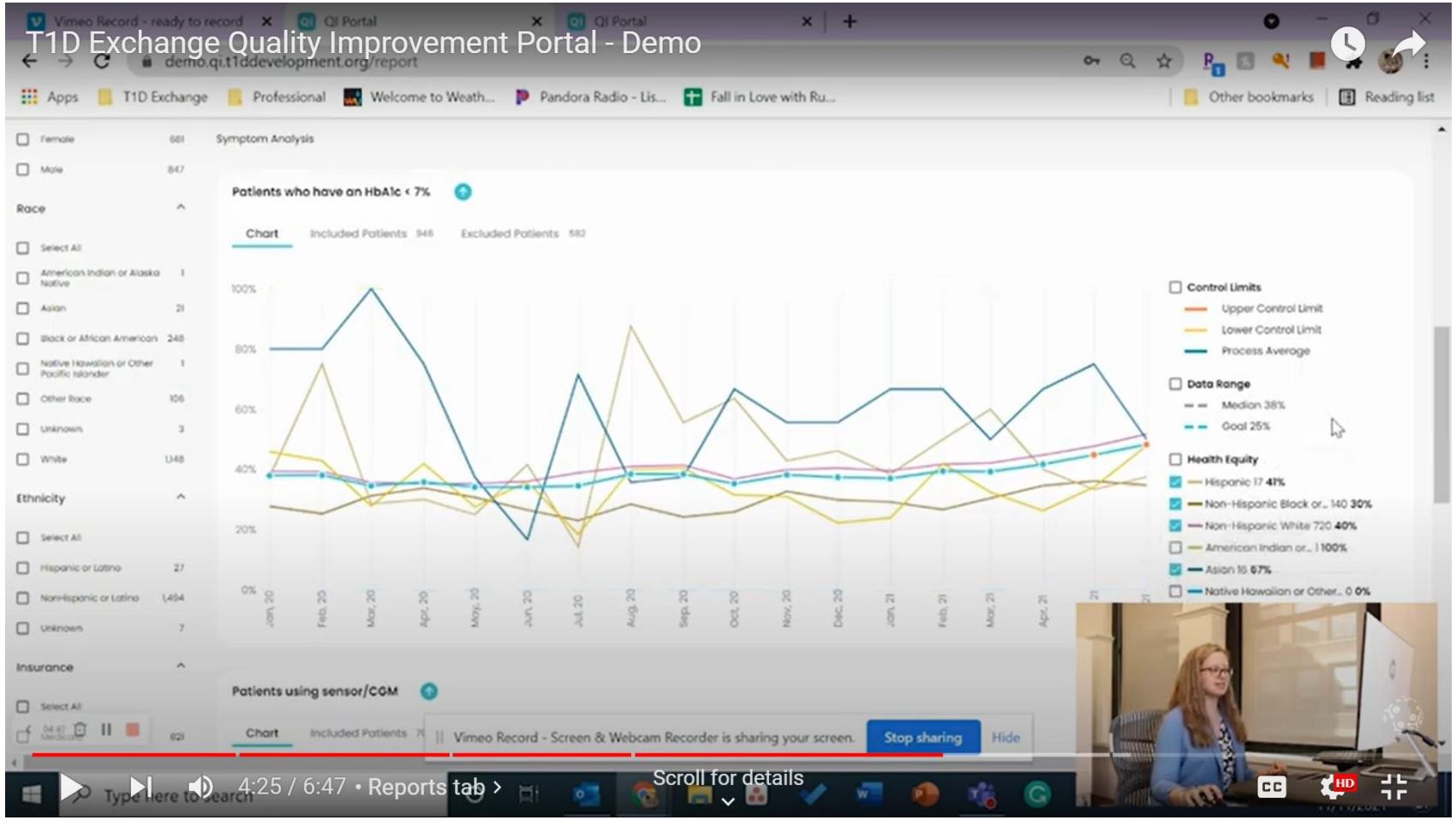
- QI Portal offers benchmarking, charting, and library resources



QI Portal Demo Video

- Five-minute overview of all four Portal tabs. Or, select tab “chapters” for a quick refresher on a specific feature

- https://www.youtube.com/watch?v=iZCe48_MtsE



Resources Available

- Monthly Collaborative Calls
- Coaching Calls with Ori, Ann, Trevon, or Don
- Center Dashboards
- QI Portal
  - Compare and Reports
  - Case Studies and Change Packages
  - EMR documentation examples and screener PDFs
- IHI Open School Courses
- PDSA cycle documentation in LifeQI

Recommendations for next 1/2 year (through June 2023)

- If not already, identify a QI project for the next 4-6 months
- If providing, wrap up 2022 data collection (provide data through December)
- Work with IT teams to update to the 3.0 version of the data specification and 2023-2025 Smartsheet measures
- Utilize the QI Portal for data trending, benchmarking, and creating notifications, and resources
- Take IHI Open School courses
- Document PDSAs in LifeQI
- Engage other faculty members in your improvement efforts by discussing/sharing these insights
- Consider submitting an abstract for your improvement work

ONLINE

QI 101: Introduction to Health Care Improvement

ADDED: 08/25/2020

880 user reviews

BMC | Increase % of patients with A1c >8.5% using HCLS by 30% over 12 months

Everyone can view

General | Driver diagram | Measures & charts | Pdsas | Discuss

Actions ↓

Change Idea: No Change Idea

New pdsa ramp +

Access to Insulin Pump Trainers
1 pdsa cycle

Referral
2 pdsa cycles

T1D Exchange