Clinical Leadership Committee

11/15/23

Publication Committee

11/15/23

# 2023 Publication Committee in Review: Outputs

- 6 article Clinical Diabetes special feature
- 40 clinics represented in 2022 published articles
- 1 oral and 5 poster presentations at ATTD
- 3 oral and 12 poster presentations at ADA *president's award recipient
- 1 oral and 2 poster presentations at ADCES
- 1 oral and 2 poster presentations at ADCES
- 45 abstract presentations at November Learning Session
- 24 articles published

Publication Proposal

- Mapped sites have access to all mapped data
- Non-mapped sites have access to aggregate smart sheet data
- Access the <u>publication policy</u>

- Please scan this QR code to access the publication proposal survey

Endocrinology and Metabolism Clinics 2024 Special Issue
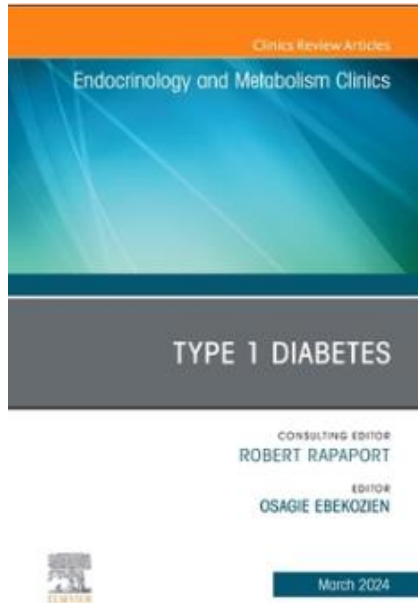
All articles available online Jan 2024

Book format available March 224

1. The Evolving Landscape of Type 1 Diabetes Management (Ebekozien et. al)
2. Emerging Technologies and Therapeutics for Type 1 Diabetes (Akturk et. al)
3. Optimizing Glycemic Outcomes for Minoritized and Medically Underserved Adults Living with Type 1 Diabetes (Steenkamp et. al)
4. Type 1 Diabetes and Cardiovascular Health (Pesantez et. al)
5. Optimizing Glycemic Outcomes for Children with Type 1 Diabetes (Wu et.al)
6. Acute and Chronic Adverse Outcomes of Type 1 Diabetes (Longendyke et. al)
7. Social Determinants of Health Screening in Type 1 Diabetes Management (Jones et. al)
8. Type 1 Diabetes Screening and Diagnosis (Gomes et. al)
9. Stakeholder Engagement in Type 1 Diabetes Research, QI and Clinical Care (Rioles et. al)
10. COVID-19 and Type 1 Diabetes (Breidbart et. al)
11. Improving Outcomes for People with Type 1 Diabetes (Ebekozien et. al)
12. Young Adults with Type 1 Diabetes (Mathias et. al)
13. Incorporating the Six Core Elements of Health Care Transition in Type 1 Diabetes Care for Emerging Adult (Malik et. al)
14. Psychosocial care for youth with type 1 diabetes: Summary of reviews to inform clinical practice" to Endocrinology and Metabolism Clinics (Shapiro et. al)

Clinics Review Articles
Endocrinology and Metabolism Clinics
TYPE 1 DIABETES
CONSULTING EDITOR
ROBERT RAPAPORT
EDITOR
OSAGIE EBEKOZIEN
March 2024

T1D Exchange

Data Governance Committee Report Out

November 2023 Learning Session

Purpose of the T1DX-QI/T2DX-QI Data Governance Committee

To expand research focus through academic and industry support for projects:
- To have a better understanding of and improvement in patient care
- Reduction in health disparities
- Improvements in understanding impact of treatments

To expand opportunities for QI team members:
- To serve as PI or Co-Investigators at their sites
- Provide patient opportunities to engage in QI research

DGC Current Members

Pediatric
- Daniel DeSalvo - TCH (Peds co-chair)
- Brittany Caswell - OHSU
- Christy Byer-Mendoza - Rady
- David Hansen - SUNY
- Grace Nelson - Le Bonheur
- Janine Sanchez- University of Miami
- Joyce Lee - Michigan
- Kathryn Obrynba - Nationwide
- Nicole Sheanon - Cincinnati Children's
- Priya Prahalad - Stanford Peds
- Ryan McDonough - Children's Mercy
- Todd Alonso - Barara Davis Center

Adult
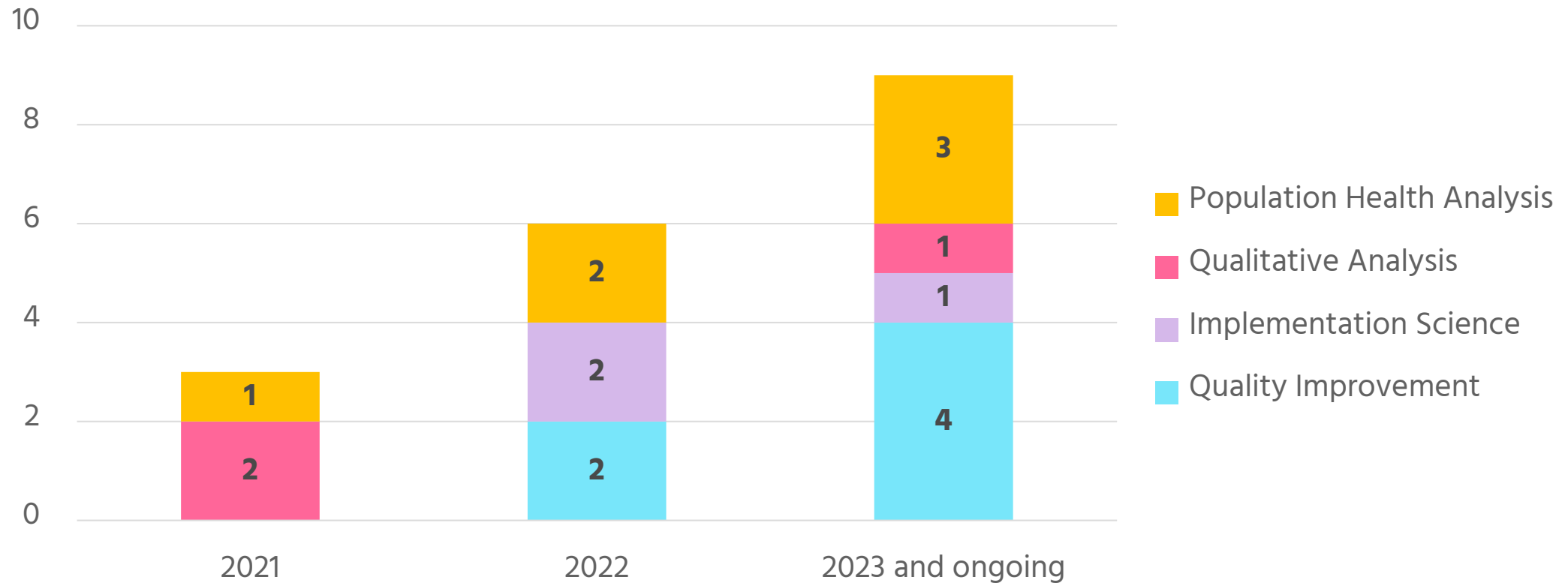- Carol Levy - Mt Sinai (Adult co-chair)
- Akankasha Goyal - NYU
- Ilona Lorincz –-Upenn
- Kathryn Fantasia - Boston Medical Center
- Marina Basina - Stanford
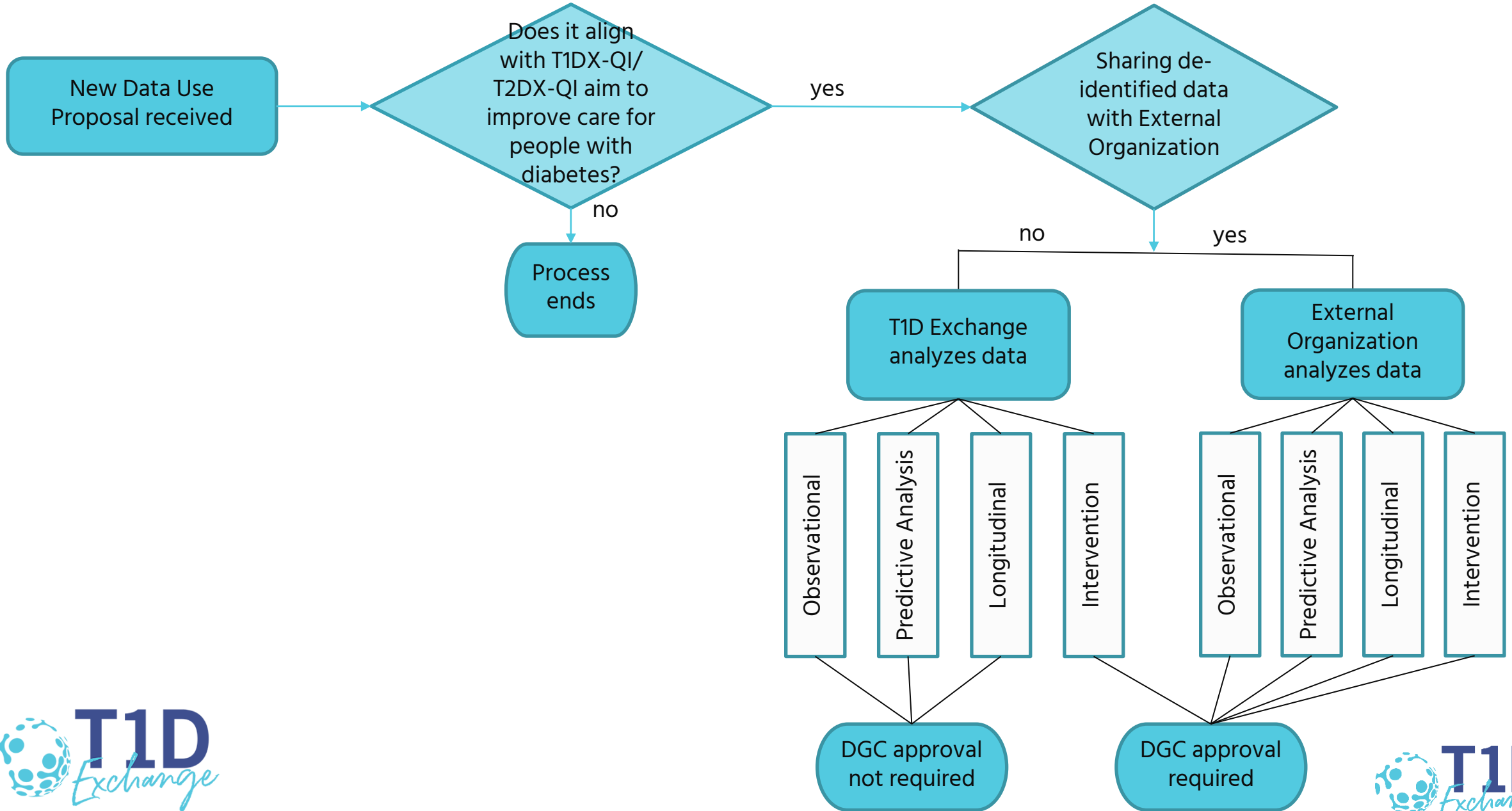- Ruth Weinstock - SUNY
- Sonya Haw - Grady

Project Summary

As of November 2023, T1DX-QI has collaborated with **9** sponsors on **18** industry projects

T1DX-QI Projects Completed by Year

T1DX-QI/T2DX-QI Data Governance Committee (DGC) Process

Ongoing Sponsored Quality Improvement Projects

Abbott T2D

Objectives:
1. Establish a **large dataset for adult T2D patients**;
2. **Evaluate this T2D dataset for benchmarking and metrics** for the purpose of supporting QI activities;
3. **Establish an independent data platform** to share and disseminate patient-level data for the T2D patient population

Medtronic Health Equity in Diabetes Technology (cohort 2)

Objectives:
1. **Implement and scale QI ideas** from pilot centers;
2. Add **6 new centers**; and
3. **Incorporate smart pen** scope into work for all new centers

ADA T2D Know Diabetes by Heart

Objectives:
1. Provide **data analysis and QI coaching support** for Know Diabetes by Heart T2D centers
2. **Use QI science to improve the quality of care for people living with T2D** by reducing cardiovascular death, heart disease, heart failure, and stroke

Eli Lilly Smart Pen Equity

Objectives:
1. Increase % of patients on a **connected pen by 5%** from baseline;
2. **Decrease % of patients on connected pen with HbA1c >9% by 5% from baseline**
3. **Reduce racial inequities** between NHW and NHB/Hispanic patients in the availability of connected pen data reporting

LD
Exchange

Ongoing Sponsored Population Health Projects

Vertex Severe Hypo Event (SHE) Analysis

Objective:
1. Analyze the **distribution of patient attributes by number of SHE events** experienced

Tandem Diabetes Technology Analysis

NEW!

Objective:
1. **Analyze diabetes technology use** (insulin pump, CGM, and AID prescriptions and usage) by device brand and model to assess market dynamics

Ongoing Sponsored Implementation Science and Qualitative Analysis Projects

JDRF Antibody Screening and Monitoring

Objectives:
1. Use **QI and implementation science to develop standardized protocols for screening and monitoring** antibody-positive screened individuals;
2. **Test processes for EMR documentation** to track antibody-positive screened individuals;
3. **Complete focus groups** with providers to quantify opinion of processes to screen and monitor antibody-positive screened individuals

Eli Lilly Tempo Smart Pen

NEW!

Objectives:
1. **Conduct qualitative research via interviews with healthcare providers and care teams** with familiarity and experience with various smart pen offerings

T1D Exchange

Reflections and ideas on special projects

Be on the lookout for surveys that assess what your experience has been

Do you have ideas for special projects?   Please send them to the DGC:
- Dan DeSalvo: desalvo@bcm.edu
- Carol Levy: carol.levy@mssm.edu
- T1D Exchange QI team: qi@t1dexchange.org

Data Science Committee Report at Learning Session 2023

Co-chairs: Joyce Lee, Marina Basina

End of 2023 Mapping Updates

- **32** sites fully mapped (from **23 sites** in Q1)

- 4 in validation phase

- Data completeness scorecards

  - Mid-year scorecards have been distributed

T1DX-QI EMR Database

58,000+ people with T1D
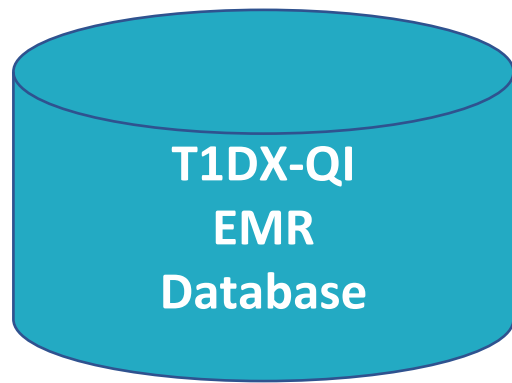
Data Mapping

Metrics on **QI Portal** (Mapped sites)

T1DX-QI Data specification

Data Spec files:
Patient
Observations
Diabetes
Encounter
Provider
Conditions
Medications

+

Population Health Research

Scorecards

- Variables with yellow for meets mapping expectation need improvement.

- Cgm_st_dt only 54% of sites are providing. Only 49% data availability for collaborative average.

- Pump_st_dt only 54% of sites are providing. Only 39% data availability for collaborative average.

- DKA variables have low data availability (7-15%)for collaborative average.

- SDOH only has 15% of sites providing.

T1Dx Phase 1 Measures	Codes from T1DX data spec	Collaborative Average	% of T1DX sites providing	Meets Mapping Expectations
Demographic data	birth_date	100%	100%	
	t1d_dx_dt	80%	85%	
	Race	98%	100%	
	Ethnicity	100%	100%	
	primary_insurance_type	99%	100%	
	39156-5 (BMI)	93%	92%	
A1c data	4548-4, 17856-6	90%	100%	
CGM Use data	cgm_binary=1	82%	46%	
	cgm_st_dt	49%	54%	(yellow)
	cgm_company	68%	81%	
	cgm_model	64%	69%	
BG check data	bgm_test_freq	37%	69%	(yellow)
Pump Use data	ins_regimen=1	49%	73%	
	pump_st_dt	39%	54%	(yellow)
	pump_company	35%	69%	(yellow)
	pump_model	34%	77%	(yellow)
HCLS	ins_pump_delivery==4	26%	31%	(yellow)
MDI Use data	ins_regimen !=1	45%	73%	
Depression screening data	55758-7, 44261-6	51%	73%	
T1Dx Phase 2 Measures				
Time in Range	time_in_range	55%	50%	
Time in Hypoglycemia	cgm_below_70	61%	35%	
Time in Severe Hypoglycemia	cgm_below_54	47%	23%	(yellow)
DKA events	dka_events_inp	15%	46%	(yellow)
	dka_events_amb	8%	42%	(yellow)
	dka_events_inp_pro	17%	39%	(yellow)
	dka_events_amb_pro	7%	35%	(yellow)
Bolus 3X among Pump users	bolus_ins_daily_inj	45%	50%	
SDOH	88124-3, 88122-7, 88123-5	43%	15%	(yellow)
Change in medication file format	drug_name	NA	65%	
	drug_name_generic	NA	54%	
	drug_sub_class	NA	46%	

Collaborative Scorecard: Averages based on 26 clinics who received scorecards for data from 7/01/2022-6/30/2023.

T2D Data Spec Overview

- Three working groups review the complete data spec and propose changes for the creation of a new data spec

  1. Patient/Provider/Encounter Files

  2. Observations/Conditions/Medications Files

  3. Diabetes files

Changes to Data Spec Request Process Map

Idea for change to current data spec

Email T1D with inquiry and complete the emailed request form

Is the request a minor change?
- Yes → Co-chairs prioritize this request
  - Yes → Updates to data spec are made
  - No → End of request
- No → Co-chairs review and prioritizes change
  - No → End of request
  - Yes → Request for slide deck to explain change and where change will be made and invite to present at DSC

Present at DSC to entire group for approval
- No → End of request
- Yes → Determine if this should be tested as a pilot
  - No → Perform a full rule out among all sites
  - Yes → Test pilot study in a few sites

Test pilot study in a few sites → Pilot was successful
- Yes → Perform a full rule out among all sites
- No → End of request

Perform a full rule out among all sites → Full rule out was successful
- Yes → Updates to data spec are made
- No → End of request

November 15, 2023

The Design of the Electronic Health Record in Type 1 Diabetes Centers: Implications for Metrics and Data Availability for a Quality Collaborative

Donna S. Eng, MD[1]; Emma Ospelt, MPH[2]; Brian Miyazaki, MD[3]; Ryan McDonough, DO, FAAP[4]; Justin A. Indyk, MD, PhD[5]; Risa Wolf, MD[6]; Sarah K. Lyons, MD[7]; Anna Neyman, MD[8]; Naomi R. Fogel, MD[9]; Marina Basina, MD[10]; Mary Pat Gallagher, MD[11]; Osagie Ebekozien, MD, MPH, CPHQ[12]; G. Todd Alonso, MD[13]; Nana-Hawa Yayah Jones, MD[14]; Joyce M. Lee, MD, MPH[15]

[1]Michigan State University Helen DeVos Children's Hospital; [2]T1D Exchange, Quality Improvement and Population Health; [3]Children's Hospital of Los Angeles; [4]Children Mercy Hospitals and Clinics; [5]Nationwide Children's Hospital; [6]Johns Hopkins University; [7]Baylor College of Medicine; [8]University Hospitals Rainbow Babies & Children's Hospital; [9]Ann and Robert H. Lurie Children's Hospital of Chicago; [10]Stanford University School of Medicine; [11]NYU; [12]T1D Exchange; University of Mississippi; [13]University of Colorado Denver - Anschutz Medical Campus, Barbara Davis Center; [14]Cincinnati Children's Hospital Medical Center[15]Michigan Medicine, Pediatric Endocrinology and Susan B. Meister Child Health Evaluation and Research Center

Results

CGM
• Is the patient using and wearing a continuous glucose monitor (Yes, No) • Days worn in the past 14 days (Numeric)
• Uses CGM (Yes, No) • CGM Type (Brands) • Wears CGM>70% of the time (Yes, No) • % Wear time
• CGM Model (Brands) • Days with CGM data (out of 14) (Numeric) • % Time CGM is active
• Does Patient Have a CGM? (Does Not Have CGM, CGM Brands) • CGM Use in the last 14 days (CGM Use-10-14 days; CGM Use-1-9 days; No CGM Use-0 days)

• Are you currently using a CGM? (Yes, No)* • Which CGM are you using? (Brands)* • % of time CGM used per 2 weeks (Numeric)
• CGM Brand (Brands)
• Continuous Glucose Monitor Device (Brands) • Number of days (Numeric) • % of time CGM active (Numeric)
• CGM Brand (Brands) • Start Date of CGM (Date) • Days with CGM data (typically out of 14) (Numeric) • How does your child usually do blood sugar checks? (Finger stick and glucose meter, CGM, Both meter and CGM, Don't check blood sugars)*
• Do you use CGM (Never used, Intermittent/used in past, Regular/currently in use) • Name of CGM Manufacturer (Brands) • % time CGM worn/active (Numeric)

Corewell Health™ Helen DeVos Children's Hospital

C.S. MOTT CHILDREN'S HOSPITAL UNIVERSITY OF MICHIGAN HEALTH

U-M Pediatric Diabetes T1D Exchange

Publications

The Design of the Electronic Health Record in Type 1 Diabetes Centers: Implications for Metrics and Data Availability for a Quality Collaborative" was accepted by *Journal of Diabetes Science and Technology*.

Authors: Eng, D, Ospelt, E, Miyazaki, B, McDonough, R, Indyk, J, Wolf, R, Lyons, S, Neyman, A, Fogel, N, Basina, M, Gallagher, M.P, Ebekozien, O, Alonso, G.T, Yayah Jones, N-H, Lee Joyce.

Diabetes Distress Screening

T1D EXCHANGE WORKING GROUP UPDATE, NOVEMBER 15, 2023

Participating Clinical Centers

Adult	Pediatric
1. Boston Medical Center	1. Indiana University
2. Oregon Health & Science University	2. Le Bonheur, University of Tennessee
3. University of Michigan	3. Nationwide Children's Hospital
	4. NYU Langone
	5. Seattle Children's Hospital
	6. Texas Children's Hospital
	7. University of Alabama
	8. University of Michigan, Mott Children's
	9. University Wisconsin
T1DX team: Nicole Rioles, Emma Ospelt, Ann Mungmode, Don Buckingham, and Margaret Gillis Registry: Emiliee Cornelius, Katie Chapman	

Diabetes Distress

Diabetes distress (DD) is described as the negative emotional impact of living with diabetes

ADA guidelines: "Assess youth with diabetes for psychosocial and diabetes-related distress, generally starting at 7–8 years of age"

In studies looking at adolescents and young adults with T1D, the prevalence of DD is 17-36%

DD is associated with lower self-esteem, satisfaction with life and self-efficacy

In multiple studies, DD has been associated with higher hemoglobin A1c

Diabetes Distress and Depression Screening are different, albeit complementary

Group Aims

1. Determine best practices for screening for diabetes distress (recommended tool, population, process, response)

2. Track diabetes distress screening vis Smartsheets, then new specs

3. Share screening processes and responses

4. Perform PDSA cycles to improve screening rates with participating clinics

PAID-T- recommended at each visit for ages 12-18 yo

- **Not feeling motivated to keep up with my daily diabetes tasks.**

- **Feeling that my friends or family act like "diabetes police" (e.g. nag about eating properly, checking blood sugars, not trying hard enough).**

- **Feeling that my friends or family don't understand how difficult living with diabetes can be.**

- **Worrying that diabetes gets in the way of having fun and being with my friends.**

14 items, total score calculated
Validated ages 12-18 yo
Shapiro et. Al -> score >=44 indicated high DD
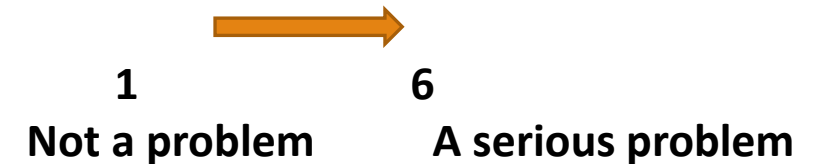
1   6
Not a problem   **A serious problem**

Psychometric Properties of the Problem Areas in Diabetes: Teen and Parent of Teen Versions

Jenna B. Shapiro,[1] MA, Anthony T. Vesco,[2] PhD, Lindsey E. G. Weil,[3] MA, Meredyth A. Evans,[2,3] PhD, Korey K. Hood,[4] PhD, and Jill Weissberg-Benchell,[2,3] PhD, CDE

Ages 8-12

PAID-C (child) (26 items)

P-PAID-C (parent) (26 items)

Psychometric Properties of the Parent and Child Problem Areas in Diabetes Measures

Meredyth A Evans, PhD,[1] Lindsey E G Weil, MA, MS,[2] Jenna B Shapiro, MA,[3] Lindsay M Anderson, PhD,[1] Anthony T Vesco, PhD,[1] Karen Rychlik, MS,[4] Marisa E Hilliard, PhD,[5] Jeanne Antisdel, PhD,[1] and Jill Weissberg-Benchell, PhD, CDE[1]

▸ Author information ▸ Article notes ▸ Copyright and License information   PMC Disclaimer

Diabetes Distress Scale - recommended at each visit for ages 18+

T2D predominance in adult practice

Original Diabetes Distress Scale (17-item DDS) and newer Diabetes Distress Assessment System (DDAS)

Recommendation: T1DDAS and T2DDAS. Both scales have the same **core scale** of 8 items. Each also has a set of **source scales**: 7 for the T2DDAS and 10 for the T1DDAS

8 item core scale: **Intensity** of DD in both types of diabetes using a single measure.

If score > 2.0, what to do next clinically? Where is the DD coming from? Use the source scale data to start a clinical conversation

~75% of patients with T2D score >2.0 on the core scale, may be best to simply complete the whole scale

	Not A Problem (1)	A Little Problem (2)	A Moderate Problem (3)	A Serious Problem (4)	A Very Serious Problem (5)
1. I feel burned out by all of the attention and effort that diabetes demands of me.					
2. It bothers me that diabetes seems to control my life.					
3. I am frustrated that even when I do what I am supposed to for my diabetes, it doesn't seem to make a difference.					
4. No matter how hard I try with my diabetes, it feels like it will never be good enough.					
5. I am so tired of having to worry about diabetes all the time.					
6. When it comes to my diabetes, I often feel like a failure.					
7. It depresses me when I realize that my diabetes will likely never go away.					
8. Living with diabetes is overwhelming for me.					

Core scale

DD

Type 1 Diabetes Assessment System (T1-DDAS)

If you are interested in measuring your own diabetes distress and you are an adult with type 1 diabetes, click here.

Click here for the T1-DDAS in English   Click here for the T1-DDAS in Spanish

Type 1 Diabetes Distress Scale (T1-DDS)

If you are interested in measuring your own diabetes distress with the older, original type 1 diabetes distress scale, and you are an adult with type 1 diabetes, click here.

Click here for the T1-DDS in English   Click here for the T1-DDS in Spanish

Type 2 Diabetes Distress Assessment System (T2-DDAS)

If you are interested in measuring your own diabetes distress and you are an adult with type 2 diabetes, click here.

Click here for the T2-DDAS in English   Click here for the T2-DDAS in Spanish

https://diabetesdistress.org/take-dd-survey/

Your T1-DDS Summary Report (page 1)

Little or none 0 to 1.9	Moderate DD 2.0 to 2.9	High DD 3.0 and up

TOTAL

3.93

FEELINGS OF POWERLESSNESS

4.40

MANAGEMENT DISTRESS

4.50

HYPOGLYCEMIC DISTRESS

2.25

SOCIAL PERCEPTION DISTRESS

3.25

EATING DISTRESS

4.67

PHYSICIAN DISTRESS

3.50

FAMILY DISTRESS

5.00
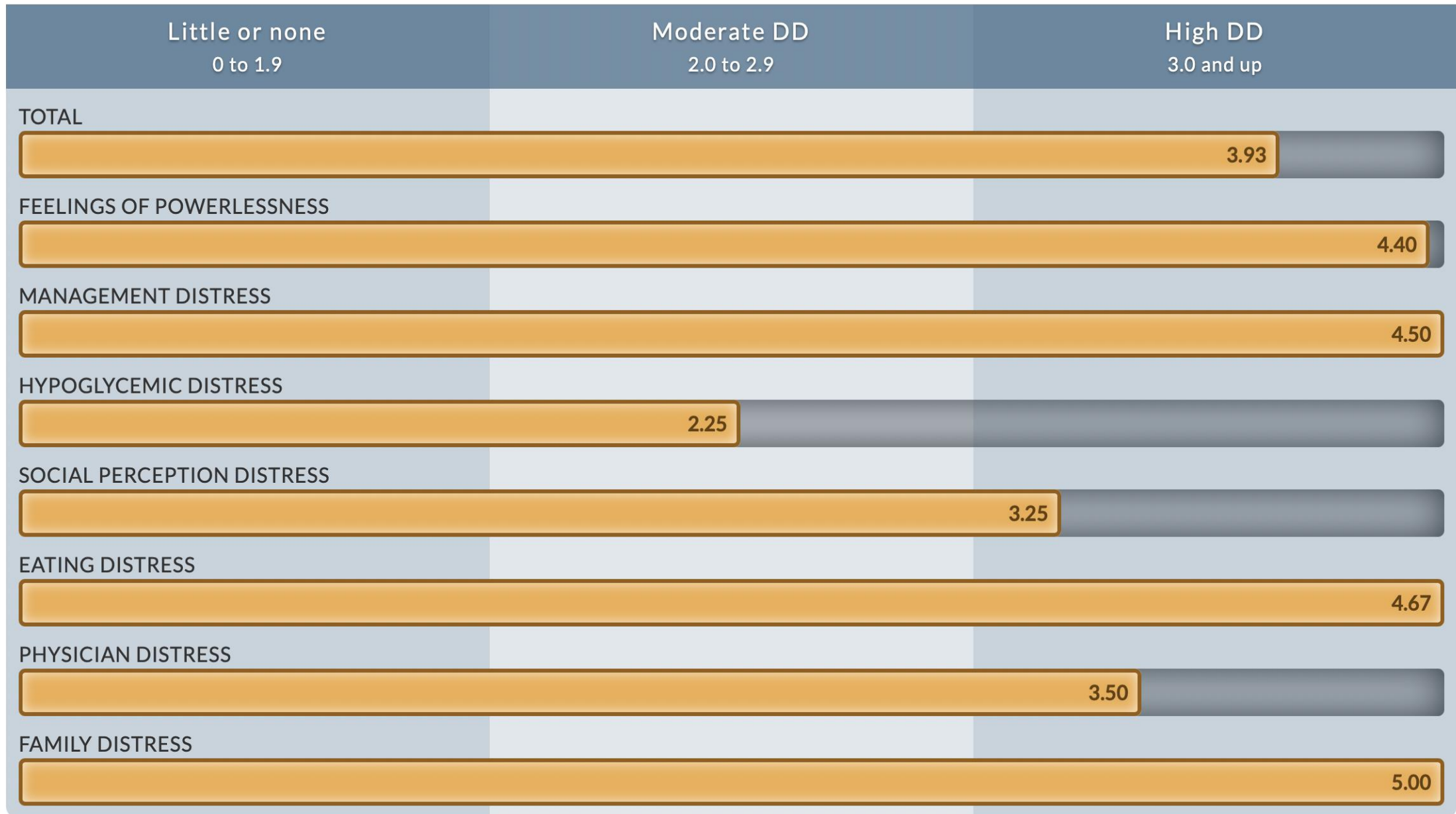
A score of 2.0 or higher on any scale suggests significant diabetes distress.

Next Steps

T1DX: There are Diabetes Distress measures in the Smartsheet measures

Plan to ask clinics to report any Diabetes Distress tracking in Smartsheet in the coming months

Data Science Committee is setting a goal to add Diabetes Distress elements into the Data Spec over the next 6 months so that mapped clinics that have been documenting diabetes distress will be able to report data

We ask clinics that have been able to integrate DDS into EMR to share screenshots to help other clinics incorporate into their own EMR systems.

Hybrid Closed Loop Working Group

November Progress Report

Hybrid Closed Loop Work-Group

1. **Leaders:** Emily Coppedge NP, CDCES (Weil Cornell Medical Center-Pediatrics) and Carol Levy MD, CDCES (Mt. Sinai Hospital- Adult)

2. **Plan interventions:** Currently, the group is developing interventions to test.

3. **Data visualization:** Run-chart

4. **November Progress Report:**
   A. Meetings have been occurring every month sharing best practices, workflows and protocols in place at each site . The group has created an AIM Statement.

AIM Statement

AIM Statement

- Increase the utilization of Automated Insulin Delivery System use among people with T1D by 10% from baseline in 6 months.

T1D Exchange Quality Improvement Collaborative
Health Care Transition Workgroup Update

FAISAL MALIK, MD, MSHS

Assistant Professor | Department Pediatrics | University of Washington School of Medicine
Investigator | Seattle Children's Research Institute
Co-Director | Health Services and Quality of Care Research Fellowship
Director of Research & Medical Co-Director| Achieving Health in Emerging Adults with Diabetes (AHEAD) Program

SARAH CORATHERS, MD

Associate Professor | UC Department of Pediatrics | UC Department of Internal Medicine
Clinical Director | Division of Endocrinology
Director | Quality Scholars Program

SHIVANI AGARWAL, MD, MPH

Associate Professor | Department of Medicine| Albert Einstein College of Medicine
Associate Director | Fleischer Institute for Diabetes and Metabolism
Director | Supporting Emerging Adults with Diabetes (SEAD) Program
Director | Type 1 Diabetes Programs

Objectives

- Define ~~transitions of care~~ health care transition

- Discuss application of Six Core Elements of health care transition in type 1 diabetes care for emerging adults

- Review current and planned T1DX-QI health care transition metrics

Health Care Transition

Health care transition is the **planned, purposeful** movement from a child to an adult model of health care with or without a transfer to a new clinician

With a structured health care transition process, statistically significant positive outcomes are seen:

- **Population health:** improved adherence to care, improved self-care skills

- **Experience of care:** increased satisfaction, reduced barriers to care

- **Health care utilization:** decreased time between last pediatric and 1st adult visit, increased adult visits, decreased hospital admissions and length of stay

Six Core Elements of Health Care Transition

Incorporating the Six Core Elements of Health Care Transition in Type 1 Diabetes Care for Emerging Adults

Faisal S. Malik, MD, MSHS[a,b,*], Kathryn W. Weaver, MD[c],
Sarah D. Corathers, MD[d], Patience H. White, MD, MA[e]

KEYWORDS

- Type 1 diabetes • Adolescents • Young adults • Health care transition

KEY POINTS

- Implementation of a structured transition process can support improved patient health and societal outcomes for emerging adults with type 1 diabetes.
- Pediatric diabetes providers play a critical role in supporting health care transition planning and successful transfer to adult diabetes care.
- Effective transition to adult care requires active involvement from adult diabetes providers to plan for incorporation of emerging adults into their practice.

Six Core Elements for Pediatric and Adult Diabetes Care

Pediatric Diabetes Care

Core Element 1:
Transition and Care Policy/Guide
- Development of the practice's health care transition (HCT) policy to share with youth and family

Core Element 2:
Tracking and Monitoring
- Development of the practice's process to track youth receipt of HCT services

Core Element 3:
Transition Readiness
- HCT readiness assessment (for youth and parent/caregiver)
- Tailored education to support independence with diabetes self-management and health care navigation

Core Element 4:
Transition Planning
- Preparation/update of medical summary and emergency care plan
- Preparation of plan of care with HCT goals for youth
- Discussion and practice of an adult model of diabetes care at age 18
- Assistance with identifying an adult clinician

Core Element 5:
Transfer of Care
- Preparation of transfer package
- Outreach to adult clinician to confirm appointment adherence to support successful transfer to adult diabetes care

Core Element 6:
Transfer Completion
- Consultation support to adult clinicians, if needed
- Feedback from young adult and parent/caregiver about transfer experience

Transfer of Care
(ages 18-22)

Transfer package exchange
Communication between pediatric and adult clinicians

Adult Diabetes Care

Core Element 1:
Transition and Care Policy/Guide
- Development of a HCT policy for accepting young adult patients into the practice and sharing of the policy with young adult and family

Core Element 2:
Tracking and Monitoring
- Development of the practice's process to track young adult receipt of HCT services

Core Element 3:
Orientation to Adult Practice
- Identification of adult clinicians to care for young adults
- Preparation of FAQs and orientation information

Core Element 4:
Integration into Adult Practice
- Pre-visit outreach and appointment reminders

Core Element 5:
Initial Adult Practice Visit
- Review of new patient records
- Initial face-to-face visit with young adult with orientation to adult care
- Update of plan of care and emergency care
- Diabetes self-management skill assessment and education

Core Element 6:
Ongoing Care
- Ongoing diabetes education and support
- Assistance in establishing referrals for medical specialists, behavioral health, and reproductive care depending on need
- Feedback from young adults about adult diabetes care experience

Fig. 1. Six Core Elements of health care transition for pediatric and adult diabetes practices. (*The Six Core Elements of Health Care Transition*™ are the copyright of Got Transition®. *This version of the Six Core Elements has been modified and is used with permission.*)

Six Core Elements for Pediatric Diabetes Care

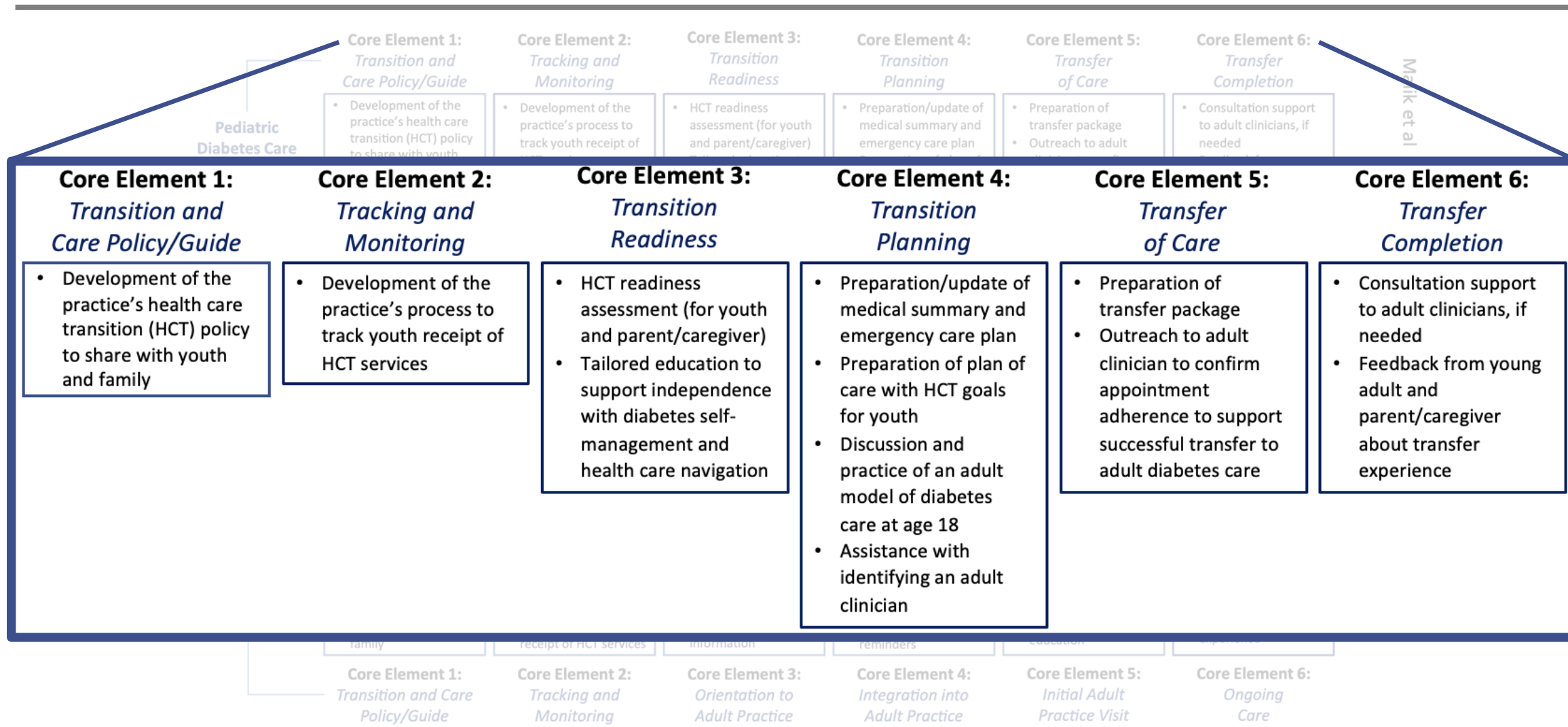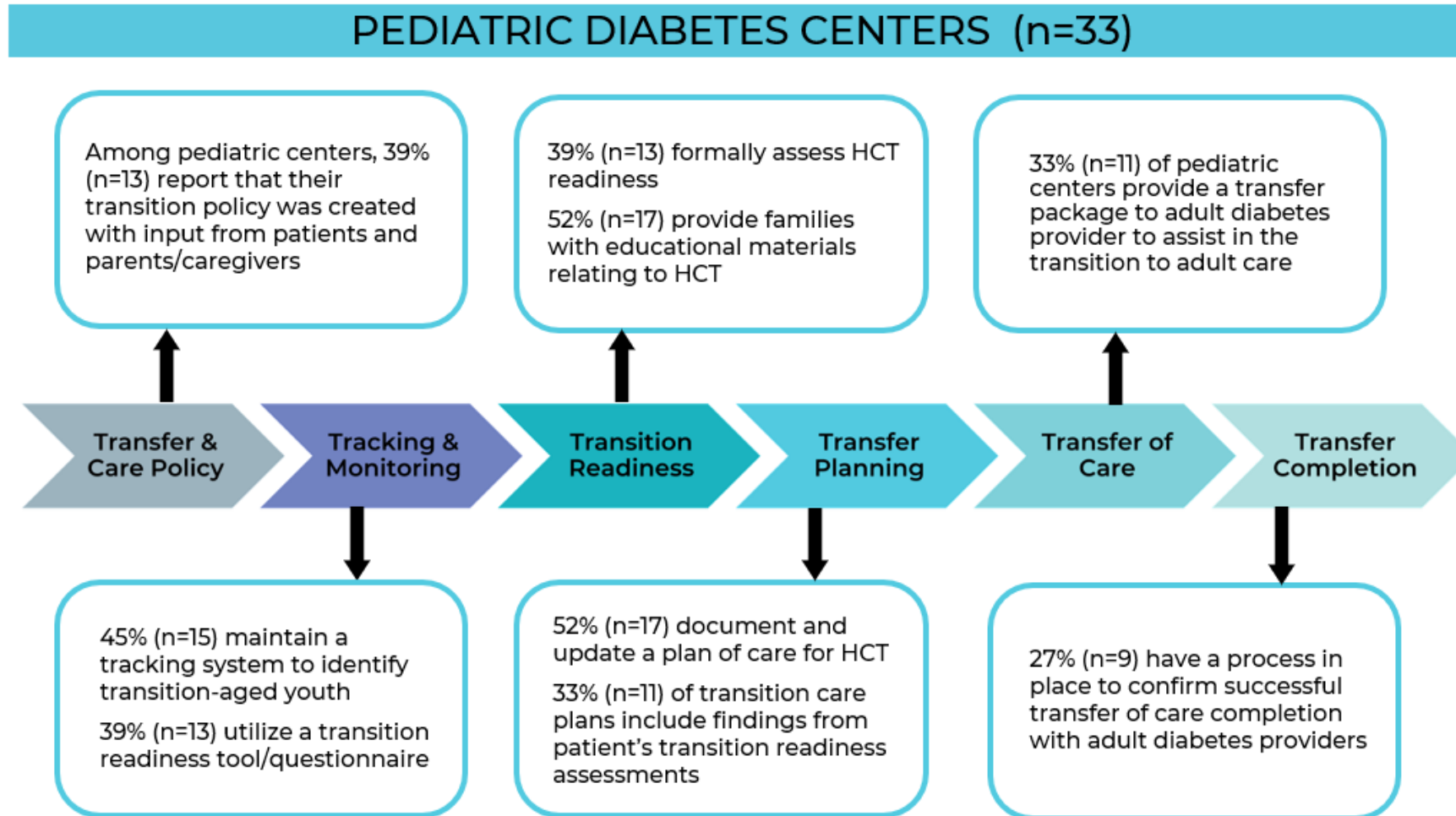| **Core Element 1:** Transition and Care Policy/Guide	**Core Element 2:** Tracking and Monitoring	**Core Element 3:** Transition Readiness	**Core Element 4:** Transition Planning	**Core Element 5:** Transfer of Care	**Core Element 6:** Transfer Completion
• Development of the practice's health care transition (HCT) policy to share with youth and family	• Development of the practice's process to track youth receipt of HCT services	• HCT readiness assessment (for youth and parent/caregiver) • Tailored education to support independence with diabetes self-management and health care navigation	• Preparation/update of medical summary and emergency care plan • Preparation of plan of care with HCT goals for youth • Discussion and practice of an adult model of diabetes care at age 18 • Assistance with identifying an adult clinician	• Preparation of transfer package • Outreach to adult clinician to confirm appointment adherence to support successful transfer to adult diabetes care	• Consultation support to adult clinicians, if needed • Feedback from young adult and parent/caregiver about transfer experience

Fig. 1. Six Core Elements of health care transition for pediatric and adult diabetes practices. (*The Six Core Elements of Health Care Transition*™ are the copyright of Got Transition®. This version of the Six Core Elements has been modified and is used with permission.)

Health Care Transition Practices in T1DX-QI Pediatric Centers

PEDIATRIC DIABETES CENTERS (n=33)

Among pediatric centers, 39% (n=13) report that their transition policy was created with input from patients and parents/caregivers

39% (n=13) formally assess HCT readiness

52% (n=17) provide families with educational materials relating to HCT

33% (n=11) of pediatric centers provide a transfer package to adult diabetes provider to assist in the transition to adult care

Transfer & Care Policy — **Tracking & Monitoring** — **Transition Readiness** — **Transfer Planning** — **Transfer of Care** — **Transfer Completion**

45% (n=15) maintain a tracking system to identify transition-aged youth

39% (n=13) utilize a transition readiness tool/questionnaire

52% (n=17) document and update a plan of care for HCT

33% (n=11) of transition care plans include findings from patient's transition readiness assessments

27% (n=9) have a process in place to confirm successful transfer of care completion with adult diabetes providers

PEDIATRIC CENTERS | T1DX-QI Health Care Transition Metric

Transition & Care Policy	Tracking & Monitoring	Transition Readiness	Transfer Planning	Transfer of Care	Transfer Completion

Number of eligible patients seen in the reporting month that have a documented transition plan from pediatric to adult diabetes care
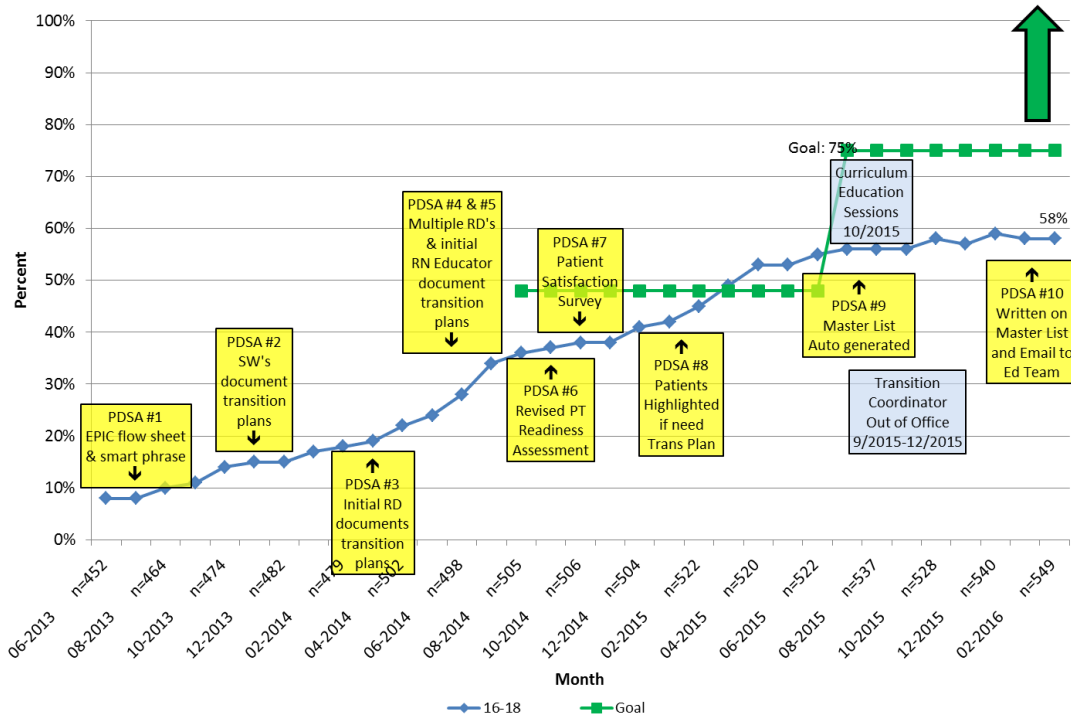
(Eligible: site-specific age criteria expected to transition to adult care within 12-18 months)

52% of pediatric centers document and update a plan of care for health care transition

33% of transition care plans include findings from patient's transition readiness assessments

Increasing Rates of Documented Transition Plans

Percent of Diabetes Patients age 16 - 18 who have Transition Plan

PDSA #1 EPIC flow sheet & smart phrase

PDSA #2 SW's document transition plans

PDSA #3 Initial RD documents transition plans

PDSA #4 & #5 Multiple RD's & initial RN Educator document transition plans

PDSA #6 Revised PT Readiness Assessment

PDSA #7 Patient Satisfaction Survey

PDSA #8 Patients Highlighted if need Trans Plan

PDSA #9 Master List Auto generated

PDSA #10 Written on Master List and Email to Ed Team

Transition Coordinator Out of Office 9/2015-12/2015

Curriculum Education Sessions 10/2015

Goal: 75%

58%

Last Updated 3/9/2016 by S. Ellsworth, James M. Anderson Center for Health Systems Excellence

Percent of Diabetes Patients age 19 and Over who have Transition Plan

Goal: 90%

86%
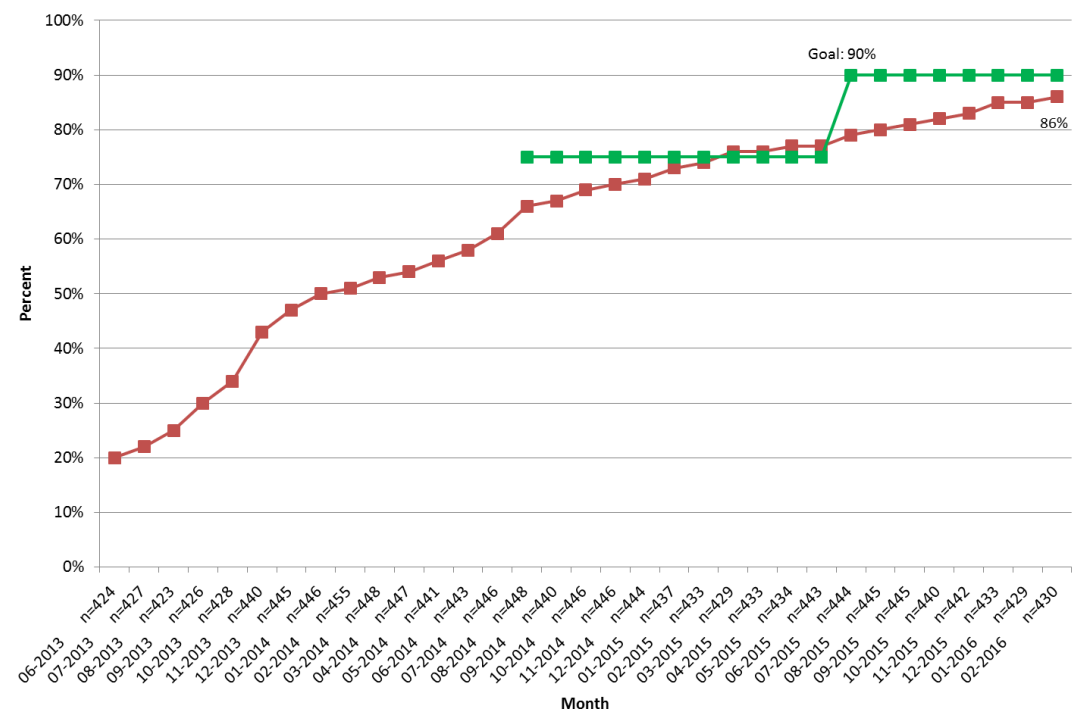
Last Updated 3/9/2016 by S. Ellsworth, James M. Anderson Center for Health Systems Excellence

Six Core Elements for Adult Diabetes Care

Core Element 1:
Transition and Care Policy/Guide
- Development of a HCT policy for accepting young adult patients into the practice and sharing of the policy with young adult and family

Core Element 2:
Tracking and Monitoring
- Development of the practice's process to track young adult receipt of HCT services

Core Element 3:
Orientation to Adult Practice
- Identification of adult clinicians to care for young adults
- Preparation of FAQs and orientation information

Core Element 4:
Integration into Adult Practice
- Pre-visit outreach and appointment reminders

Core Element 5:
Initial Adult Practice Visit
- Review of new patient records
- Initial face-to-face visit with young adult with orientation to adult care
- Update of plan of care and emergency care
- Diabetes self-management skill assessment and education

Core Element 6:
Ongoing Care
- Ongoing diabetes education and support
- Assistance in establishing referrals for medical specialists, behavioral health, and reproductive care depending on need
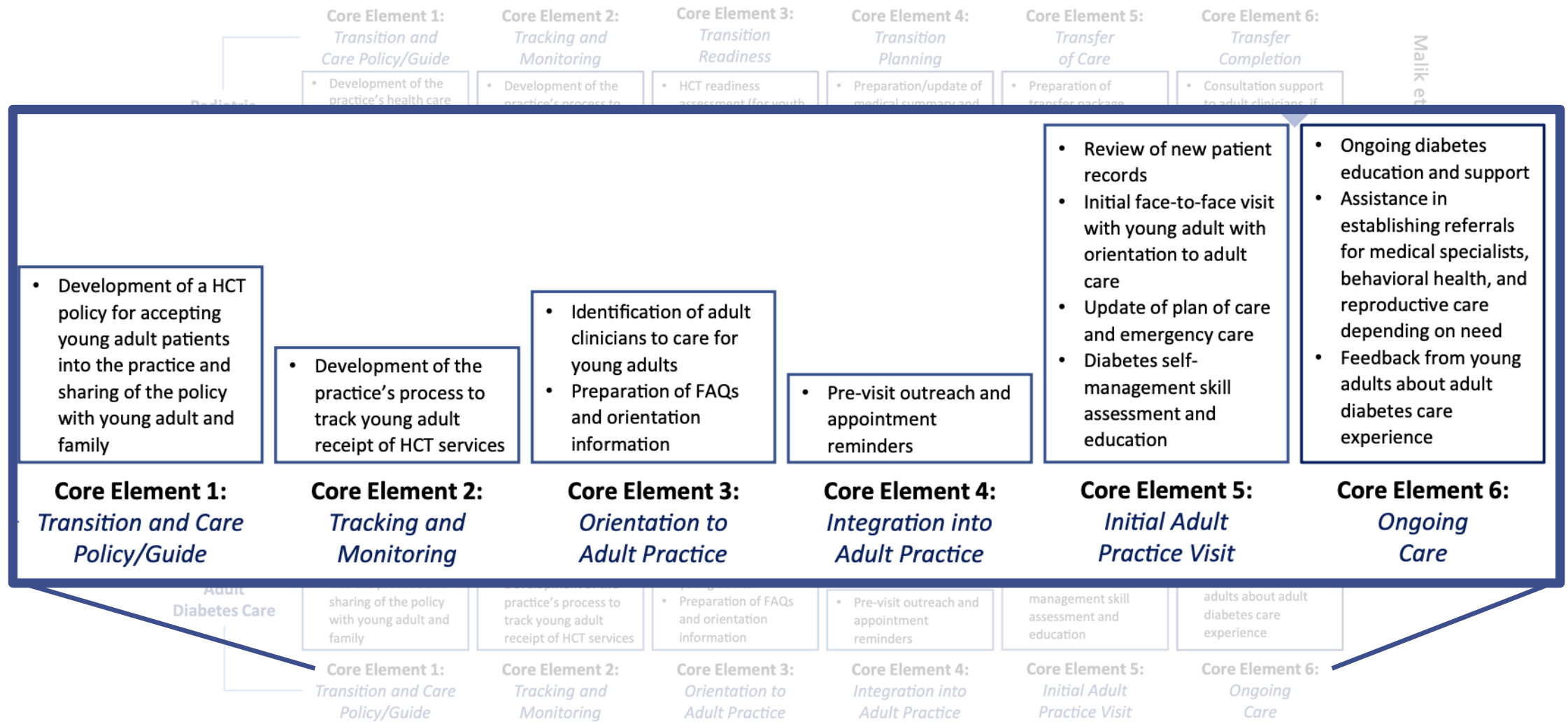- Feedback from young adults about adult diabetes care experience

Fig. 1. Six Core Elements of health care transition for pediatric and adult diabetes practices. (*The Six Core Elements of Health Care Transition*™ are the copyright of Got Transition®. This version of the Six Core Elements has been modified and is used with permission.)

# ADULT CENTERS | T1DX-QI Health Care Transition SMART Aim

Transition & Care Policy → Tracking & Monitoring → Orientation to Adult Practice → Integration into Adult Practice → Initial Adult Practice Visit → Ongoing Care

Increase the percentage of adult T1DX-QI centers with a health care transition policy by 30% by November 2024

29% of adult centers have a health care transition policy for accepting young adult patients into their practice

Join the Workgroup!
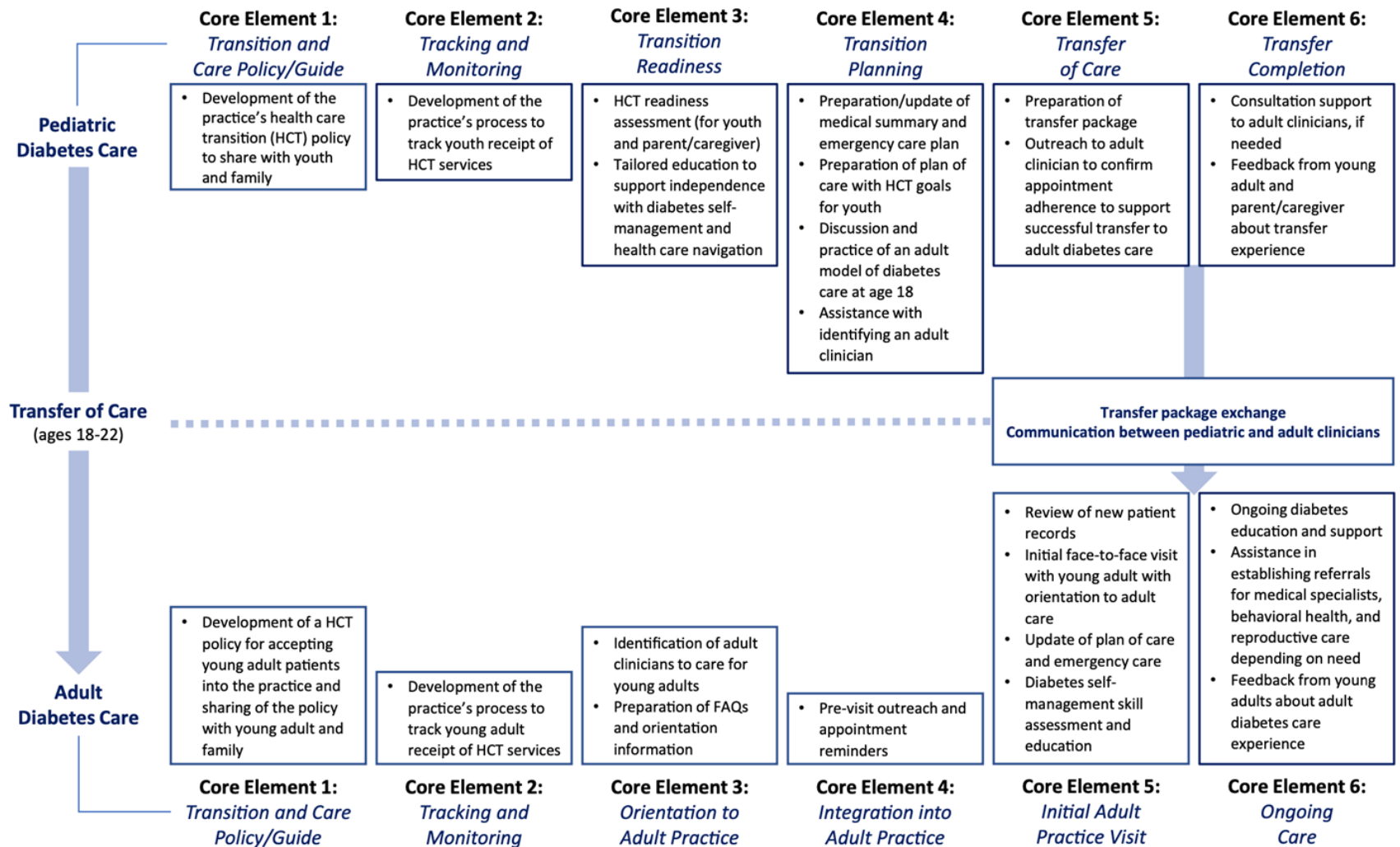
Fig. 1. Six Core Elements of health care transition for pediatric and adult diabetes practices. (*The Six Core Elements of Health Care Transition*™ *are the copyright of Got Transition®. This version of the Six Core Elements has been modified and is used with permission.*)

CGM Work Group Update

Marina Basina

Lily Chao

Objective

- Identify CGM related project that could be completed within 1 year with a measurable outcome

Brainstorming

Initial Ideas

- Developing tools to help clinicians discuss CGM with families

- Advanced CGM use: trend arrows and self-adjustment tools

- Develop handouts on skin care

- Assessing patient's ability to self-start

Avoid Redundancies

- Many centers already have high CGM usage rate

- Many handouts already available

- Existing T1D Exchange project related to increasing CGM use among non-Hispanic black and Hispanic population

Current Objective

- Develop center-specific strategies to map AGP metrics to T1D Exchange database, to measure CGM outcomes
  - Develop smart phrases with check boxes for the following (check all that apply):
    - ☐ TAR (>250) <10%
    - ☐ TIR>50%
    - ☐ TIR>70%
    - ☐ TBR (<70) <4%
    - ☐ TBR (<54) <1%
    - ☐ Data reviewed (to distinguish between data reviewed but none applies vs data not documented)
  - Centers with discrete fields that could be mapped: data could be numerical (instead of checkboxes)
  - Data could be collated from both sources
  - Pilot with 5 to 10 participating centers

Outcomes

- % patients with CGM outcomes – goal to increase CGM reporting by 20% for participating centers

- Stratify AGP by insurance, age, device use