T1D Exchange

T1DX-QI Collaborative Call with Pediatric Centers

January 25, 2024

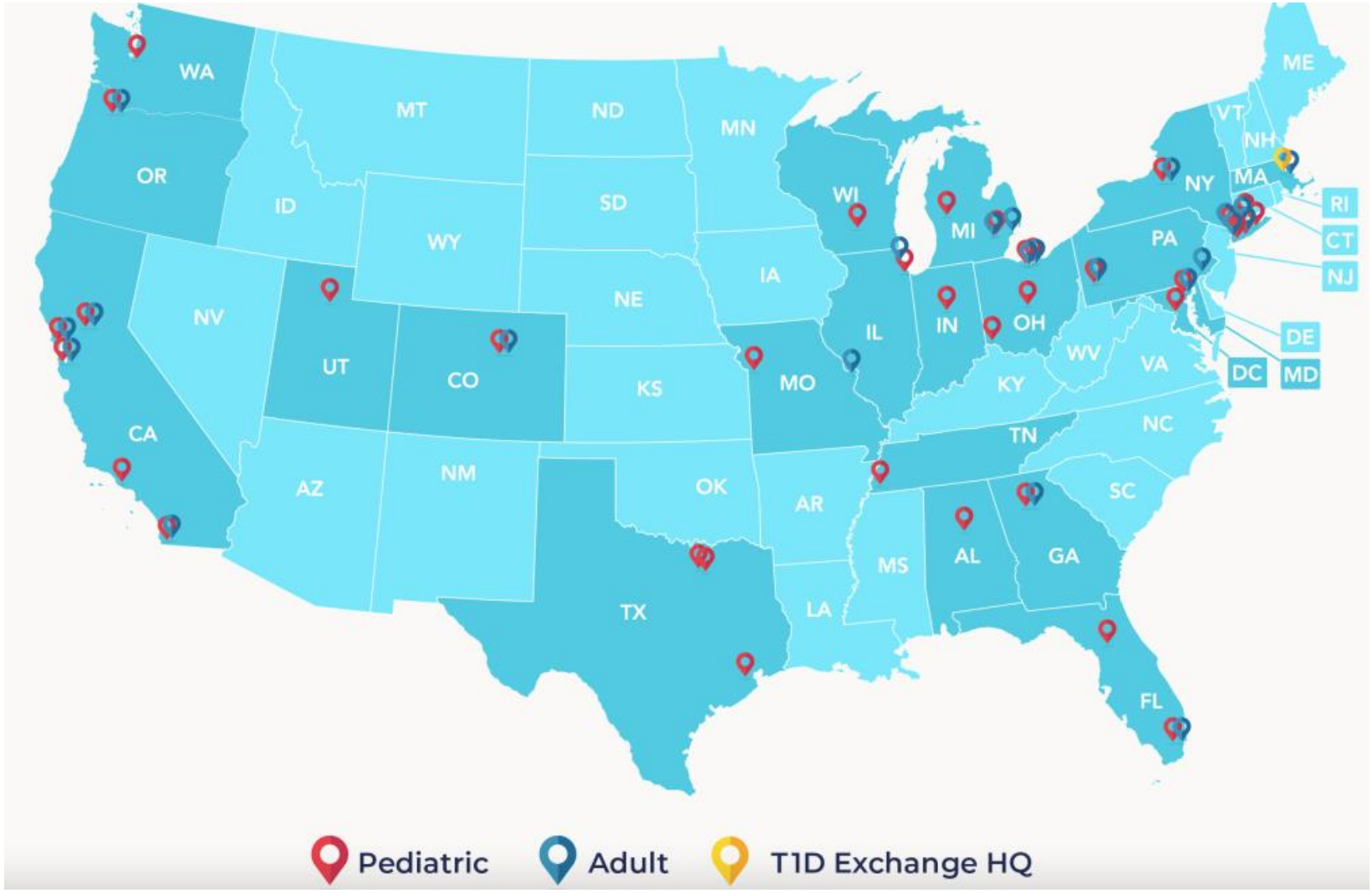
Agenda

- Welcome & introductions, Osagie Ebekozien, MD, MPH, CPHQ
- Clinical center presentations
  - Children's Healthcare of Atlanta, Kristina Cossen, MD
  - University of Miami, Veronica Figueredo, MD
  - University of Pittsburgh Medical Center, Alissa Guarneri, MD

- Collaborative Updates, Holly Hardison, BS
  - Invoicing reminders and deadline for 2023 work
  - Committee Chair opportunities and transition timelines
  - Evaluation feedback from the November 2023 Learning Session

T1D Exchange

T1DX-QI network of 60 centers, caring for 100,000+ PWD across 22 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. November 2021

QI and Population Health Team Priorities

2019

Building Infrastructure

2020

Capturing Opportunities/Tailwinds

2021

Takeoff

2022

Growth and Expansion

2023

Cruising - Satisfaction and Experience

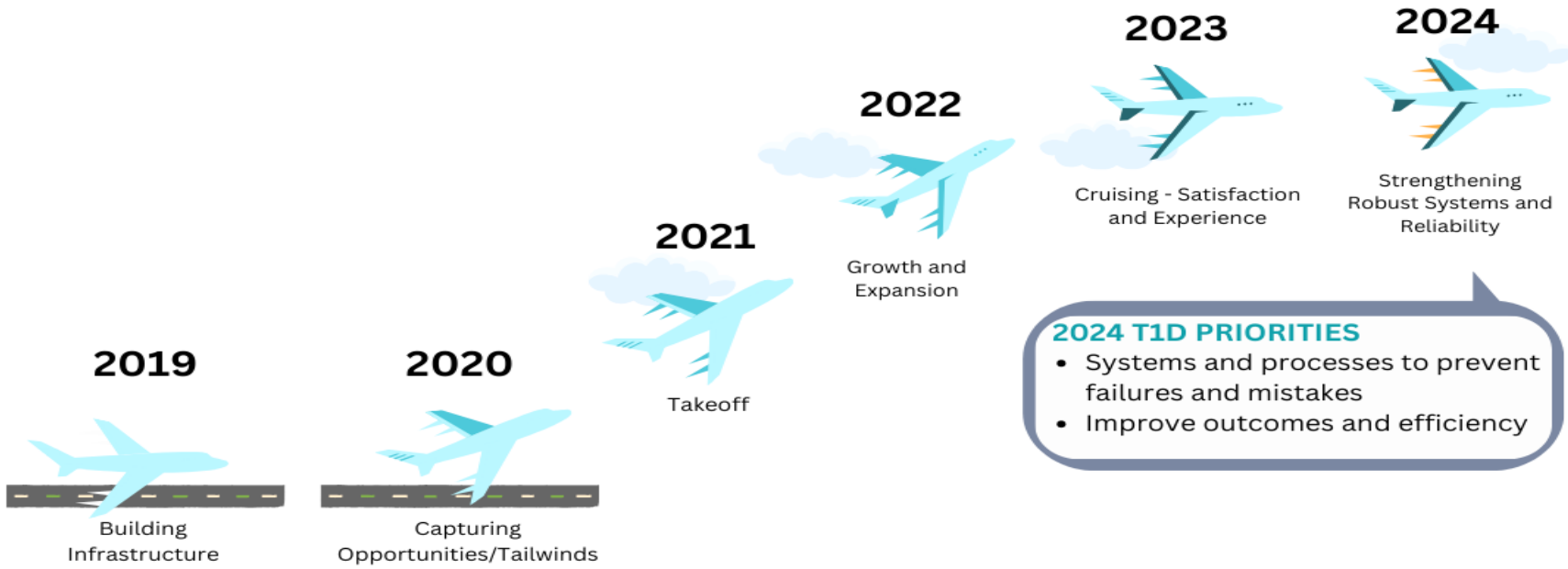
2024

Strengthening Robust Systems and Reliability

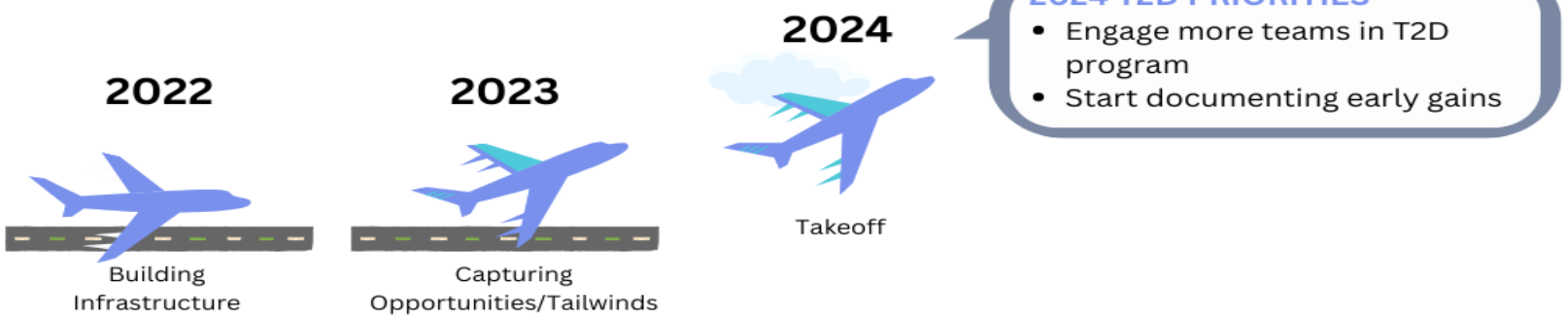
2024 PRIORITIES

- Systems and processes to prevent failures and mistakes
- Improve outcomes and efficiency

T1D Exchange Type 1 Diabetes Program



T2D EXCHANGE Type 2 Diabetes Program



Updated 1/4/24

Quality Improvement Collaborative Accomplishments

135,000+ People with diabetes served

Improved QI Portal Benchmarking Tool

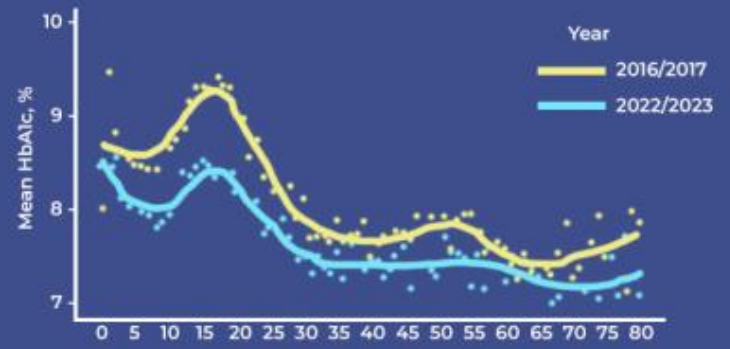
42 Centers are data mapped

95+ active projects

60 T1D Centers

10 T2D Centers

Improvement in **A1c** trends



82 publications in top journals

190 presentations at international conferences

Expanded
Health Equity Program

Welcome new clinical centers!

1. The Berrie Center, New York, NY

2. Rainbow Babies & Children's Hospital, Cleveland, OH

Center Presentations

From Registry to Health Maintenance: Improving EMR for Diabetes Care

Kristina Cossen, MD

Sobenna George, MD

Tonya Bennett, LPN BSHI

Questions

1) What is the frequency of microalbuminuria reported by NIH in 2022 for pediatric patients with T1D?
   A. 10%
   B. 15%
   C. 25%
   D. 30%

2) Utilizing tools within EMR can successfully improve adherence to the ADA recommended guidelines for youth with T1D
   A. True
   B. False

Learning Objectives

Review struggles of building a registry

Review rationale for using Health Maintenance Topics

Share PDSA cycles intended to improve data entry

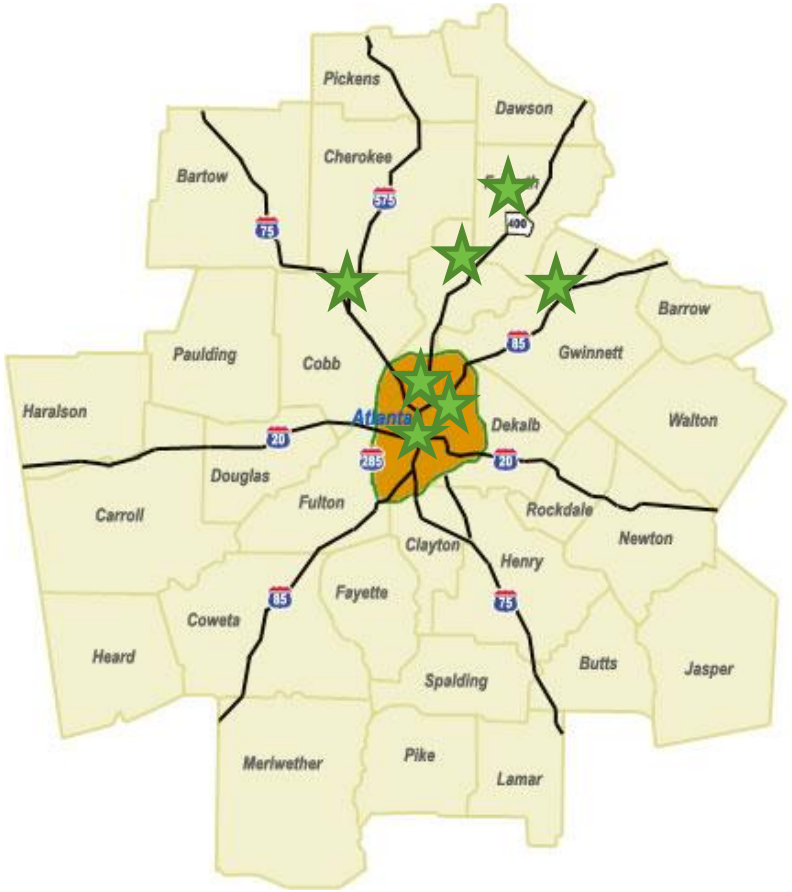
Children's Healthcare of Atlanta

Caring for 3500 T1D and 1500 T2D <21yo in Georgia.

48% Medicaid, 48% Private

42% non-white

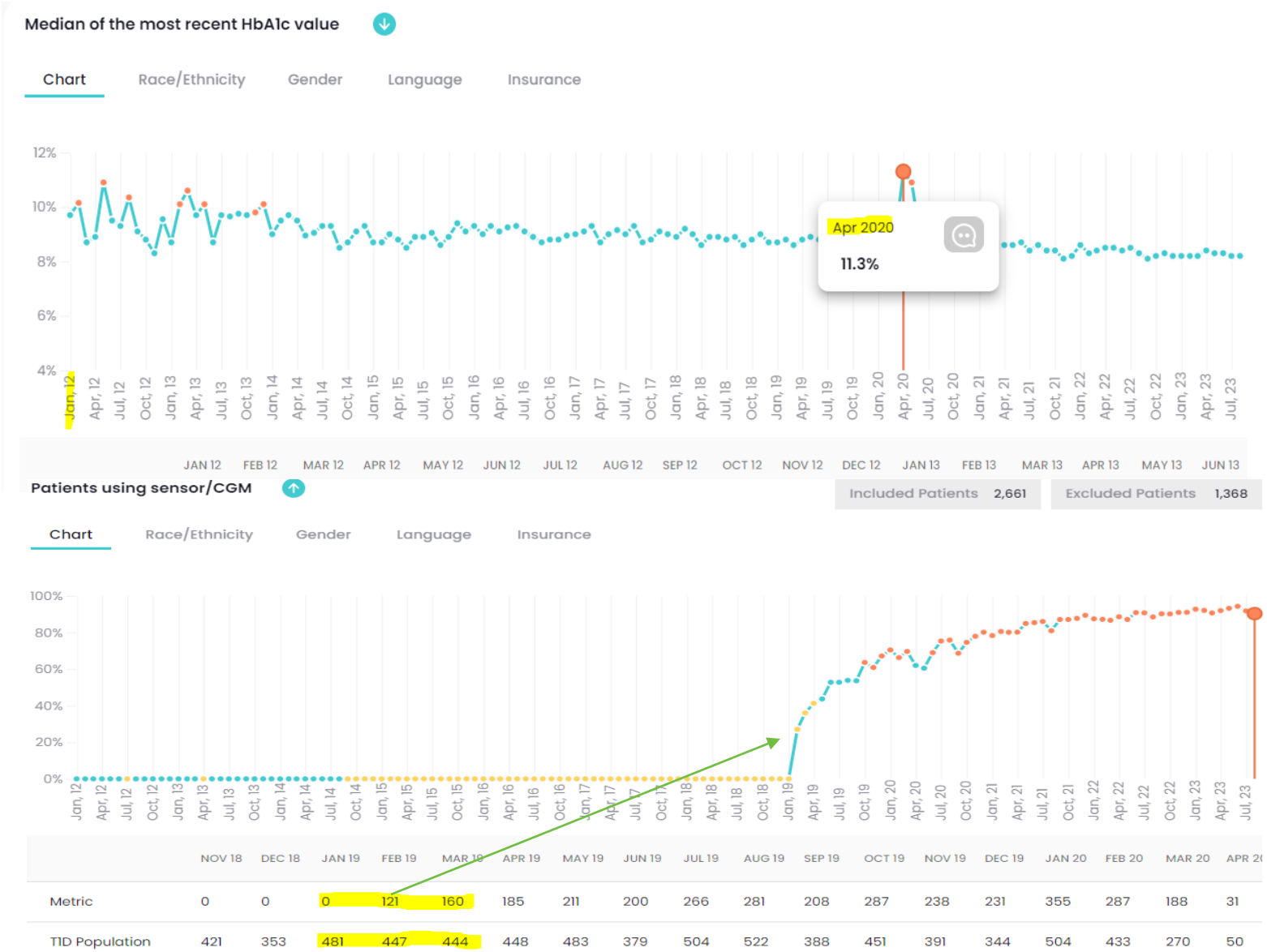
2023: 478 new T1D, 251 new T2D

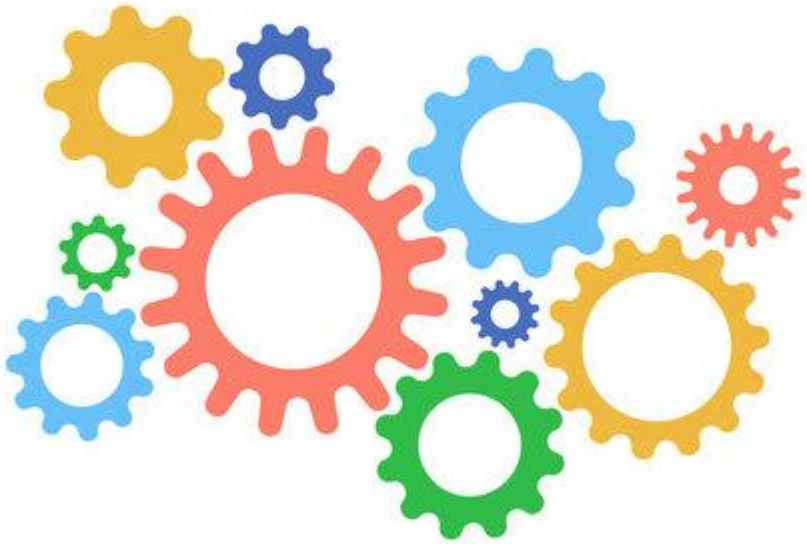


- Providers: **14.2**
- APPs: **7.2**
- Social workers: **2.8**
- Psychologists: **2.0**
- RNs: **10.9**
- Registered dieticians: **6.0** (w/ CDCES)
- Registered Nurses: **4.2** (w/ CDCES)

- 12 month A1c Range: **8.1-8.4%**
- Patient with A1c >9%: **31-38%**

Having data, not pulling it





- **PROBLEM**
  - Attempts with Best Practice Alerts/Advisories in the past were not well constructed and found to be ineffective at CHOA for diabetes comorbidities screenings
  - Rates of urine microalbumin screening 75% (USWNR)

- **ISSUE**
  - Diabetes registry had flaws in initial build

- **AIM STATEMENT**
  - Improve build of diabetes registry that would correctly identify type of diabetes 95% of time thus allowing creating of HEALTH MAINTENCE tools within Epic to improve urine microalbumin screening to 80% (USWNR)

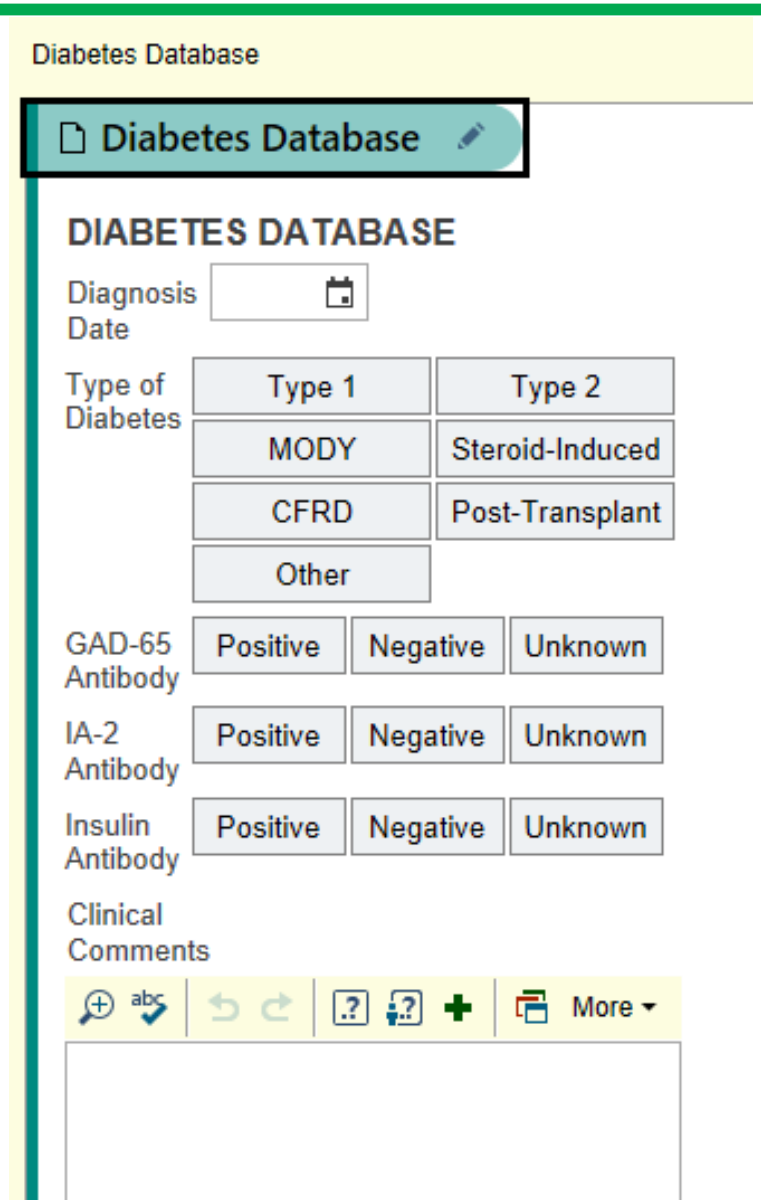
How to PULL Diabetes Diagnosis Correctly

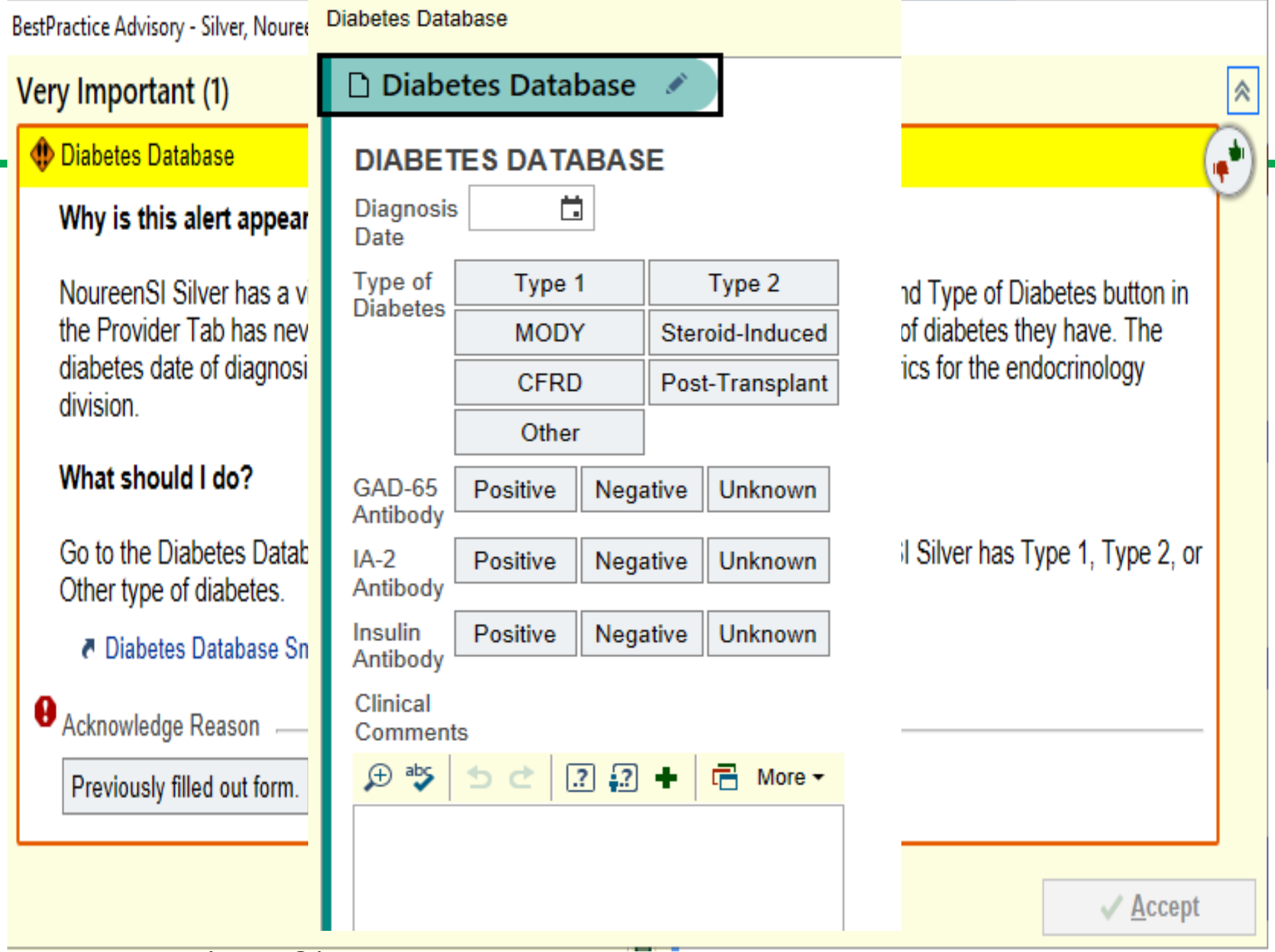
- Issues getting T1D and T2D pulled correctly
  - Diagnosis codes
  - Problem list
  - Visit codes

- We also wanted ENDO specific patients for reporting

- CHOA doesn't get antibodies on all newly diagnosed patients

Provider Tab




BestPractice Advisory - Silver, Noure
Very Important (1)
Diabetes Database
Why is this alert appear
NoureenSI Silver has a v
the Provider Tab has nev
diabetes date of diagnosi
division.
What should I do?
Go to the Diabetes Datab
Other type of diabetes.
Diabetes Database Sn
Acknowledge Reason
Previously filled out form.
Diabetes Database
Diabetes Database
DIABETES DATABASE
Diagnosis Date
Type of Diabetes
Type 1
Type 2
MODY
Steroid-Induced
CFRD
Post-Transplant
Other
GAD-65 Antibody
Positive
Negative
Unknown
IA-2 Antibody
Positive
Negative
Unknown
Insulin Antibody
Positive
Negative
Unknown
Clinical Comments
More
nd Type of Diabetes button in
of diabetes they have. The
ics for the endocrinology
l Silver has Type 1, Type 2, or
Accept

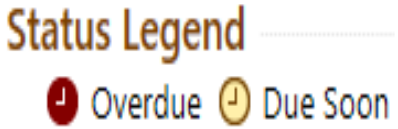
Healthy Planet / Care Gaps / Health Maintenance

- Healthy Planet: Functionality that supports population management by providing tools to collect data to aid in **identifying patients** that may require more immediate attention and to give **providers metrics** they need to make important clinical decisions

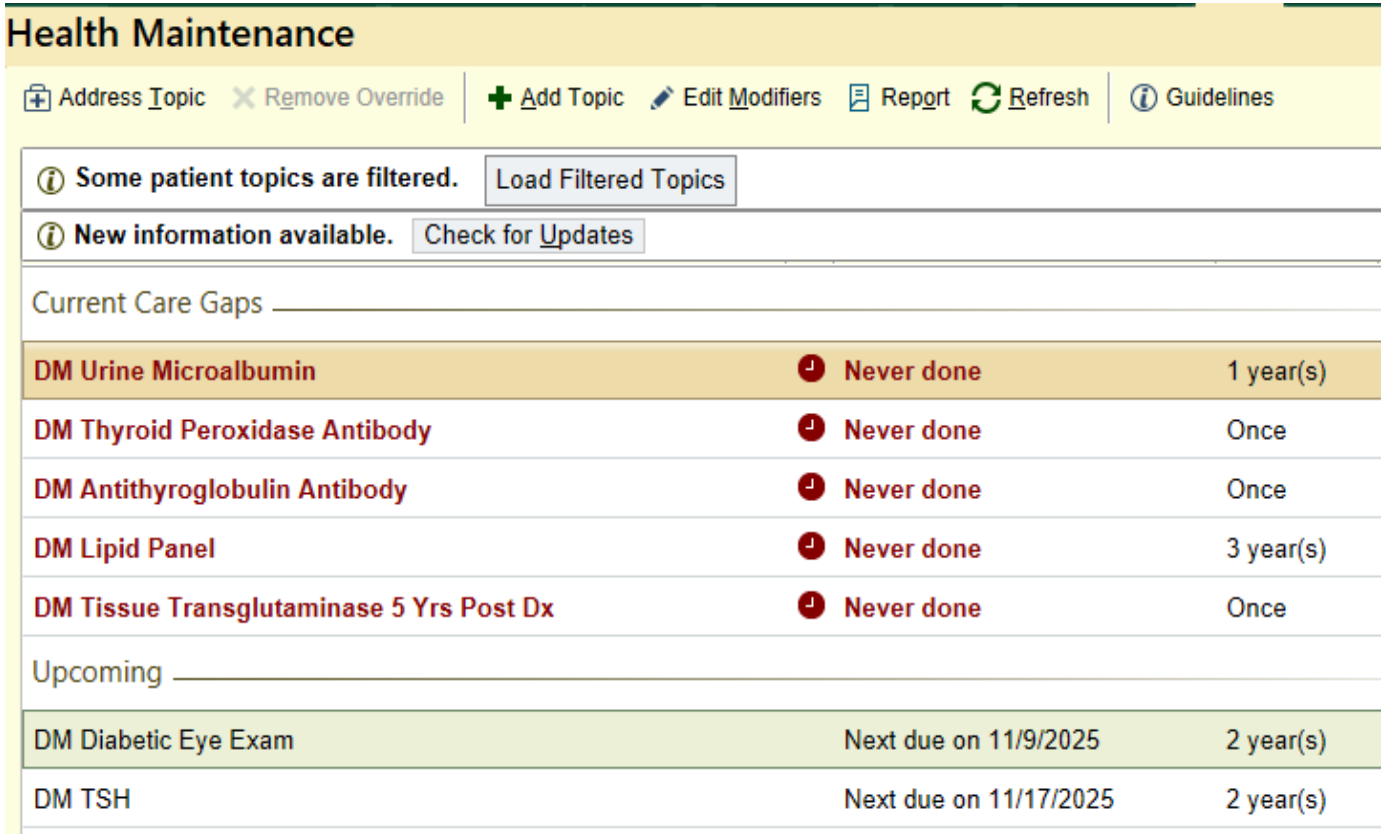
- BPA: A pop-up that **notifies clinicians** when they need to tend to important tasks, such as reviewing a patient's allergies, writing orders and completing charting. BPAs serve as **provider reminders** or warnings and can appear during clinical workflows based on specific criteria.

Completing HealthMaintenance

Diabetes HM Due	Patient	Age/Gender
	Endo, Mario	17y / M
	Endo, Princess P.	16y / F
	Endo, Luigi	11y / M
	Endo, Toad	6m / M



Completing HealthMaintenance



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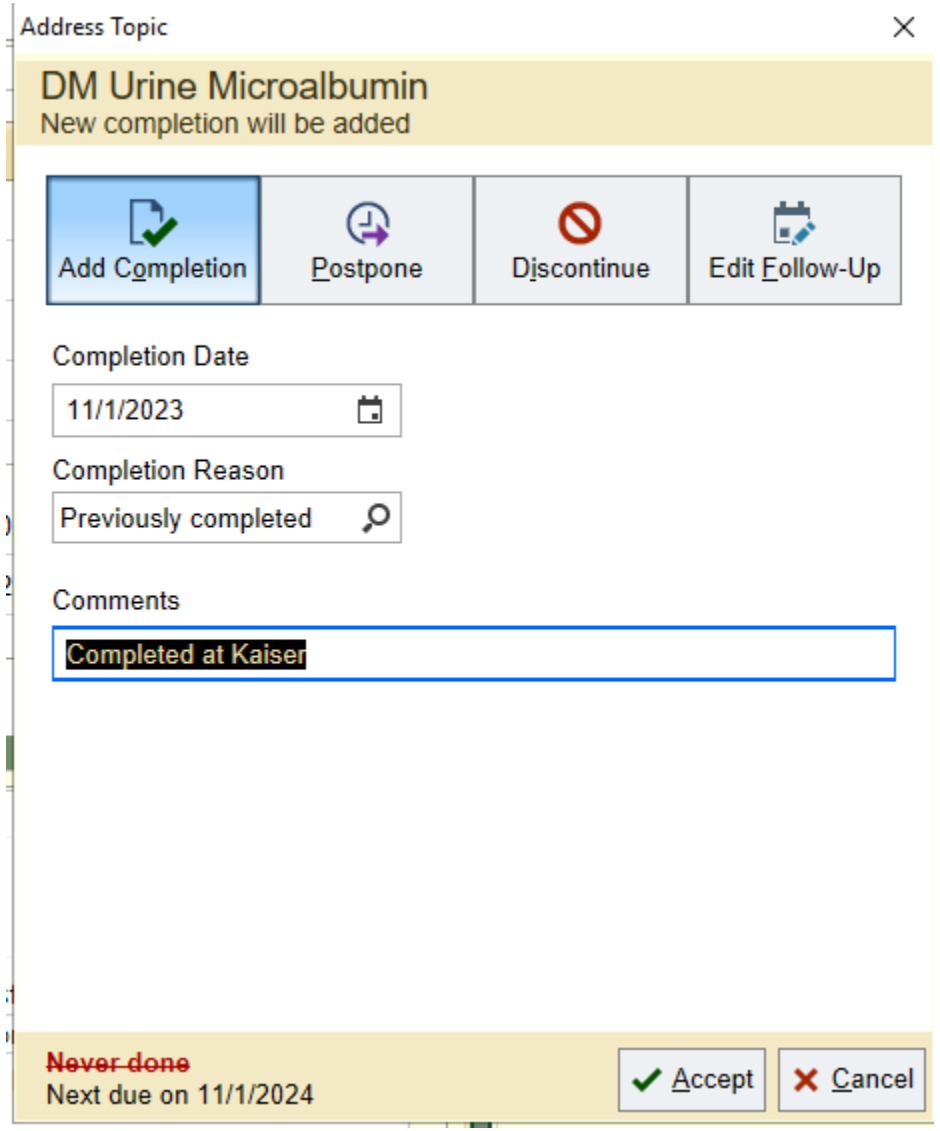
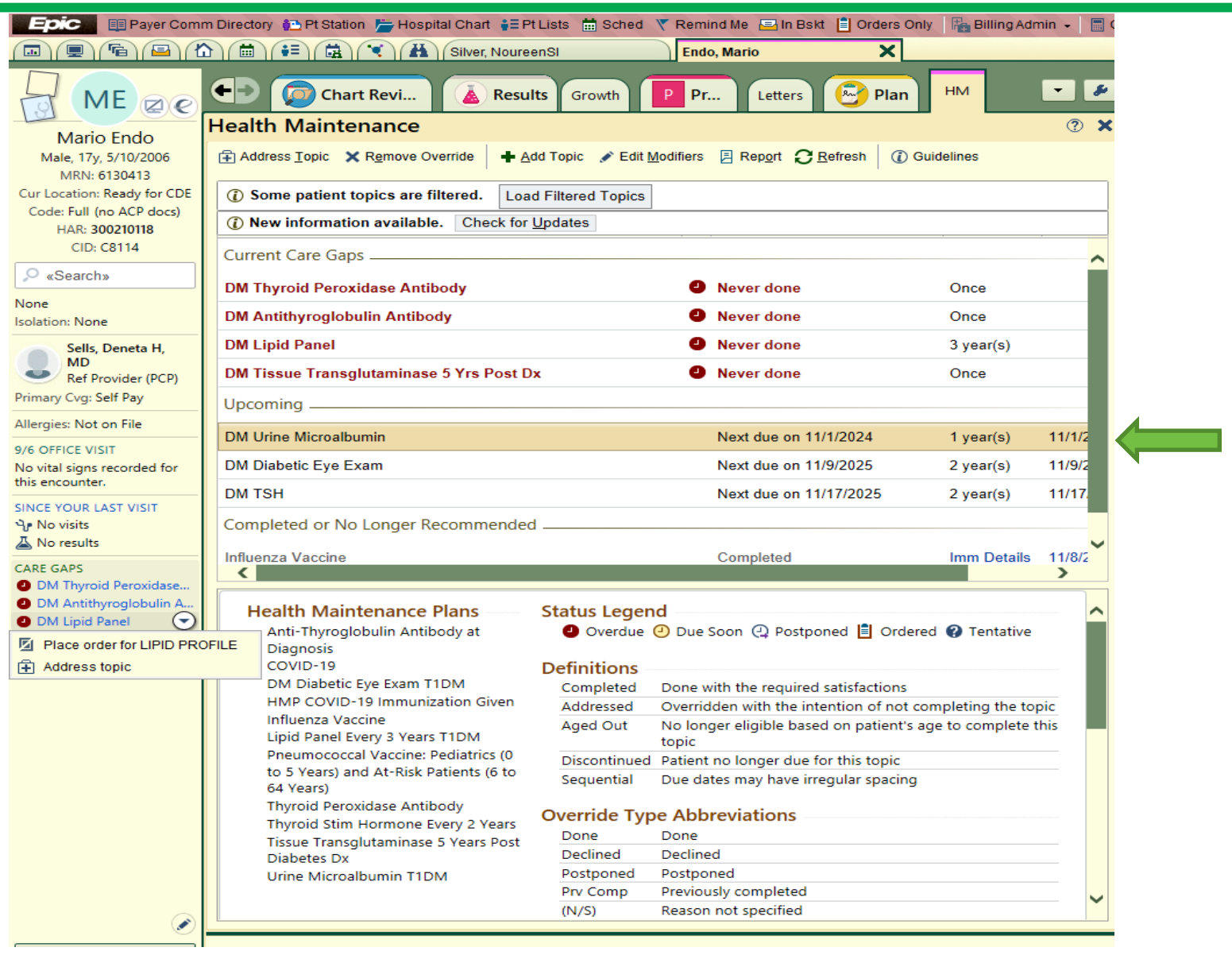
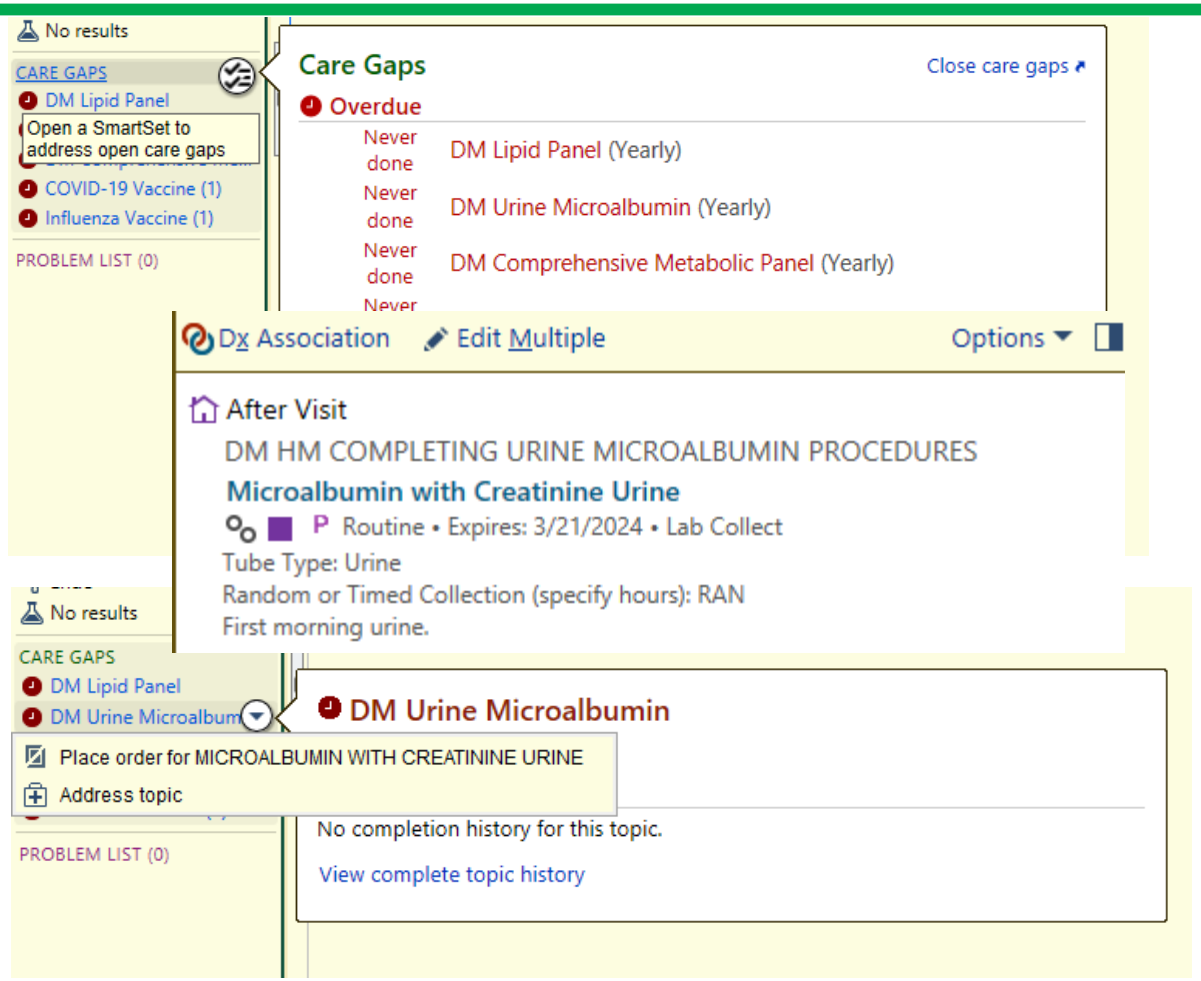
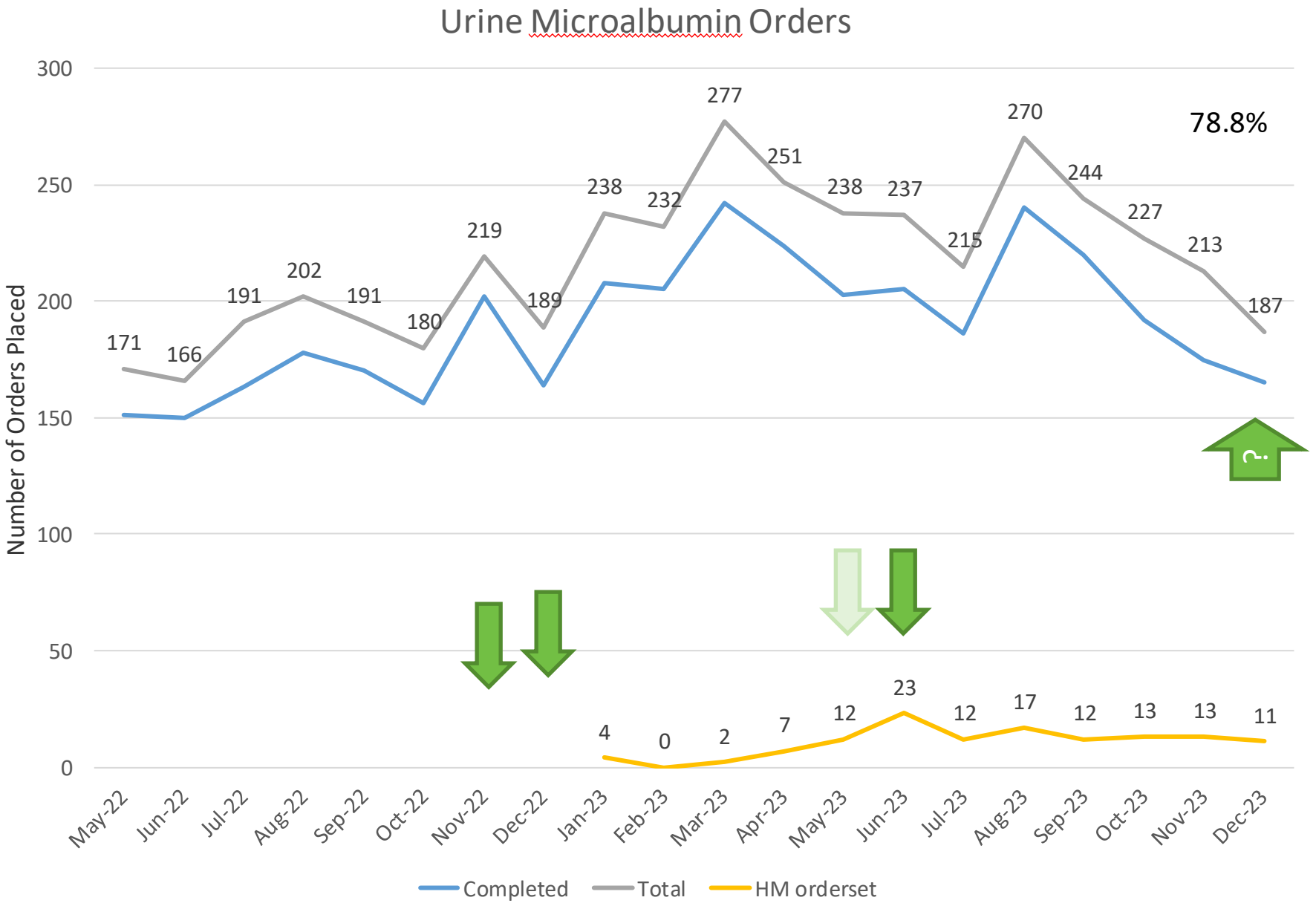


Completing HealthMaintenance



StoryBoard HealthMaintenance




Urine Microalbumin Orders
Number of Orders Placed
300
250
200
150
100
50
0
171
166
191
202
191
180
219
189
238
232
277
251
238
237
215
270
244
227
213
187
78.8%
4
0
2
7
12
23
12
17
12
13
13
11
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Completed
Total
HM orderset

Next steps

- We did see improvement in percentage completing comorbidity screenings
  - We did increase our USNWR group urine microalbumin completion rate
  - Expanding to other screenings (feet/eye)
- Difficulties in EPIC
  - Looking retrospectively at who needed testing and completed causing data collection issues
- Ongoing review of use of HM for providers is evident by the decline after initial use
  - Plan for twice yearly updates (summer for new fellows and winter with ADA updates)

Questions?

Integrated Behavioral Healthcare for Low-Income Ethnic Minority Youth with Type 1 Diabetes

Veronica Figueredo, MD; Luiza Vianna Mali, Ph.D.; Joelle Dorsett, B.S.

University of Miami

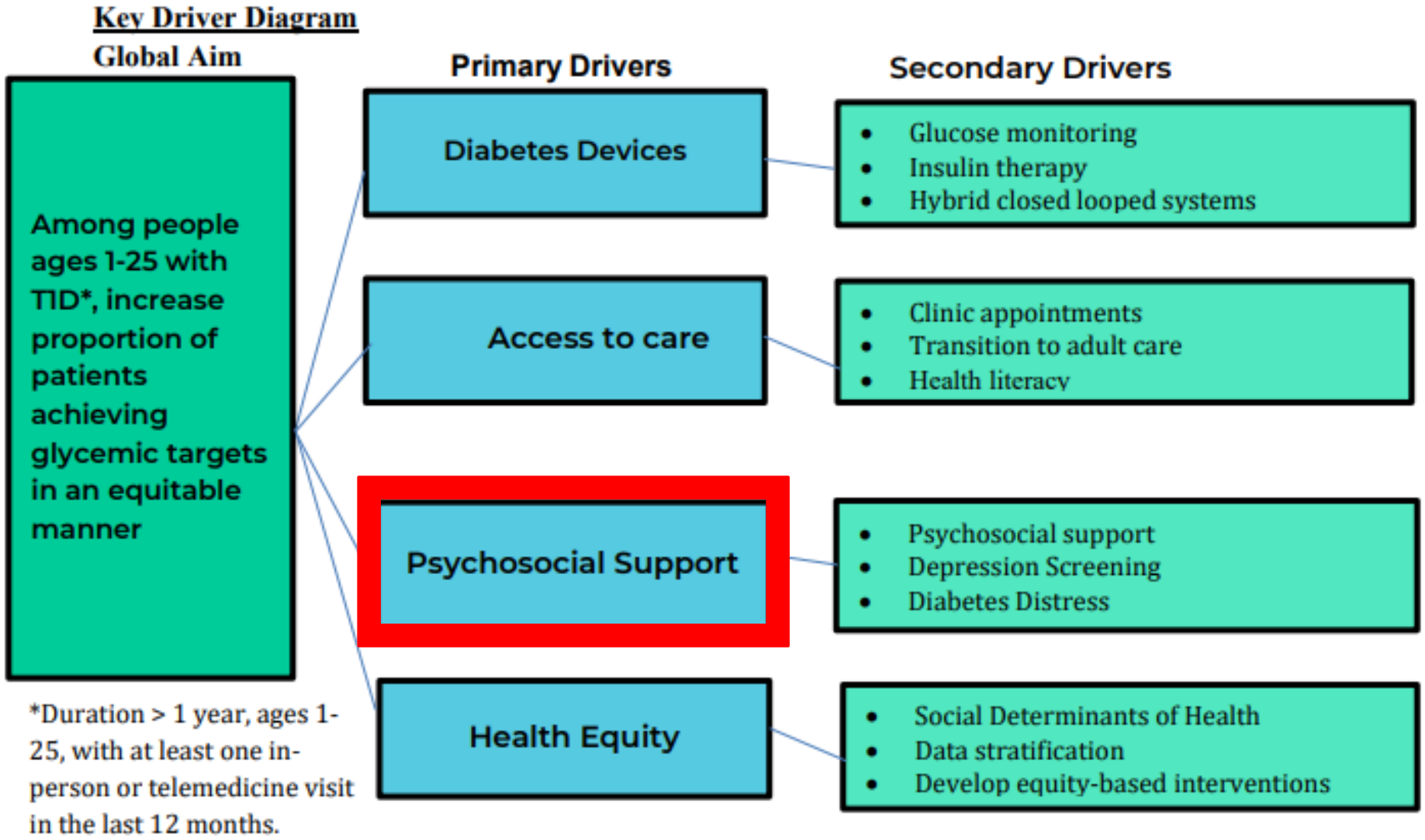
Discussion Questions

What are some barriers to youth receiving behavioral health care?

a) Attitudinal barriers
b) Structural barriers
c) Both

Studies have shown that ethnic minority youths have significantly worse glycemic control.

a) True
b) False


Key Driver Diagram
Global Aim
Among people ages 1-25 with T1D*, increase proportion of patients achieving glycemic targets in an equitable manner
*Duration > 1 year, ages 1-25, with at least one in-person or telemedicine visit in the last 12 months.
Primary Drivers
Diabetes Devices
Access to care
Psychosocial Support
Health Equity
Secondary Drivers
Glucose monitoring
Insulin therapy
Hybrid closed looped systems
Clinic appointments
Transition to adult care
Health literacy
Psychosocial support
Depression Screening
Diabetes Distress
Social Determinants of Health
Data stratification
Develop equity-based interventions

Learning Objectives:

1. Provide rationale for integrated behavioral healthcare approach
2. Review model of care at University of Miami
3. Describe how ongoing research can fill a gap in provision of care

1

Rationale for Integrated Behavioral Healthcare

Why Integrated Behavioral Care?

- Being diagnosed with diabetes in childhood or adolescence can interfere with normative development and interact with psychological and social factors in youth and their families.
- Low-income ethnic minority youth with T1D often experience structural and attitudinal barriers to access of mental health care and have significantly worse glycemic control.
- Integrated behavioral health care can help overcome many of these barriers and may help improve glycemic control in low-income ethnic minority youth with T1D.
- Integrated, collaborative care is therefore necessary.

Demographic Factors and Diabetes Management

- Studies have shown that ethnic minority youths, have significantly worse glycemic control (GC) and more acute and long-term complications than their majority counterparts [1,2,3].
- Larger increases in the annual incidence of diabetes rates among Latino youth have been documented compared to White Non-Latino youth [4].
- Few potential explanations for the observed racial/ethnic disparities in GC: sociodemographic factors such as parent education level and marital status.
- Lower regimen adherence and single-parent status has been found to partially explain poorer GC of minority youths.
- Findings have also shown that lower-income ethnic minority children with T1D are less often using intensive insulin regimens [5].

1. Wood, J.R., et al., Most youth with type 1 diabetes in the T1D exchange clinic registry do not meet American Diabetes Association or International Society for Pediatric and Adolescent Diabetes Clinical Guidelines. Diabetes Care, 2013. 36(7): p. 2035-2037.
2. Delamater, A.M., et al., Risk for metabolic control problems in minority youth with diabetes. Diabetes Care, 1999. 22(5): p. 700-705.
3. Petitti, D.B., et al., Glycemic control in youth with diabetes: The SEARCH for diabetes in youth study. The Journal of Pediatrics, 2009. 155(5): p. 668-672.e3.
4. Mayer-Davis EJ, Lawrence JM, Dabelea D, Divers J, Isom S, Dolan L, et al. Incidence trends of type 1 and type 2 diabetes among youths, 2002-2012. (2017) New England Journal of Medicine, 376(15):1419–29.
5. Valenzuela, J.M., et al., Prescribed regimen intensity in diverse youth with type 1 diabetes: role of family and provider perceptions. Pediatric Diabetes, 2011. 12(8): p. 696-703.

Barriers to Receiving Behavioral Health Services

Attitudinal

- Stigma
- Perceptions of mental health problems

Structural

- Financial barriers
- Inconvenience
- Distance
- Long wait times

Psychosocial and Behavioral Interventions

- There is substantial literature addressing psychosocial and behavioral interventions for the treatment of children and adolescents with T1D.
- Systematic reviews including meta-analyses have shown the efficacy of various approaches including family-based interventions.
- While methodological limitations have been noted, it can generally be concluded that there is a solid evidence base for psychosocial and behavioral interventions although the effects on glycemic outcomes are inconsistent.

- Although integrated behavioral health care can overcome common barriers related to access of mental health care for patients with T1D, more research is needed to demonstrate its effectiveness.
- This is especially the case for low-income ethnic minority youth with T1D, who are at high risk for GC problems and are often not included in controlled studies examining the efficacy of psychosocial and behavioral interventions for youth with diabetes.

2

The University of Miami's Model of Care

University of Miami, Pediatric Endocrinology

Location

- Main clinic at University of Miami Miller School of Medicine (private)
- Satellite clinic in South Miami
- Inpatient: Jackson Memorial Holtz Children's Hospital and Jackson North Medical Center (public)

Multidisciplinary Team Members

- 5 Board Certified Pediatric Endocrinologists
- 3 Fellows
- 1 Advanced Practice Provider
- 2 Certified Diabetes Care and Education Specialists
- 1 Psychologist and 5 trainees
- 2 Registered Dietician (DRI)
- 1 Social Worker (JMH)
- 1 Child Life Specialist (JMH)

Patient Population

75 new/newly diagnosed T1D patients seen annually

452 established T1D patients

0-19 years old

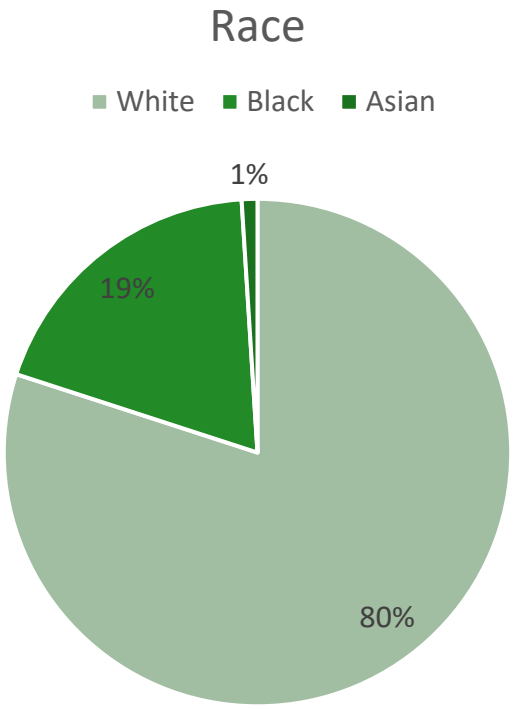
Insurance

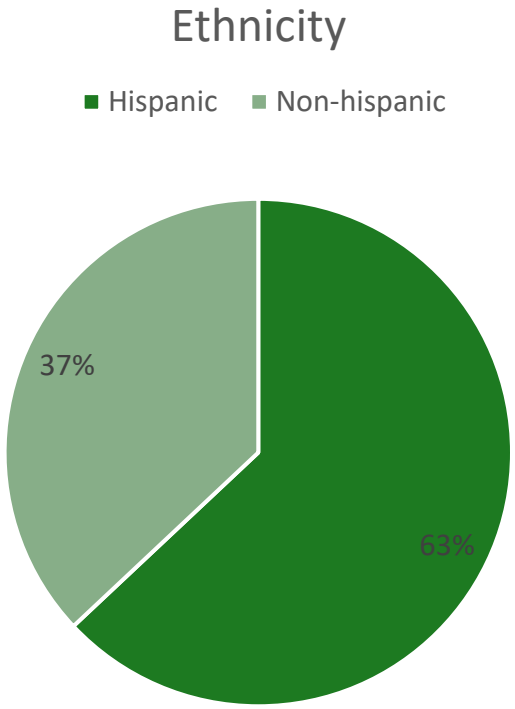
PRIVATE: 58%

MEDICAID: 40%

UNINSURED: 2%

Ethnic/Racial Composition





Comprehensive Psychology Screening

- Following recommendations from ISPAD guidelines for psychological care in pediatric diabetes
- Guidelines also emphasize:
  - Preventive interventions targeting family support, problem-solving, self-management, realistic expectations
  - Use of motivational interviewing to clarify goals and resolve ambivalence
  - Increasing responsibility/transition of care
  - Evidence-based interventions with active consideration of developmental needs

Patient Name

Patient DOB

Date of screening

Measure	Positive (Y/N)
Suicide Risk	N
Life Satisfaction	N
PHQ-9	N
GAD-7	N
Diabetes Stress	N
Family Conflict	N
Blood Glucose Monitoring	N
Self-Management	N
Eating Disorder	N
Motivation	N

Summary: Patient completed the mental health screen. He did not screen positive in any of the areas assessed.

Follow-up: Patient will be rescreened in one year.

Services Provided at UM

What we do:

- Consultation and brief intervention during and between visits
- Linkage with services
- *Ability to follow patients over time depends on insurance and is facilitated through adjacent pediatric psychology clinic.*

What we cannot currently do:

- Psychology unable to provide ongoing support for patients with Medicaid/CMS.

3

Research Study

Integrated Behavioral Healthcare for Low-Income Ethnic Minority Youth with Type 1 Diabetes

Eligibility

INCLUSION CRITERIA

- Youth (ages 10-17) with T1D diagnosed for 1+ years
- Latino or Black ethnicity/race
- English or Spanish oral and reading proficiency
- Medicaid insurance (low-income status)
- Elevated psychosocial screen and/or A1c greater than 8% or history of DKA in the previous year

EXCLUSION CRITERIA

- Significant developmental disability
- Serious psychiatric disorder
- Another serious chronic illness (except thyroid disease or celiac disease)

Study Design

- Recruitment during clinic visit.
- After informed consent and assent, education will be provided about participation in clinical research, to enhance retention over the course of the study.
- Participants will complete an assessment of behavioral and psychosocial measures via surveys, after which they will be randomized (25 participants receiving the 4-month integrated behavioral health care intervention/ 25 referred to behavioral health care in the community).
- After 4 months, participants will repeat the same assessment battery.
- Each adolescent-parent dyad will receive gift coupons worth $30 for completion of the baseline assessment and $70 for completion of the 4-month assessment.

Assessment Measures

Demographic Variables

- Questionnaire assessing age, gender, ethnic status, preferred language, parental education, occupation, and marital status.
- Social determinants of health assessed by 15-item questionnaire from the American Academy of Family Physicians (baseline assessment only).

Glycemic Control Variables

- Glycosylated hemoglobin A1c
- Meter or CGM data to provide mean, SD, and range, of BG and % time in range
- Chart review to establish health care utilization (DKA or severe hypoglycemia requiring medical attention or hospitalization).

Assessment Measures

Behavioral Variables

- Diabetes Management Questionnaire (DMQ): 20 items assessing five domains (physical activity, meals/snacks, low blood sugars, high blood sugars and insulin/glucose monitoring).
- Meter or CGM data to provide mean daily BG monitoring frequency; for patients on insulin pumps, bolus activity documented using pump data.

Psychosocial Variables

- Diabetes Family Conflict Scale: 19-items measuring conflict between parents and children regarding DM tasks.
- Collaborative Parental Involvement Scale: 12-items measuring collaborative parental involvement in DM tasks.
- Patient Health Questionnaire (PHQ-8): 8-item measure assessing for depression.

Assessment Measures

Psychosocial Variables cont.

- Pediatric QOL Scale (PedsQL), and the PedsQL-Diabetes Module: General and diabetes-specific QOL
- Intrinsic Motivation Inventory for Diabetes Management (IMI-DM): 12-item modified version of Intrinsic Motivation Inventory (IMI) to assess diabetes-specific IM
- The Perceived Stress Scale: 14-items assessing degree of parental perceived stress (parental only measure)
- Consumer satisfaction measure to evaluate youth and parent perceptions of care received (for both treatment and control groups; 4-month assessment only)
- For control group receiving care in the community, parental interview to document types of behavioral health services received, number of sessions attended, the types of professionals providing services, and communications with the diabetes clinic team (4-month assessment only)

Intervention

- Average of 8 sessions with the first 4 held weekly and the rest held bi-weekly, monthly, or as-needed.
- Flexible, modular approach, with order of intervention components varying with each patient.
- Family-based, with the goal of promoting teamwork between parents and youth.
- Modules targeting self-management habits associated with improved glycemic control (e.g., regular glucose checks or use of continuous glucose monitor; appropriate timing and frequency of boluses; reviewing glucose data since last clinic visit)
- Motivational interviewing (MI) techniques and evidence-based behavior management strategies, including self-monitoring, goal-setting, behavioral contracting, and positive reinforcement.
- Culturally-sensitive and case formulation that incorporates the impact of a range of social, health, and living factors

Objectives

- To evaluate the feasibility (with attention to recruitment, attendance, retention, and acceptability) of an intervention by conducting a field test over a four-month period
- To increase access to evidence-based, integrated behavioral health care services for high-risk low-income, ethnic minority youth with type 1 diabetes (T1D) to promote diabetes management and improve glycemic control

Key Drivers:

- Access to Care
- Psychosocial Support
- Health Equity

Project Update

- Project is ongoing (2 families have been recruited)
- Recruitment challenges, particularly follow through
- Inform future efforts to integrate care

Questions?

UPMC | CHILDREN'S HOSPITAL OF PITTSBURGH

Improving Depression Screening in Youth with Type 1 Diabetes

Alissa Guarneri-Tragone, MD MBOE

Thursday, January 25th, 2024

Pediatric Diabetes Center at UPMC Children's Hospital of Pittsburgh

- 22 MD/DO Faculty
- 13 APP
  - 7 CDCES
- 10 Pediatric Endocrine Fellows
- 18 Diabetes Educators
  - 9 CDCES
- 3 Registered Dieticians
  - 1 CDCES
- 9 Endocrine RN
  - 1 CDCES
- 2 Social Workers
- 1 Diabetes Psychologist

- Volume and Demographics
  - 2300 patients with type 1 diabetes for more than one year receiving ongoing care
- Average newly diagnosed patients per year
  - 250
- Insurance
  - 50% public
- Race
  - 83% White
  - 10% Black
  - 2% Asian
  - 5% Biracial/unknown/other
  - ~3% Hispanic

Learning Objectives

- Understand the significance of screening for depression in youth with type 1 diabetes
- Review the importance of a process map in standardizing work for a process
- Discuss PDSA cycles and outcomes
- Discuss next steps

Pre-Learning Questions

1. True/False: Type 1 diabetes places significant stress on youth in multiple aspects, which can lead to symptoms of anxiety and depression.
   a. True
   b. False

2. True/False: By optimizing our process, we were able to improve depression screening in eligible patients with type 1 diabetes by nearly 10%.
   a. True
   b. False

Why This Project?

- Mental health in adolescents with chronic conditions has become a public health priority.
- Growing up with type 1 diabetes brings daily demands and responsibilities that, alongside the already difficult physical, psychological, and social changes of adolescence, increase the risk of anxiety and depression.[1]
- Depression alone carries significant potential for disability, but when combined with diabetes, the comorbidity carries the potential for serious long-term consequences. Depression is associated with poorer metabolic control, and thus, such youth may be more at risk for long-term complications.[2]
- The comorbidity of diabetes and depression in children and adolescents is a significant problem, affecting at least 20% of youth with diabetes compared to less than 7% of youth without diabetes.[2]

[1]. Reynolds KA et al. Annals of Behavioral Medicine 2011.
[2]. Grey M et al. Journal of Psychosomatic Research 2002.

Background

- At our Diabetes Center, eligible youth with type 1 diabetes are screened for depression via a PHQ-9 questionnaire administered between September-December annually.

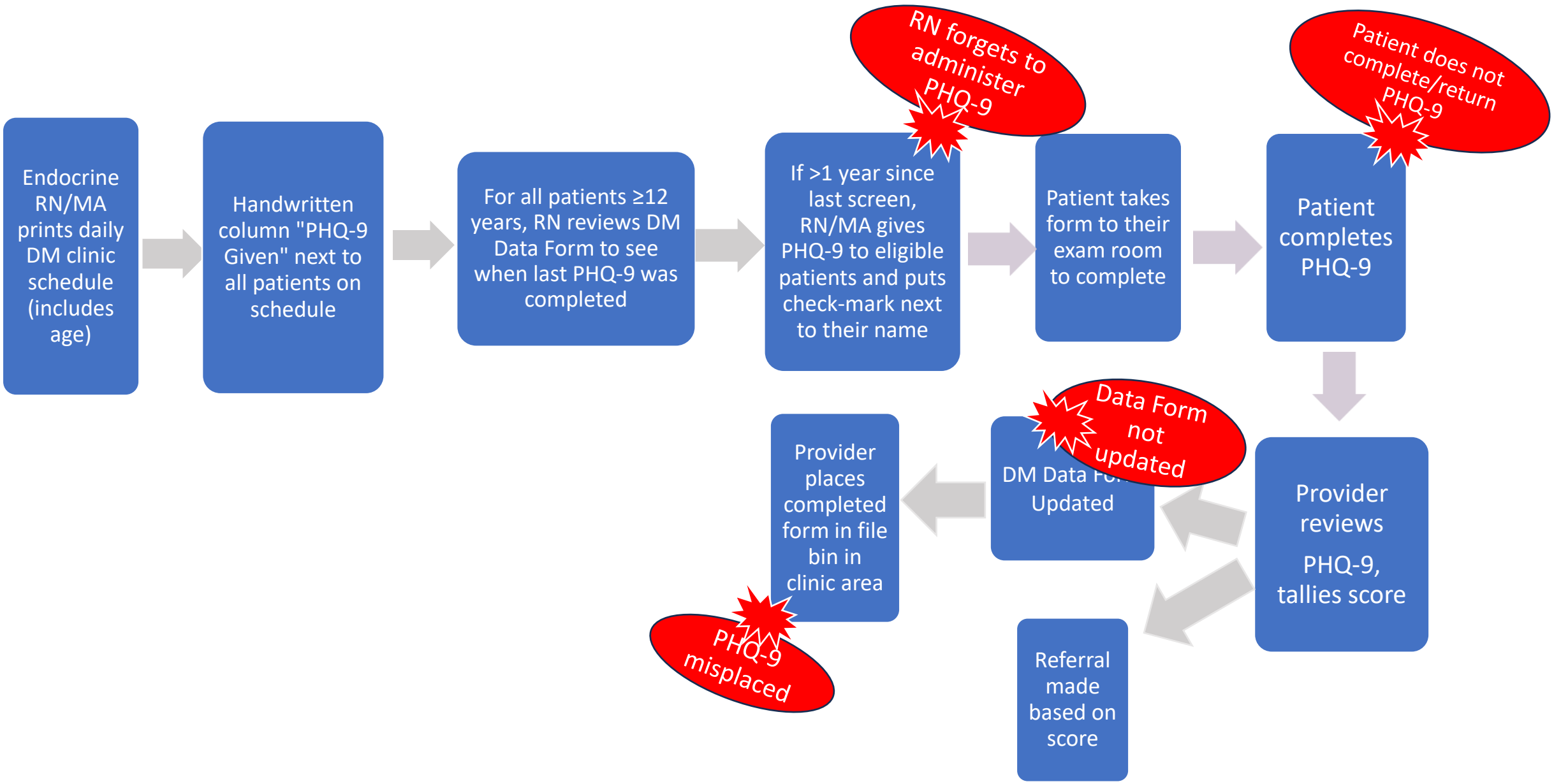
- Between September-December 2022, in a sample of 20 clinics (43 eligible patients), 35/43 **(81%)** completed a PHQ-9 questionnaire and had appropriate documentation in EMR.

- <u>Problem:</u>
  <100% of eligible patients (≥ 12 years with type 1 diabetes mellitus for >12 months) complete annual PHQ-9 depression screening with appropriate documentation.

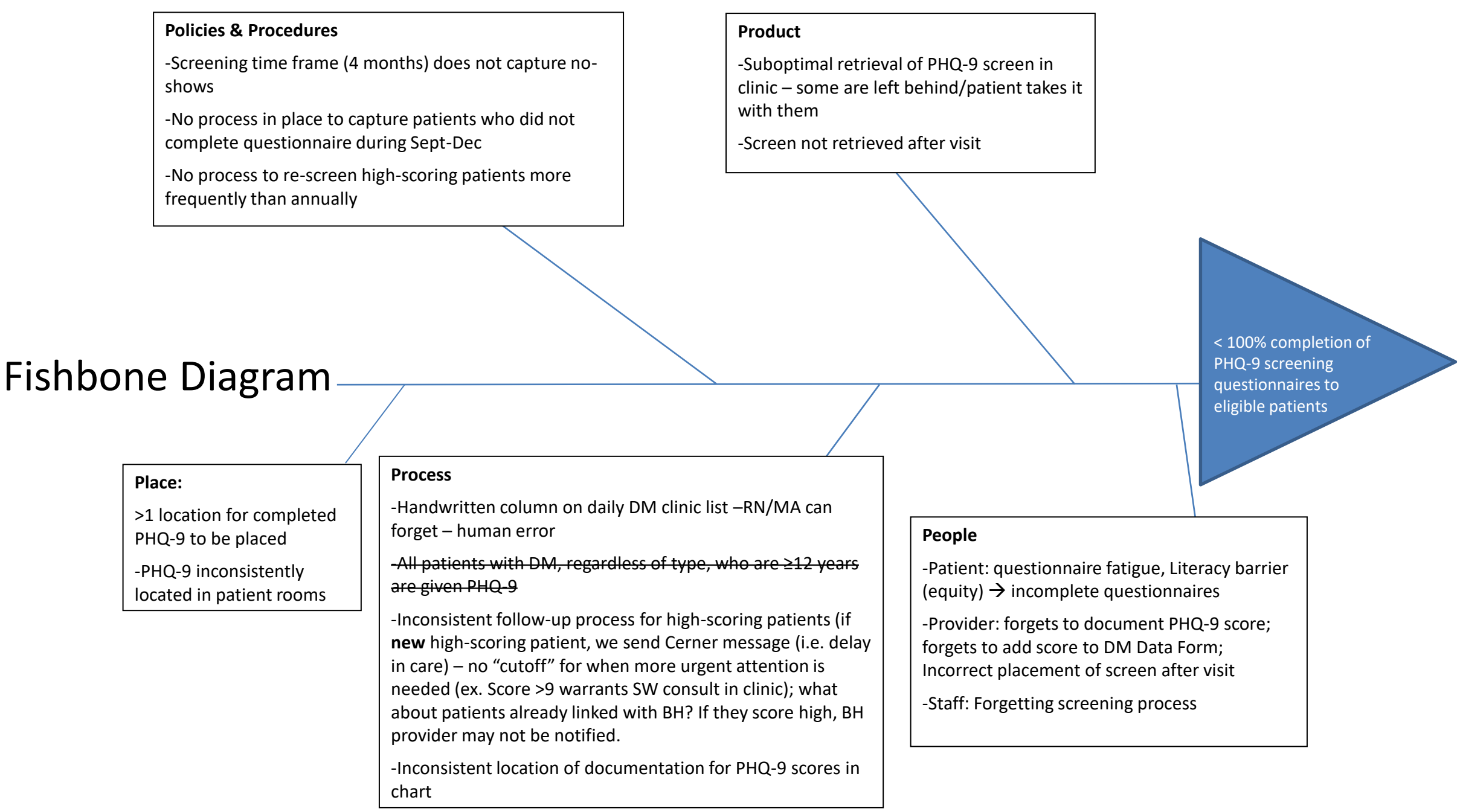
SIPOC

Supplier (Who)	Input (Object/What)	Process (Activity)	Output (Object)	Recipient (Who)
RN/MA	Daily DM clinic schedule	Identifies patients age ≥12 years	Provides PHQ-9 to eligible patients	Patient
Patient	Receives PQH-9	Completes PHQ-9	Completed PHQ-9	Provider
Provider	Completed PHQ-9	Reviews completed PHQ-9	Score <9	Filing Bin for scanning
Provider	Completed PHQ-9	Score: >9 → SW consult >15 → BH consult Mark 'yes' for SI →ED	 -SW provides resources -BH appointment made -ED evaluation	Patient

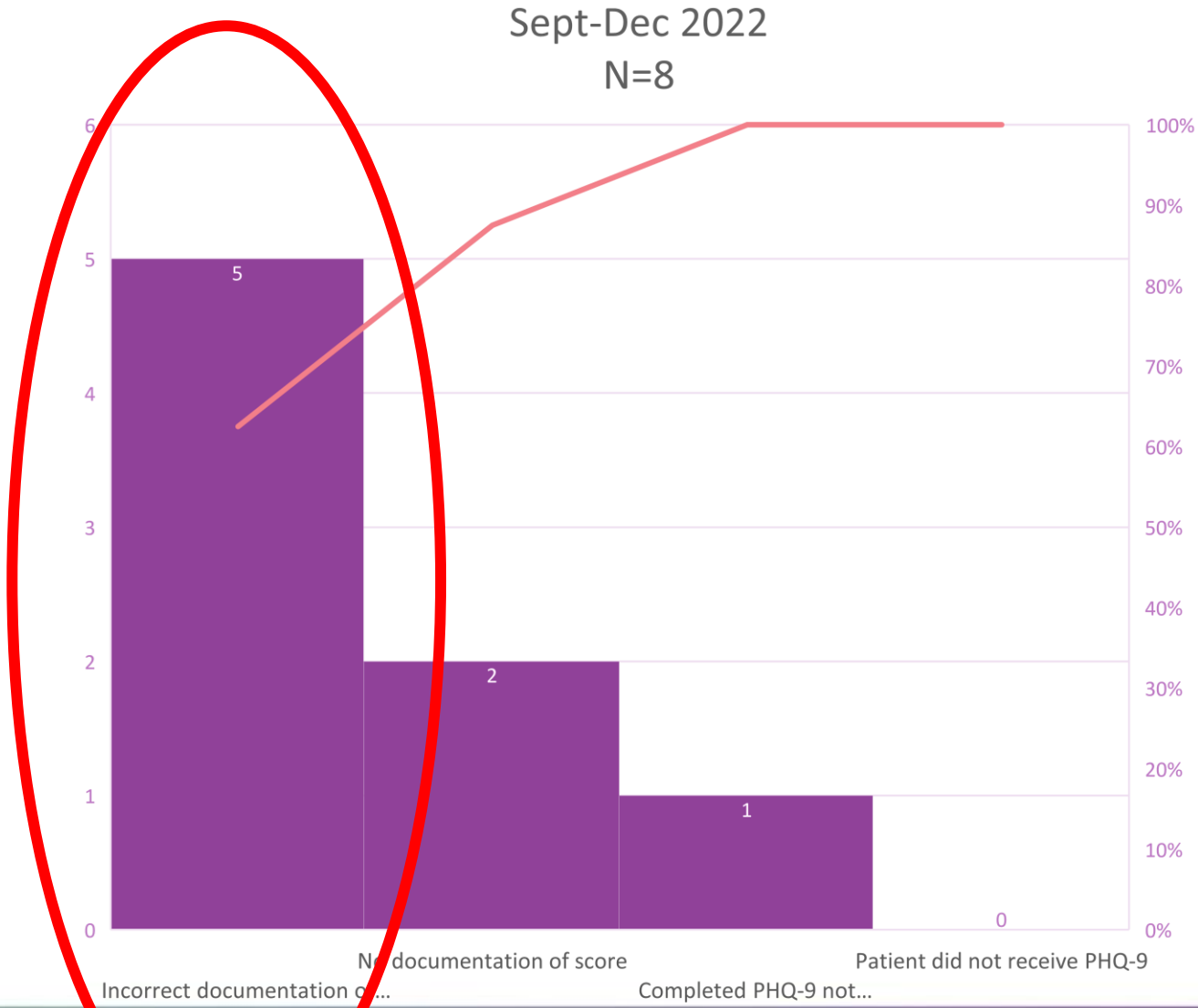
Process map


Endocrine RN/MA prints daily DM clinic schedule (includes age)
Handwritten column "PHQ-9 Given" next to all patients on schedule
For all patients ≥12 years, RN reviews DM Data Form to see when last PHQ-9 was completed
If >1 year since last screen, RN/MA gives PHQ-9 to eligible patients and puts check-mark next to their name
RN forgets to administer PHQ-9
Patient takes form to their exam room to complete
Patient completes PHQ-9
Patient does not complete/return PHQ-9
Provider reviews PHQ-9, tallies score
DM Data Form Updated
Data Form not updated
Provider places completed form in file bin in clinic area
PHQ-9 misplaced
Referral made based on score

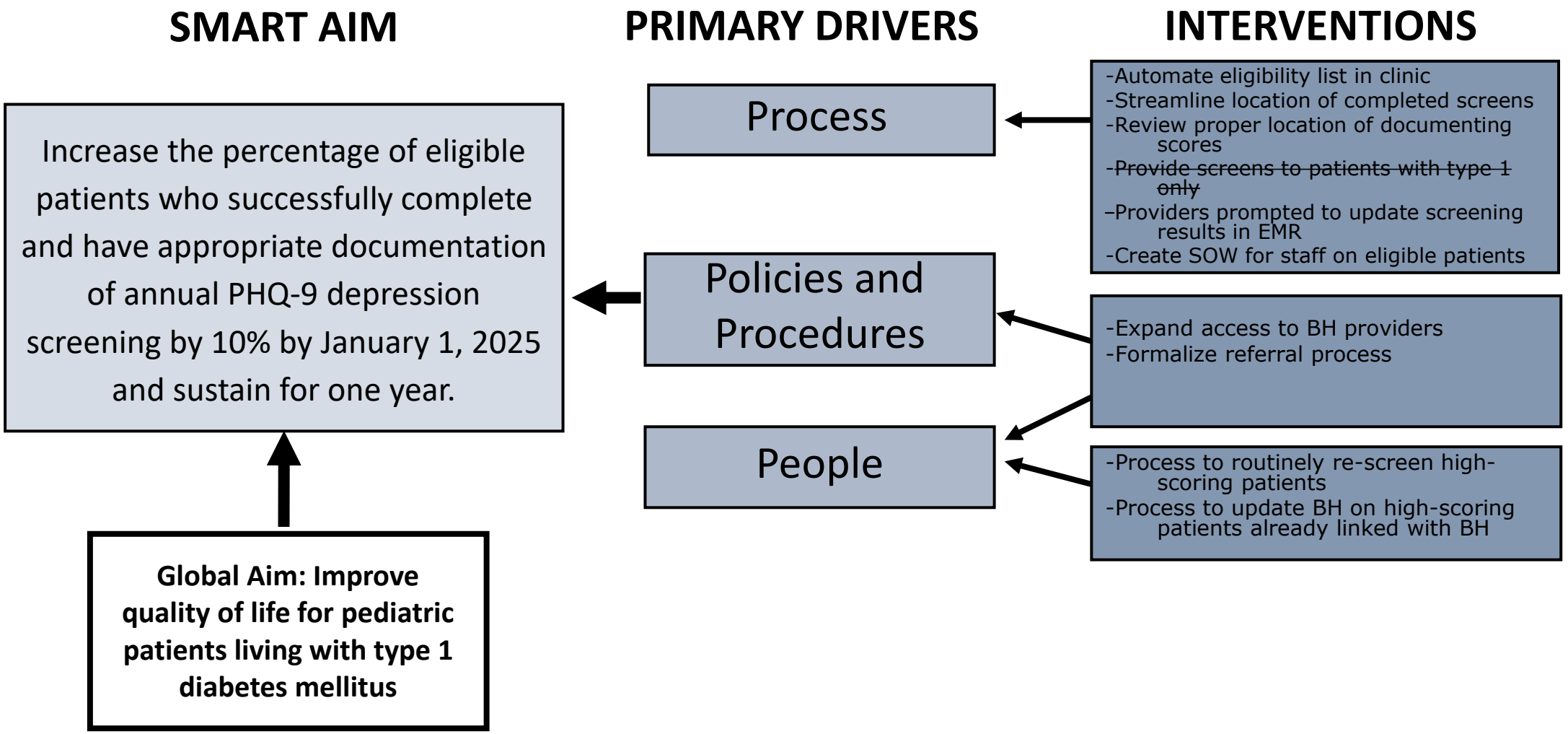
Fishbone Diagram



Missed PHQ-9 Screening Opportunities



Improving Depression Screening in Youth with Type 1 Diabetes



Impact Effort Matrix

Prioritize Interventions

1. Streamline location of completed screen
2. ~~Automate eligibility list in clinic~~
3. Providers reminded to update screening results in EMR
4. Expand access to BH providers
5. Formalize referral process
6. Process to routinely re-screen high-scoring patients
7. Process to update BH on high-scoring patients already linked with BH

Impact Effort Matrix

	Low Effort	High Effort
High Impact	1 3	4 5 7 6
Low Impact		2

PDSA Cycles

#1
- Specified location for completed screens
- 2 iterations

#2
- Increase provider awareness of PHQ-9 screening
- Verbal announcement

#3
- Increase provider awareness of PHQ-9 screening
- Visual reminder in provider area in clinic

#4
- Create standard work for staff
- Clearly list responsibilities to minimize error

RAIL

Implementation Rolling Action Item List							
Key Driver	**Interventions**	**PDSAs**	**Owner**	**Check Date**	**Progress Notes**	**Next Steps**	**Status**
Process	~~Automate eligibility list in clinic~~						
	Streamline location of completed screens	1	AG	5/22/2023	Complete	N/A	
	Provider awareness -announcement	2	AG	8/1/2023	Complete	N/A	
	Provider awareness -visual reminder	3	AG	8/15/2023	Complete	N/A	
Policies and Procedures	~~Expand access to BH providers~~						
	Formalize referral process	2	AG	TBD	In Process		
	Process to routinely re-screen high-scoring patients			TBD			
People	Create SW for eligible patients	4	AG	10/1/2023			

In place/Working
In process
Problem/Haven't started

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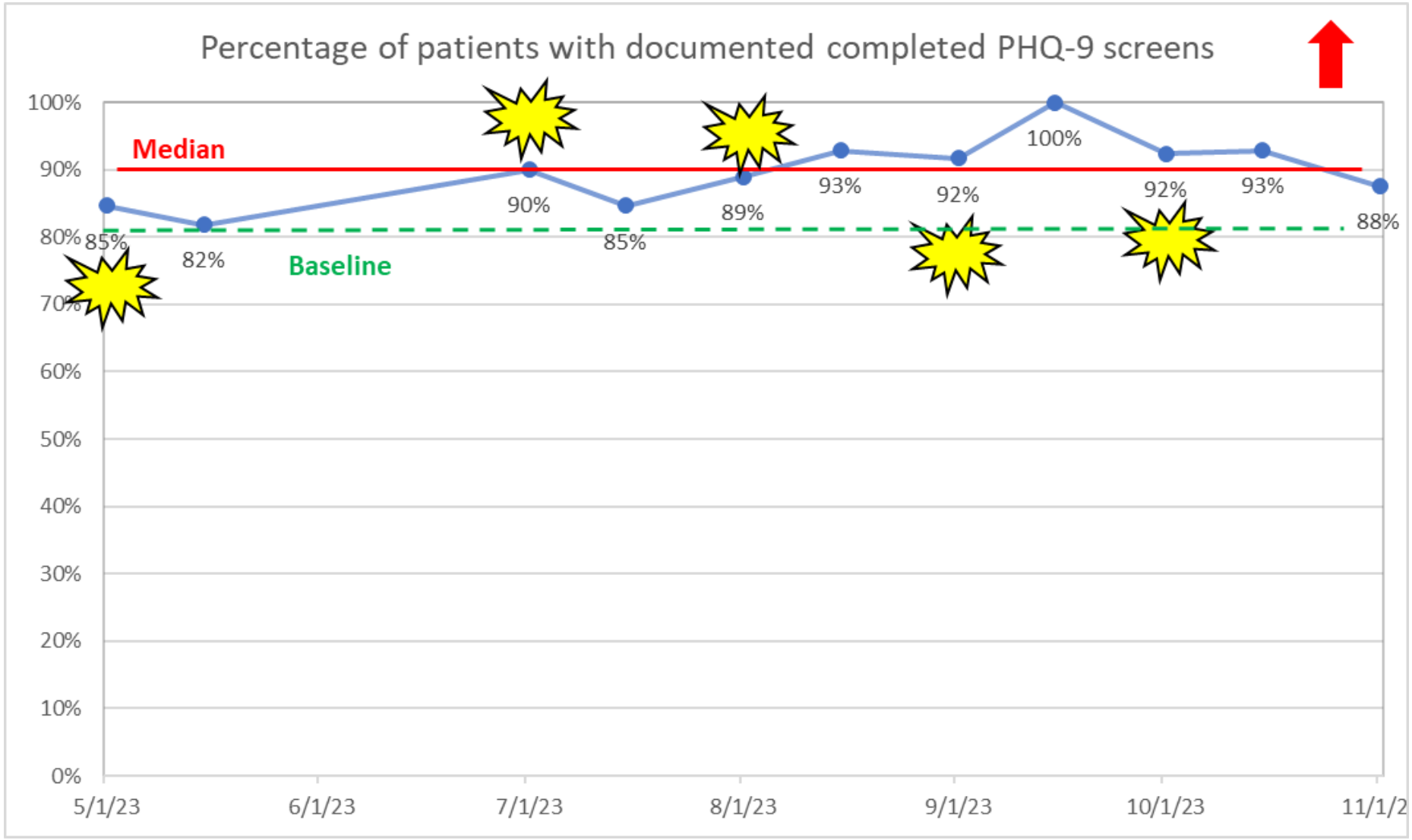
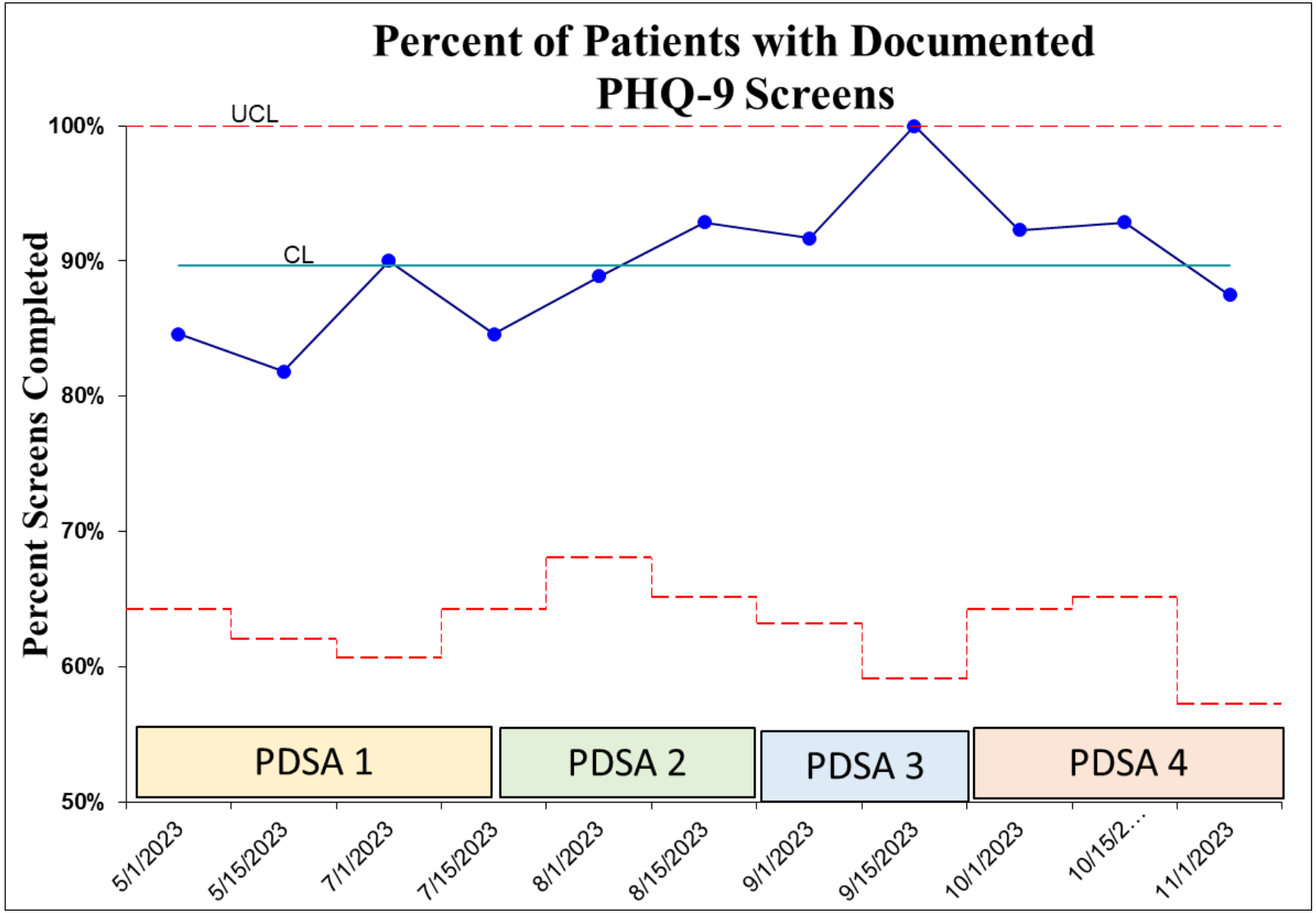
Results

Period	# of eligible patients with documented depression screening	# patients eligible for depression screening	Percent of patients with documented completed PHQ-9 screens	Baseline median	
1-May	11	13	85%		PDSA 1
15-May	9	11	82%		PDSA 1
1-Jul	9	10	90%		PDSA 1
15-Jul	11	13	85%		PDSA 1
1-Aug	16	18	89%		PDSA 2
15-Aug	13	14	93%		PDSA 2
1-Sep	11	12	92%		PDSA 3
15-Sep	9	9	100%		PDSA 3
1-Oct	12	13	92%		PDSA 4
15-Oct	13	14	93%		PDSA 4
1-Nov	7	8	88%		PDSA 4

Results – Run Chart



Results - Control Chart



Key Learnings

- Despite baseline percentage of 81%, there was no standard work for process of how PHQ-9 questionnaires were being documented and completed questionnaires triaged
- Balancing Measure: Potential increased frequency of depression identified in youth with type 1 diabetes

Future Steps

- Did our incidence of depression increase with improved screening documentation?
  - Formalize referral process – PDSA #5
- Sustainability:
  - Revisit in 2024 to see if we sustain our 90% - compare data to next year

Questions?

Thank you!

Updates from the Coordinating Center

Invoicing reminder

Invoices for work performed in 2023 are due now. Deadline for submitting invoice is March 31, 2024. Payments will not be made for invoices received after 3/31/2024.

- Communicate invoicing request to your finance/contracting/grants office
- Consult/reference Statement of Work for details
- Invoices should be sent via email attachment Invoices should be sent via email attachment
  To: Nicole Rioles- nrioles@t1dexchange.org
  CC: Rene Weathers- rweathers@t1dexchange.org
  Linda Crasco- linda.crasco@t1dexchange.org
  qi@t1dexchange.org

Co-Chair Nominations

- New Co-Chair terms will begin June 1st
- To learn more about the committees and view the charters please use the following links:
  - Clinical Leadership Committee
    Data Science Committee
    Data Governance Committee
    Publication Committee
    Advisory Committee
    QI Champions
    HEAL
- Use this link or scan the QR code to submit nomination
  - Please review the committee charter before nominating

T1D Exchange

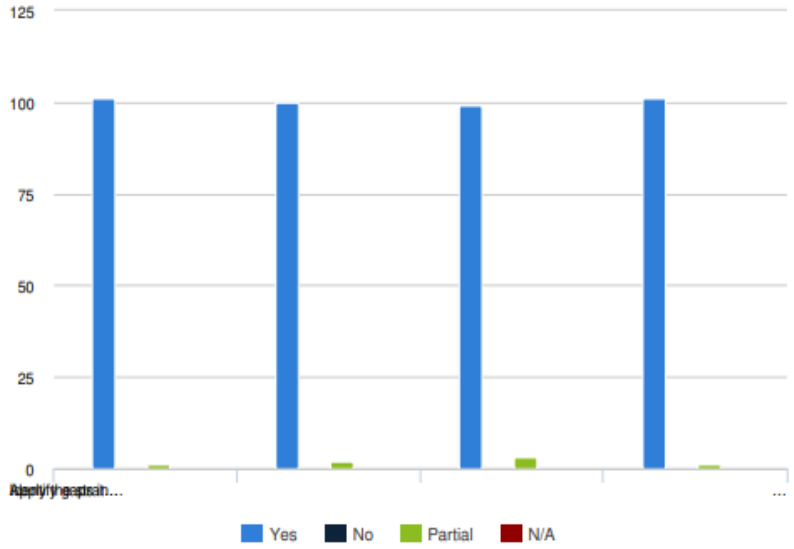
T1DX-QI 2023 November Learning Session Evaluation

Claim Your CME Credit

Reminder, if you have not yet claimed your CME credit from the November Learning Session, use this link!

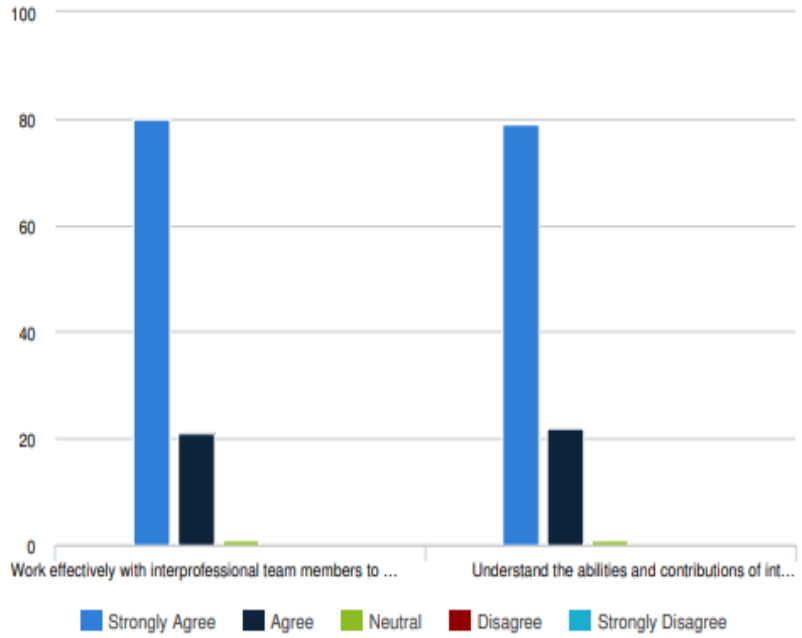
Evaluation Results

Learning Objectives



	Yes	No	Partial	N/A
Describe the future of novel therapies, interventions, quality improvements, and solutions to today's diabetes care challenges.	101	0	1	0
Identify gaps in population health needs and state 3 ways that they can provide more equitable care over the next 2 years.	100	0	2	0
Apply the strategies of the T1DX-QI Equity Framework which can help to improve diabetes health outcomes and increase diabetes device access for BIPOC T1D and T2D patients.	99	0	3	0
Discuss expectations for patient care and patient engagement and describe ways to co-design care with patients and family members.	101	0	1	0

After this activity, I am better able to



	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Work effectively with interprofessional team members to enhance care	80	21	1	0	0
Understand the abilities and contributions of interprofessional team members	79	22	1	0	0

What You Liked Most

- Breakout Sessions
- Wide Range of Topics
- Collaboration with Other Centers
- In Person and Virtual Options
- Emphasis of Sharing
- Networking
- Shared Success
- Panel Discussions
- PWD Talk and Perspective
- Partnering with Other Who Share the Same Passions
- EVERYTHING!

What You Want to See in the Future

- Future Technologies Coming Down the Pipeline
- Global Outreach to Middle Income Countries
- Diabetes Education
- EMR Integration
- More Time for Group Discussions
- T2D Presentations and Learning
- History of Diabetes
- AID
- Psychosocial and SDOH
- Including Voice of PWD