T1D Exchange

Clinical Leadership Committee

9/27/2024

Agenda:

- Welcome and Introductions (Carla Demeterco-Berggren, MD, PhD and Francesco Vendrame, MD, PhD)
- Member Website questions
  - Grace Nelson, MD
  - Allison Smego, MD
- T1DX-QI Learning Session Agenda
  - Review Agenda
- ADEPT
  - Review Agenda
- 2024 Annual Center Survey
- Clinical Perspectives for the Committee
  - Review of 2025 Measures and KDD

T1D Exchange

Member Website Questions

Question:

What platform(s) are people using for device downloads these days. Do they integrate to EMR? With all the cloud based services for pumps the need for these are fewer, but not 0 at this time. Also if it pulls into EMR that would be cool.

Name: Grace Nelson, MD

Question:

We are curious if other institutions are using concentrated insulin in insulin pumps. And if so, do you have an resources for the team/patients/families to minimize the risk for dosing errors.

Name: Allison Smego, MD

T1D Exchange

November Learning Session Agenda

NOV 11th		
7:00 – 8:00 AM 8:00 – 8:10 AM	Breakfast Welcome and Logistics and thank you, Nicole Rioles, MA	5th Fl Chicago Ballroom
8:10-8:40 AM	Introduction and Welcome by Chicago, IL PIs Clinical Leadership Co-Chairs (Francesco Vendrame, MD, PhD and Carla Demeterco-Berggren, MD, PhD) Grazia Aleppo, MD Naomi Fogel, MD and Laura Levin, DO Diabetes Care in Chicago	5th Fl Chicago Ballroom
8:40-8:55 AM	Opening Remarks from T1D Exchange Dave Walton, MBA	5th Fl Chicago Ballroom
9:00-9:20 AM	State of the Collaborative Osagie Ebekozien, MD, MPH, CPHQ	5th Fl Chicago Ballroom
9:20-10:05 AM	Keynote, Louis Philipson, MD, PhD, University of Chicago Early-Stage Diabetes Diagnosis and Treatment	5th Fl Chicago Ballroom
10:05-10:50	Leading Sustainable Improvements: Being a Leader in your team Moderated by: Manmohan Kamboj	5th Fl Chicago Ballroom

10:50-11:05 PM	Break	
11:10 – 12:30 PM	Breakout 1	
12:30-1:30 PM	Lunch and People with Diabetes Perspectives Facilitated by: Jeniece Ilkowitz and Emily Coppedge Lakeesha McDonald-Kee Kobe Kee Sydnee McDonald	5th Fl Chicago Ballroom
1:30-2:20	Poster Sessions and Networking	5th Fl Chicago Ballroom
2:30-3:50 PM	Breakout 2	
4:00 – 4:45 PM	Panel Discussion Embracing IT, EHR and Data Integration	5th Fl Chicago Ballroom
4:45-5:10 PM	Updates from MannKind Grazia Aleppo, MD	5th Fl Chicago Ballroom
5:10-5:15	Closeout Nicole Rioles, MA	5th Fl Chicago Ballroom

Breakout 1 11:10-12:30PM

Diabetes Distress

Moderated by

Pediatrics

Jill Weissberg-Benchell, PhD, CDCES

Adult

Ryan Tweet, PSyD

Plenary (Ballroom)

Implementing Successful Programs

Moderated by Sarah Lyons

Room 1 (A-C)

Moving on Up: Employing a Mobile Care Center to Enhance Access to Care for Youth with Type 1 Diabetes: Gajanthan Muthuvel

Design and Launch of First Pediatric Specialty Value Based Program for T1D Patients: Luke Harris

Implementation of Type 1 Diabetes Transition Clinic and Visit Checklist: Jordan Ross

Implementing High-Risk Programs at Four Pediatric Endocrinology Clinics in the T1D Exchange QI Collaborative: Ori Odugbesan

Diabetes Devices

Moderated by: Ryan McDonough

Room 2 (F-H)

Increasing continuous glucose monitoring (CGM) utilization in pediatric type 1 diabetes (T1D) patients with hemoglobin A1c values ≥ 8.5%: Patrick Hanley

Standardizing Insulin Pump Back-Up Plans: Improving Documentation and Patient Confidence Through Quality Improvement: Kai Jones

Optimizing Automated Insulin Delivery System use in Youth with Recent Onset T1D: Mili Vakharia

Improving Continuous Glucose Monitors Prescribing Behaviors in Primary Care: Jovan Milosavljevic

Reducing Disparities and Promoting Equitable Care

Moderated by: Nirali Shah

Room 3 (Denver-KC)

BRIDGE (Barrier Reduction in Insulin Delivery for Greater Equity) Project: Increasing Insulin Pump Use in Youth with Type 1 Diabetes with a Language of Care Other than English: Samantha Goldklang

Reducing Disparities in Continuous Glucose Monitor Adoption and Use Among Children and Adolescents with Type 1 Diabetes: Ashley Garrity

CDCES Clinical Workflows Can Address Challenges and Barriers to Equitable Care in New Onset T1D: Jeanine Leverenz

ConnecT1D Data Visualization: Informing Interventions and Equitable Improvement in Outcomes for Type 1 Diabetes (T1D) Patients: Amanda Howell

Age Related Diabetes Milestone

Moderated by: Elizabeth Mann

Room 4 (LA-Scottsdale)

Ongoing Efforts for Increasing Retinopathy Screening at a Pediatric Diabetes Center: Jeniece Ilkowitz

Age-appropriate Self-management of Type 1 Diabetes: Claire Moore

Diabetes Autonomy Milestones: Educator and Family Expectations: Jessica Schmitt

Improving Microalbuminuria Screening Rates Among Pediatric Diabetes Patients: A Clinic-Wide Initiative: Sarah Lydia Holly

Breakout 2 2:30-3:50PM

Insights on New Education Tools

Moderated by: Todd Alonso

Plenary (Ballroom)

Standardizing Inpatient Nursing Diabetes Education: Elizabeth Gunckle

New QI Tools and Methods: Don Buckingham

T1DX-QI Screening and Monitoring Efforts: Emma Ospelt

Best Practice Advisory Insights: Trevon Wright

SDOH and Depression Screening

Moderated by: Roberto Izquierdo

Room 1 (A-C)

Increasing Screening for Social Drivers of Health in Pediatric Diabetes: Barbara Liepman

Full-Scale Launch of Eating Disorder Screening at a Large Pediatric Diabetes Clinic: Claire Zimmerman

Improving Depression Screening Rates among Adolescents with Type 1 Diabetes using Limited Clinical Resources: Samantha Jimenez

Addressing Disparities in Diabetes Care: Implementing SDOH Screening at Diagnosis: Sarah Lydia Holly

Transitions of Care

Moderated by: Stephanie Crossen

Room 2 (F-H)

Y'all READDY for This?: Embedding Transition Readiness Screening Across Sites in a Pediatric Diabetes Practice: Andrew Lavik

STRIDE Project: Supporting Transition Readiness in Diabetes Education: Sarah Rosenheck

Transition of Care of T1D Pediatric Population to Adult Services: Angela Mojica

Assessing Readiness to Transition to Adult Care among Young Adults with T1D: Jody Beth Grundman

Type 2 Diabetes

Moderated by Francesco Vendrame

Room 3 (Denver-KC)

Improving Prescribing Rates of GLP1 Receptor Agonists (GLP1- RA) in Youth with Type 2 Diabetes: Yasi Mohsenian

Use of Non-Insulin Medications in Youth with T2D: Mili Vakharia

Developing a Tracking Tool for Insulin Pump Prescriptions Among Children and Adolescents with Type 1 & Type 2 Diabetes: Amanda Perkins

Increasing Lipid Profile Screening in Youth with Type 2 Diabetes: Puja Singh

Positive Interventions for High Risk Populations

Moderated by: Halis Akturk

Room 4 (LA-Scottsdale)

Implementation of the ASQ suicide risk screening in routine pediatric diabetes care: Risa Wolf

Family Centered Team Meetings for People with HbA1c >9% for >12 months: Jeniece Ilkowitz

Insulin Cost and Rationing in the Pediatric Type 1 Diabetes Population: Lauren Waterman

ConnecT1D: Proactive Outreach Intervention to Improve Equitable Care for Youth with Type 1 Diabetes: Jennifer Kelly

ADEPT Agenda

Day 1: November 12, 2024

7:00 – 8:30 AM	**Breakfast**	
8:30 –8:45 AM	**Opening Remarks** Charles (Chuck) Henderson, American Diabetes Association	
8:45 – 9:00 AM	Dave Walton, T1D Exchange	
9:00-10:15 AM	**Panel Discussion: Achieving Diabetes Equity; Are we there yet?** Facilitated by Dr. Osagie Ebekozien Potential Panelists: Terri Wiggins, SVP, Health Equity, ADA James Gavin, MD, MPH Monica Peek, MD, MPH Bryan Buckley, DrPH	
10:15-10:30 AM	**Break**	
	Breakout Session 1	
	Track 1 Moderator: Juan Espinoza, MD	Track 2 Moderator: Grazia Aleppo, MD
10:35-10:55 AM	Topic: Using QI methodology to improve equity Speaker: Dr. Grace Nelson	Topic: Supporting underserved patients with T2D Speaker: Dr Sonya Haw
10:55-11:15 AM	Topic: Incorporating health equity into routine improvement efforts. Speaker: Dr. Nana-Hawa Yayah Jones	Topic: Addressing stigma in diabetes and obesity Speaker: Matthew Garza
11:15-11:35 AM	Topic: Improving Equity in T1D Technology Speaker: Dr. Ananta Addala	Topic: Supporting children with diabetes and obesity Speaker: Stephanie Sisley
11:35-11:55 AM	Topic: Improving racial-ethnic equity of CGM uptake in pediatric patients Speaker: Dr. Kajal Gandhi	Topic: ADA Addressing inequities in diabetes obesity Speaker: Dr. Ihuoma Eneli
12:00-1:00 PM	**Lunch and Networking; Meet our Sponsors**	

	Breakout Session 2	
	Track 1 Moderator: Margarita Ochoa Maya, MD	Track 2 Moderator: Manmohan Kamboj, MD
1:05-1:25 PM	Topic: Kyler Cares Kyle Banks	Topic: Screening for social determinants of health in adults with diabetes Speaker: Dr. Ruth Weinstock
1:25-1:45 PM	Topic: Advancing Equity in a Large Urban Center Speaker: Dr. Selorm Dei-Tutu	Topic: T1DX-QI Portal Ann Mugnmode and Holly Hardison
1:45-2:05 PM	Topic: Using "TechQuity" to reduce inequities in glycemic outcomes in children with T1D Speaker: Dr. Jenise Wong	Topic: Grandmothers to the Rescue - Healthy Outcomes through Peer Educators (HOPE) Speaker: Dr. Eva M. Vivian
2:05-2:25 PM	Topic: Commercial Insurance Coverage and Diabetes Care Access Speaker: Christine Monahan	Topic: Diabetes Prevention in the Hispanic Community Speaker: Dr. Tainayah Whitney Thomas
2:30-3:30 PM	**Insights from Industry Partners** Facilitator: Terri Wiggins, SVP, Health Equity, ADA Vertex: Eli Lilly:	
3:30-3:45 PM	**Break**	
3:45-4:45 PM	**Screening and Prevention of Diabetes Panel** Facilitator: Carla Demeterco-Berggren, MD, PhD Breakthrough T1D- Anastasia Albanese O'Neil, PhD, APRN, CDCES Ralph Ruggiero, MD Shideh Majidi, MD	
4:45-6:00 PM	**Networking** Light refreshments to be served	

ADEPT Agenda

Time	Session	
7:30 – 8:30 AM	**Breakfast**	
8:30-9:30 AM	**Keynote** **Learning from our past and advancing towards the future**	
	Breakout Session 3- 15-minute presentations followed by 5 minutes of Q&A and then at the end of the session, 10 minutes for panel discussion	
	Track 1 Moderator: Viral Shah, MD	Track 2 Moderator: Shideh Majidi, MD, MSCS
9:35-9:55 AM	Topic: The role of community-based organizations (CBOs) in advancing health and wellness Speaker: Brandon Cleveland, Executive Director	Topic: Using digital health to support health equity in diabetes Speaker: Bola Bukoye
9:55-10:15 AM	Topic: Implementing and sustaining QI projects to address T1D health equity Speaker: Dr. Shivani Agarwal	Topic: Advancements in digital health equity Dr. David Kerr
10:15-10:35 AM	Topic: Achieving equity for Hispanic patients with T1D Dr. Janine Sanchez	Topic: Digital Health Inequities and Diabetes in Pregnancy Speaker: Dr. Farnoosh Farrohki
10:35-10:55 AM	Topic: Supporting Health Equity Infrastructure Speaker: Dr. Carla Demeterco-Berggren	Topic: Project ECHO as a model to increase access to specialist Care Speaker: Dr. Ashly Walker
11:00-12:00 PM	Topic: Psychosocial Care and Diabetes Panel Facilitator: Jenise Wong, MD Michael Harris, PhD	
12:00-12:30 PM	Topic: Equity Starts and Ends with Community Dr. Joshua Jospeh	
12:30-12:45 PM	Topic: Conference Closeout and Evaluation Dr. Osagie Ebekozien	

T1D Exchange

2024 Annual Center Survey

The 2024 Annual Center survey is now live. The PDF of the survey and link was shared with the PI's and coordinators for each center.

Thank you for participating in the 2024 T1DX-QI Center Practice Survey. Please have one individual fill out this survey for your center. It should take no longer than 25 minutes to complete.

Name of Center:

Name and email of person completing report:

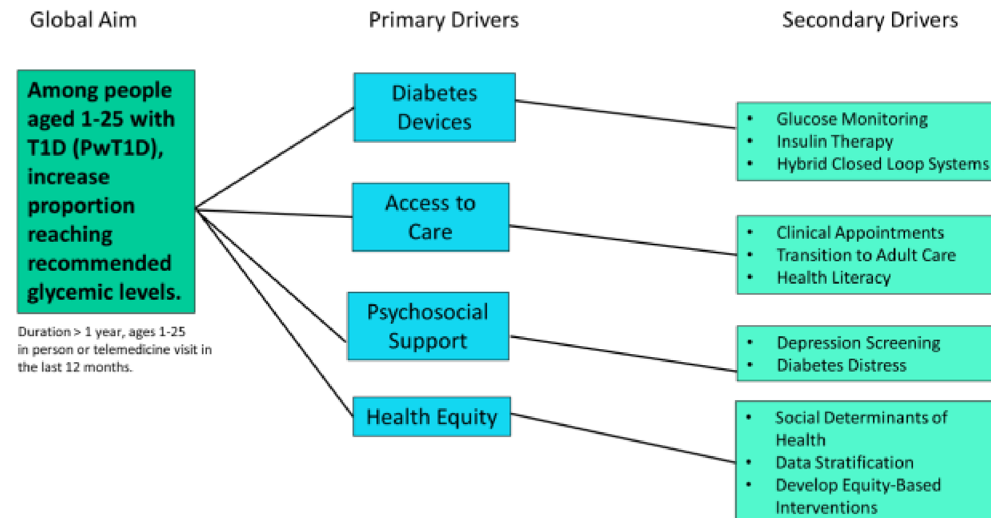
Please use this link or scan the QR code to submit no later than Friday October 18th.

Pediatric KDD and Measures

Aim Statement for 2023-2025
Among people aged 1-25 with T1D (PwT1D), increase proportion reaching recommended glycemic levels.

1. Optimize glycemic outcomes as measured by HbA1C.
   a. Increase % of people with HbA1c <7 by 5%.
   b. Decrease % of people with HbA1c >9 by 5%.
2. Optimize glycemic outcomes as measured by TIR.
   a) Increase % of people with Time in Range >70% by 5%.
   b) Increase % of people with Time in Range >50% by 10%.
   c) Decease % of people with Time below Range (<70 mmol/dL) <4% by 5%.

Key Driver Diagram



Pediatric KDD and Measures

Numerator:

1. HbA1c
   a. Number of PwT1D in (A) with HbA1c <7 (Most recent HbA1c)
   b. Number of PwT1D in (A) with HbA1c >9 (Most recent HbA1c)
   c. Median HbA1c for all PwT1D
2. Continuous Glucose Monitor (CGM)[2]:
   a. Number of PwT1D in (A) using CGM
   b. Number of PwT1D in (A) using CGM at using at least 14 days 70% of the time in the reporting month
   c. Number of PwT1D in (3) with Time in Range (70-180 mg/dL) >50%
   d. Number of PwT1D in (3) with Time in Range (70-180 mg/dL) >70%
   e. Number of PwT1D in (3) with Time below Range (less than 70 mg/dL) <4%
3. Insulin Delivery: The number in (A) with evidence of:
   a. Insulin delivery system use including:
      i. Pumps
      ii. Open Loop
      iii. Closed loop/AID/HCL
   b. AID/HCL
   c. Smart or Connected Pen use
4. Depression Screening
   a. Number in A (12 years and older) who have not had depression screening in the last 12 months.
   b. Number in (5a) who have been screened for depression (PHQ-2, 4, 8or 9)
   c. Number in (5b) that screened positive for depression (PHQ8/PHQ-9 score above 10)
   d. Number in (5c) that received a behavioral health referral.
   e. Number in (5d) who received referral and kept their behavioral health visit.
5. Diabetes Ketoacidosis (DKA)[4] Hospitalization: -Number in (A) with at least one DKA hospitalization in the last 12 months.
6. Severe Hypoglycemia (SHE) Hospitalization: Number of patients A) with at least one SHE hospitalization in the last 12 months.
7. Transition plan
   a. Number of patients in (A) age 16 and older
   b. Number of patients in (6a) with the documented transition plan in the last 12 months
8. Social Determinant of Health Screening
   a. Food Insecurity: Number in (A) asked at least one of the questions below or similar questions.
      1. Within the past 12 months we worried whether our food would run out before we got money to buy more."
      2. Within the past 12 months the food we bought just didn't last and we didn't have money to get more."
         i. Number in (6a) who answered Yes to 6a 1 or 2.
         ii. Number in (6ai) who received a referral for food resources

Jan 1, 2023-Dec 31, 2025, T1DX-QI Pediatric Quality Improvement Measures

Optional Measures. These elective measures should only be done after completing Measures 1-8

9. Economics
   a. Number in A who have been screened for financial needs: How hard is it for you to pay for the very basics like food, housing, medical care, and heating? [Sample Responses: Very hard, Hard, somewhat hard, not very hard, Not hard at all, Patient refused, Not asked]
   b. The number in A for the reporting month who have been screenedfor medication affordability. Are you able to afford your medication?
      i. Yes; 2. No
10. Transportation
    a. Number of A who have been screened for transportation needs. Inthe past 12 months, has lack of transportation kept you from medical appointments or from getting medication?
       i. Yes; 2. No
    b. In the past 12 months, has lack of transportation kept you from meetings, work orfrom getting things needed for daily life?
       i. Yes; 2. No

T1D Exchange

Pediatric KDD and Measures

11. Housing
    a. Number of (A) for the reporting month who have been screened forhousing needs. What is your housing situation today?
        i. I have a steady place to live
        ii. I have a stead place to live today, but I am worried about it in the future
        iii. I do not have a steady place to live (I am temporarily staying with others,in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
        iv. Unknown
    b. In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?
        i. Yes 2. No
12. Tobacco The number (A) seen in the reporting month who have been screened for tobacco use in the past year.
        i. Never, ii. Current (within past month); iii. Past (ever); iv. Tried once
13. Number in (A) seen in the reporting month who have been screened for distress in the past year. Do you feel stressed – tense, restless, nervous, or anxious, or unable to sleep at night because your mind is troubled all the time – these days?
        i. Not at all; ii Only a little; iii to some extent; iv Rather much; v Very much
14. Number in (A) seen in the reporting month who have been screened for isolation in the past year. Social: how often do you feel isolated from others?
        i. Never, ii Rarely; iii Sometimes; iv Often; v Always

Health Equity Measures:

15. Number in (A) with at least one in person or virtual visit in the reporting month.
    a. Number in (15A) by race and ethnicity.
        1. NH White
        2. NH Black
        3. Hispanic

        1. Asian
        2. Other
        3. Not Reported
    b. Number in (15A) by insurance type.
        1. Public
        2. Private
        3. Uninsured
        4. Other
16. Number in (A) who reported using insulin pump during the reporting month.
    a. Number in (16A) by race and ethnicity.
        1. NH White
        2. NH Black
        3. Hispanic
        4. Asian
        5. Other
        i. Not Reported
    b. Number in (16A) by insurance type.
        1. Public
        2. Private
        3. Uninsured
        4. Other

T1D Exchange

Pediatric KDD and Measures

17. Number in (A) who were not on pump previously, were prescribed insulin pump in the reporting month.
    a. Number (17A) by race and ethnicity.
        1. NH White
        2. NH Black
        3. Hispanic
        4. Asian
        5. Other
        6. Not Reported
    b. Number in (17A) by insurance type
        1. Public
        2. Private
        3. Uninsured
        4. Other

Screening and Monitoring:

18. Number in (A) wo have been screened for T1D antibodies.
19. Number in (A) that have been screened and confirmed positive for antibodies (GAD65, Anti-IA2, Tyrosine Phosphatases IAS and IA 2β, ZNT8)
    a. Number in (19A) confirmed for single autoantibody.
    b. Number in (19A) confirmed for multiple antibodies.

20. Number in (A) who have multiple islet autoantibodies, normal blood glucose.
21. Number in A who have multiple islet autoantibodies, abnormal glucose tolerance OR HbA1c 5.7-6.4%
    a. Number in (21A) offered Teplizumab prescription.
22. Number in (20A and 21A) with a scheduled endocrinologist.
23. Number of individuals in (A) monitored for T1D diagnosis in last 12 months who have a DKA in

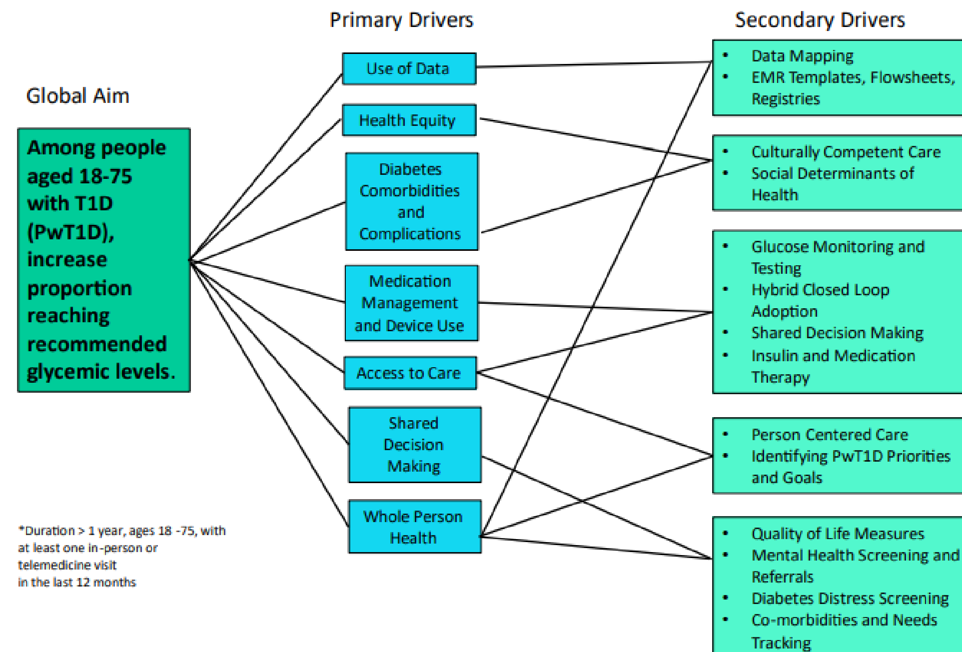
Adult KDD and Measures

Aim Statement for 2023-2025

Among people aged 18-75 with T1D (PwT1D), increase proportion reaching recommended glycemic levels.

1. Optimize glycemic outcomes as measured by HbA1c.
   a. Increase % of people with HbA1c <8 by 5%.
   b. Decrease % of people with HbA1c >9 by 5%.
   c. Reduce Median HbA1c by 5%
2. Optimize glycemic outcomes as measured by TIR.
   a. Increase % of people with Time in Range >70% by 5%.
   b. Increase % people with Time in Range >50% by 10%.
   c. Decrease % people with Time Below Range (<70mg/dL) by 5%

Key Driver Diagram



T1D Exchange

Adult KDD and Measures

Denominator (A): People with type 1 diabetes[1] (ages 18-75) with a minimum duration of diabetes ≥ 12 mths with at least 1 HbA1c in the preceding 12 months, and a diabetes related visit (in person or virtual) in the reporting month.

Numerators:

1. HbA1c
   a. Number of PwT1D in (A) with HbA1c <8% (Most recent HbA1c)
   b. Number of PwT1D in (A) with HbA1c >9% (Most recent HbA1c)
   c. Median HbA1c value for all PwT1D
2. Continuous Glucose Monitor (CGM)[2] Use: Number in (A) using CGM for atleast 14 days, 70% of the time in the reporting month.
3. Ambulatory Glucose Profile (AGP): Number of patients in (2) with:
   a. Time in Range (70-180 mg/dL) >50%
   b. Time in Range (70-180 mg/dL) >70%
   c. Time in Hypoglycemia (<70 mg/dL) <4%
   d. Time in Severe Hypoglycemia (<54 mg/dL) < 1%
4. Insulin Delivery: The number in (A) with evidence of:
   a. Insulin delivery system use including:
      1. Pumps
      2. Open Loop
      3. Closed loop/AID/HCL
   b. AID/HCL
   c. Smart or Connected Pen use
5. Depression Screening
   a. Number in A who have been screened for depression (PHQ-2, 4, 8or 9) in the last 12 months.
   b. Number in (5a) that screened positive for depression (PHQ8/PHQ-9 scoreabove 10)
   c. Number in (5b) that received a behavioral health referral.
   d. Number in (5c) who received referral and kept their behavioral health visit.
6. Social Determinant of Health Screening
   a. Food Insecurity: Number in (A) asked at least one of the questions below orsimilar questions.
      1. Within the past 12 months we worried whether our food would run out before we got money to buy more."
      2. Within the past 12 months the food we bought just didn't last and we didn't have money to get more."
   i. Number in (6a) who answered Yes to 6a 1 or 2.
   ii. Number in (6a i) who received a referral for food resources.

ii. Number in (6a i) who received a referral for food resources.

7. Diabetes Ketoacidosis (DKA)[4] Hospitalization: -Number in (A) with at least one DKA hospitalization in the last 12 months.
8. Severe Hypoglycemia (SHE) Hospitalization: - Number of patients A) with at least one SHE hospitalization in the last 12 months.

Optional Measures. These elective measures should only be done after completing measures 1-8

9. Economics
   a. Number in A who have been screened for financial needs: How hard is it for you to pay for the very

basics like food, housing, medical care, and heating? [Sample Responses: Very hard, Hard, somewhat hard, not very hard, not hard at all, Patient refused, Not asked]
   b. The number in A for the reporting month who have been screenedfor medication affordability. Are you able to afford your medication?
      1. Yes; 2. No
10. Transportation
   a. Number of A who have been screened for transportation needs. Inthe past 12 months, has lack of transportation kept you from medical appointments or from getting medication?
      1. Yes; 2. No
   b. In the past 12 months, has lack of transportation kept you from meetings, work orfrom getting things needed for daily life?
      1. Yes; 2. No
11. Housing

Adult KDD and Measures

11. Housing
    a. Number of (A) for the reporting month who have been screened forhousing needs. What is your housing situation today?
        1. I have a steady place to live
        2. I have a stead place to live today, but I am worried about it in the future
        3. I do not have a steady place to live (I am temporarily staying with others,in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
        4. Unknown
    b. In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?
        1. Yes 2. No
12. Foot Exam: Number of patients in (A) who received a foot exam (visual inspection with either a sensory exam or pulse exam) in the last 12 months.
13. Eye Exam: Number of patients in (A) who received a retinal or dilated eye exam during the measurement year or a negative retinal or dilated eye exam in last 12 months.
14. Missing Appointments: Number of patients in (A) who have not been seen within the last 180 days based on days between visits and care.
15. Angiotensin-Converting Enzyme) Inhibitors and Angiotensin Receptor Blockers (ACE-I/ARB) prescription
    a. Number of patients in (A) with a diagnosis of hypertension or blood pressure <140/90 mmHg
    a. Number of patients in (12a) who prescribed ACE-I or ARBs in the measurement year are
16. Statin prescription
    a. Number of patients in (A) with hyperlipidemia or an LDL >130 mg/dL
    b. Number of patients in (13a) who are prescribed a statin for cholesterol in the last 12 months.
17. Tobacco The number (A) seen in the reporting month who have been screened fortobacco use in the past year.
    i. Never; ii. Current (within past month); iii. Past (ever); iv. Tried once.

18. Number in (A) seen in the reporting month who have been screened for distress in thepast year. Do you feel stressed – tense, restless, nervous, or anxious, or unable to sleep at night because

your mind is troubled all the time – these days?
    i. Not at all; ii Only a little; iii to some extent; iv Rather much; v Very much
19. Number in (A) seen in the reporting month who have been screened for isolation in thepast year. Social: how often do you feel isolated from others?
    1. Never, ii Rarely; iii Sometimes; iv Often; v Always

Health Equity Measures:

20. Number in (A) with at least one in person or virtual visit in the reporting month.
    a. Number in (20A) by race and ethnicity.
        1. NH White
        1. NH Black
        2. Hispanic
        3. Asian
        4. Other
        5. Not Reported
    b. Number in (20A) by insurance type.
        1. Public
        2. Private
        3. Uninsured
        4. Other

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Adult KDD and Measures

4. Other

21. Number in (A) who reported using insulin pump during the reporting month.
    a. Number in (21A) by race and ethnicity.
        1. NH White
        2. NH Black
        3. Hispanic
        4. Asian
        5. Other
        6. Not Reported
    b. Number in (21A) by insurance type.
        1. Public
        2. Private
        3. Uninsured
        4. Other
22. Number in (A) who were not on pump previously, were prescribed insulin pump in the reporting month.
    a. Number (22A) by race and ethnicity.
        1. NH White
        2. NH Black
        3. Hispanic
        4. Asian
        5. Other

        6. Not Reported
    b. Number in (22A) by insurance type.
        1. Public
        2. Private
        3. Uninsured
        4. Other

T1D Exchange