T1D Exchange

Adult Collaborative Call

January 28, 2025

Agenda

- Updates from T1DX-QI Coordinating Center, Osagie Ebekozien, MD, MPH and Nicole Rioles, MA

- Center Presentations
  - WASHU, Kai Jones, MD and Cynthia Herrick, MD
  - Grady Memorial, Georgia Davis, MD
  - Boston Medical Center, Kathryn Fantasia, MD

2024 Invoicing

For your Statements of Work with T1D Exchange, all invoices for deliverables completed on or before December 31, 2024, must be invoiced on or before 5pm EST March 1, 2025. Please work with your finance teams to ensure that we receive your invoices as we will be unable to process past due invoices for Calendar year 2024 after 3/7/2025.

Invoice for payment following the deliverables schedule in 1.C and/or 1.D and include deliverable number and date. All payments will be made through electronic funds transfer (EFT). Please include your banking information on invoice.

1. *Bank account name & address*
2. *Bank account number*
3. *Bank account routing number*

Invoices should be sent via email attachment.

To: t1dxap@t1dexchange.org

CC: nrioles@t1dexchange.org

linda.crasco@t1dexchange.org

rweathers@t1dexchange.org

Kindly forward this reminder to your finance contacts so that they are aware of the deadline.

Thank you!

Thank you for a wonderful journey together over the past 7 years. I truly appreciate each and everyone of you who have made my time at T1D Exchange so memorable!

Please stay connected via LinkedIn (1) Osagie Ebekozien MD, MPH | LinkedIn or email Osagie.ebeks@gmail.com


University
of Colorado
Anschutz
Medical
Campus


UChicago
Medicine
SPEAKER
2024 ADEPT
CONFERENCE


Rady
Children's


HYATT


CRUNCH
FITNESS


HYATT

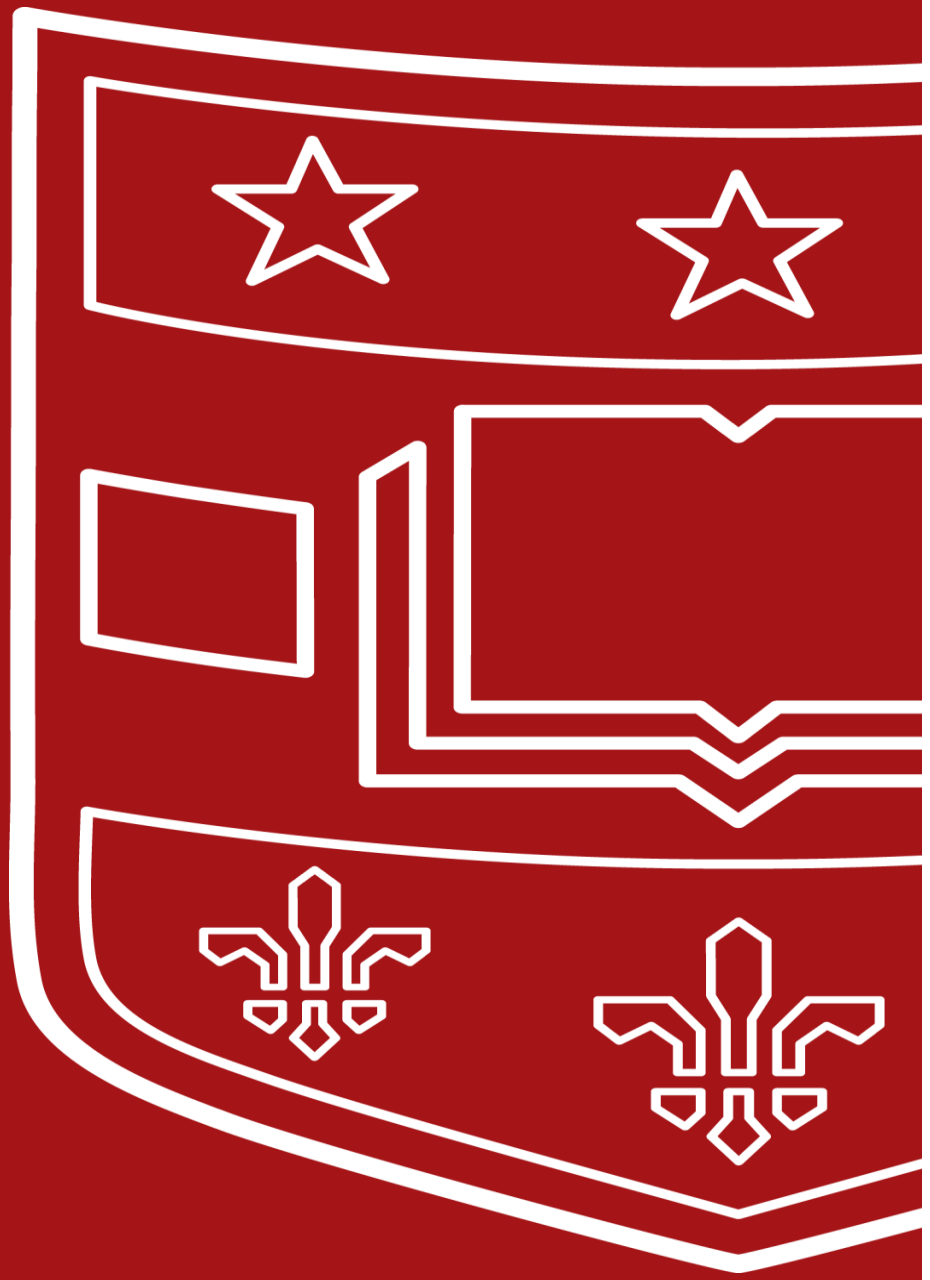

BOSTON UNIVERSITY SCHOOL OF MEDICINE


HYATT

Center Presentation

Washington University in St. Louis

Kai E. Jones
Cynthia J. Herrick
Isabelle Reed – QI Champion



Washington University in St. Louis

Background

We aim to increase use of PHQ2 for screening for depression by 50% in the next 3 months.

Survey to Providers

- Staff in Diabetes Center
  - 2 NP
  - 1 PA
  - 17 MD
- 12 responses
  - 1 NP
  - 1 PA
  - 10 MD

Survey Results

- 100% - Strongly Agree/Somewhat Agree that Screening for Depression in Patients with DM is essential to providing care
- 50% - Never perform depression screenings

Survey Results

- 70% - Listed Time as a barrier for lack of screening
  - 20% - Not aware of appropriate screening method/documentation
- 70% - Extremely Comfortable/Somewhat Comfortable with pre appointment screenings

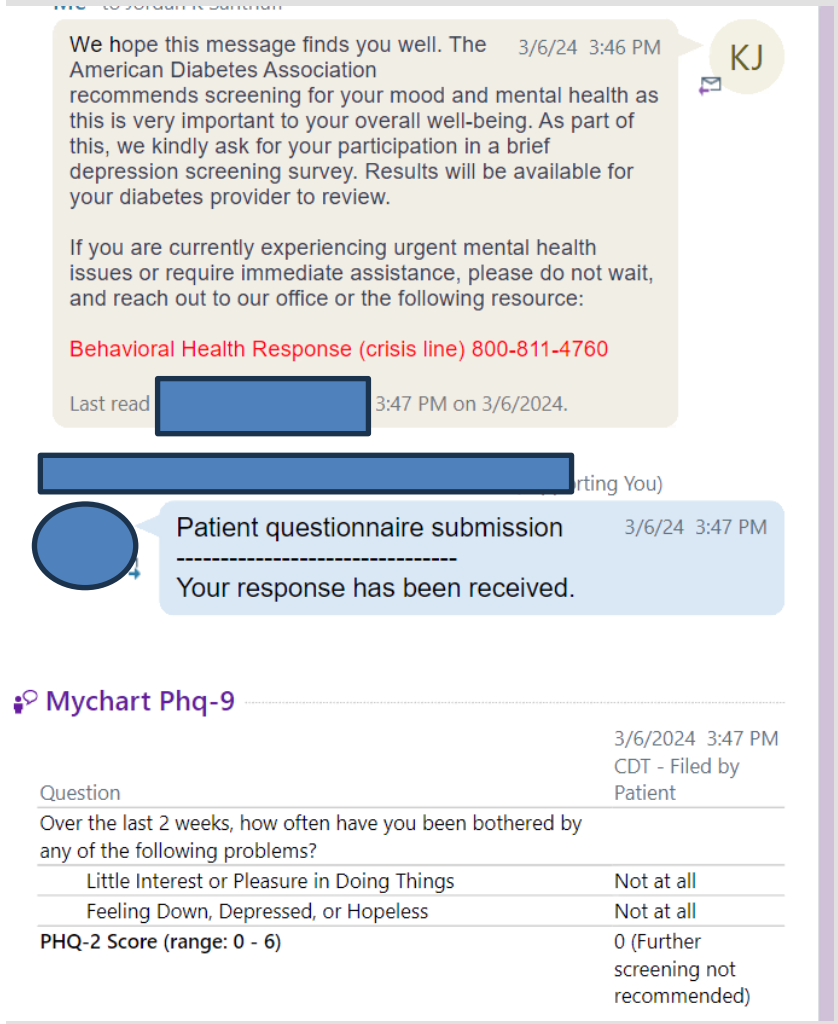
Survey Results

- 70% - Listed Time as a barrier for lack of screening
  - 20% - Not aware of appropriate screening method/documentation
- 70% - Extremely Comfortable/Somewhat Comfortable with pre appointment screenings
  - Those who were uncomfortable mentioned the following issues:
    - MyChart Screening is "impersonal"
    - Time/Method for follow-up of results
    - Next steps?

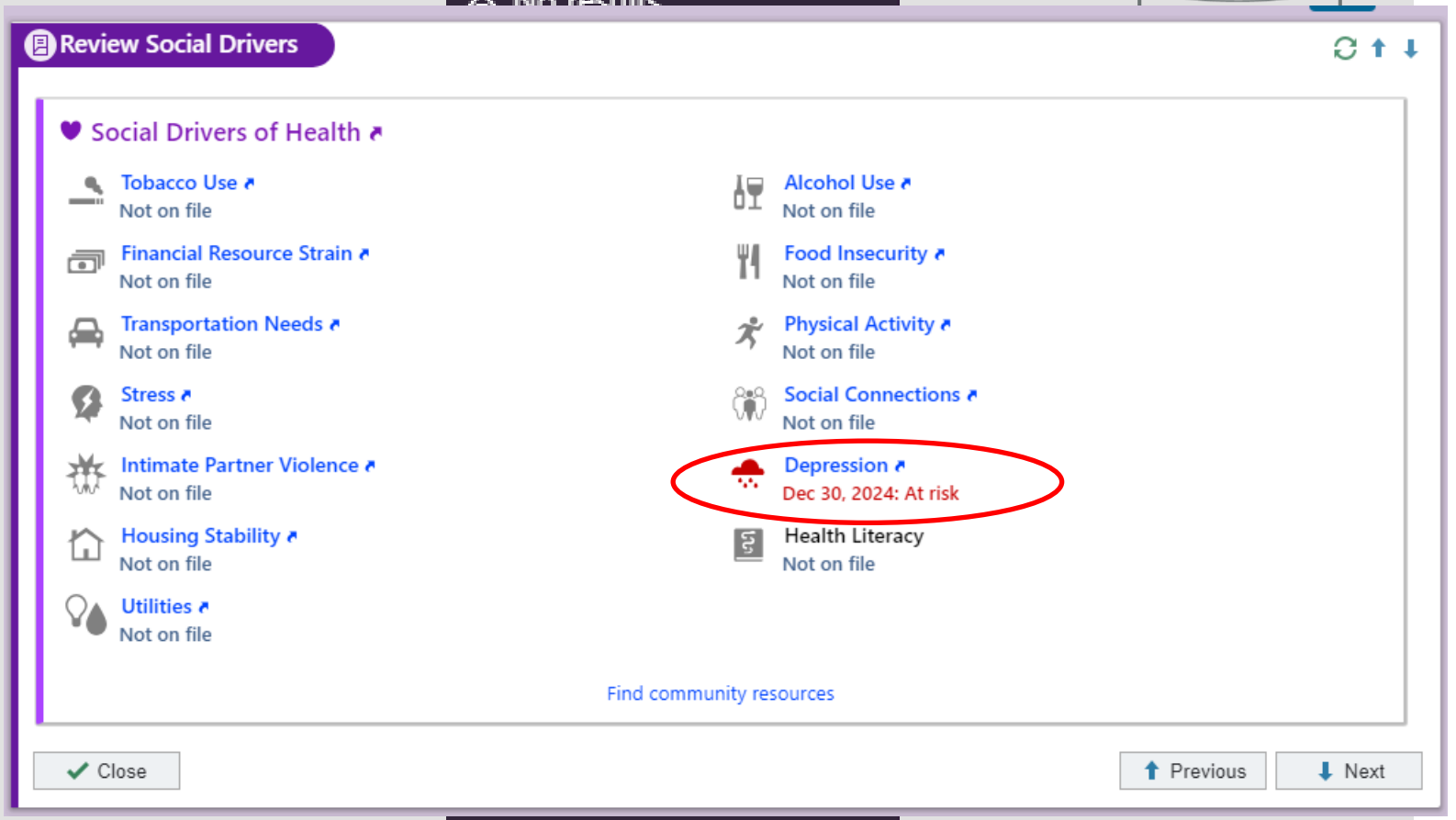
PDSA #1

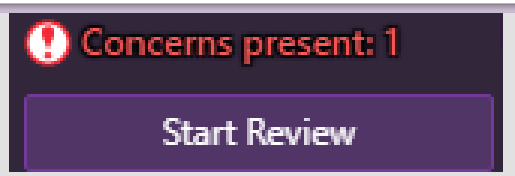
Initiate a prescreening process

Pre-appointment screening will not add additional burden or steps to the check-in process for our patients with diabetes.


We hope this message finds you well. The American Diabetes Association recommends screening for your mood and mental health as this is very important to your overall well-being. As part of this, we kindly ask for your participation in a brief depression screening survey. Results will be available for your diabetes provider to review.
3/6/24 3:46 PM
KJ
If you are currently experiencing urgent mental health issues or require immediate assistance, please do not wait, and reach out to our office or the following resource:
Behavioral Health Response (crisis line) 800-811-4760
Last read [redacted] 3:47 PM on 3/6/2024.
[redacted]
Patient questionnaire submission
3/6/24 3:47 PM
Your response has been received.
Mychart Phq-9
3/6/2024 3:47 PM CDT - Filed by Patient
Question
Over the last 2 weeks, how often have you been bothered by any of the following problems?
Little Interest or Pleasure in Doing Things
Not at all
Feeling Down, Depressed, or Hopeless
Not at all
PHQ-2 Score (range: 0 - 6)
0 (Further screening not recommended)


(2)
No results


Review Social Drivers
Social Drivers of Health
Tobacco Use
Not on file
Alcohol Use
Not on file
Financial Resource Strain
Not on file
Food Insecurity
Not on file
Transportation Needs
Not on file
Physical Activity
Not on file
Stress
Not on file
Social Connections
Not on file
Intimate Partner Violence
Not on file
Depression
Dec 30, 2024: At risk
Housing Stability
Not on file
Health Literacy
Not on file
Utilities
Not on file
Find community resources
Close
Previous
Next


Concerns present: 1
Start Review

PDSA #1

- One half day clinic for 3 months
  - 20 eligible patients with T1D – surveys sent
    - 14 were viewed by patients
  - 6/20 patient response to message – all negative
    - **2/6 – response was recorded but completed by a proxy**
  - 5 patients subsequently screened in clinic

PDSA #1

- One half day clinic for 3 months
  - 20 eligible patients with T1D – surveys sent
  - 6/20 patient response to message – all negative
    - **2/20 – response was recorded but completed by a proxy**
  - 5 patients subsequently screened in clinic

→

- Did not see those changes reflected in portal
- Discussion with IT regarding data capture
  - Able to update our mapping

PDSA #1- Reflections

- Depression data can be captured using pre-appointment surveys
  - Appropriately transmitted to the exchange
- Proxies can complete the survey

PDSA #2 – In person screening

- First week of January
- 6 Patients with T1D (only 5 eligible)
- 4 – Negative
- 1 – Intermediate
- 1 -- Positive screen

PDSA #2 – Reflections

- In person, screening with PHQ-2 was efficient
- Rarely positive
- If positive:
  - Provider needs resource list that is updated
  - Prescribing help

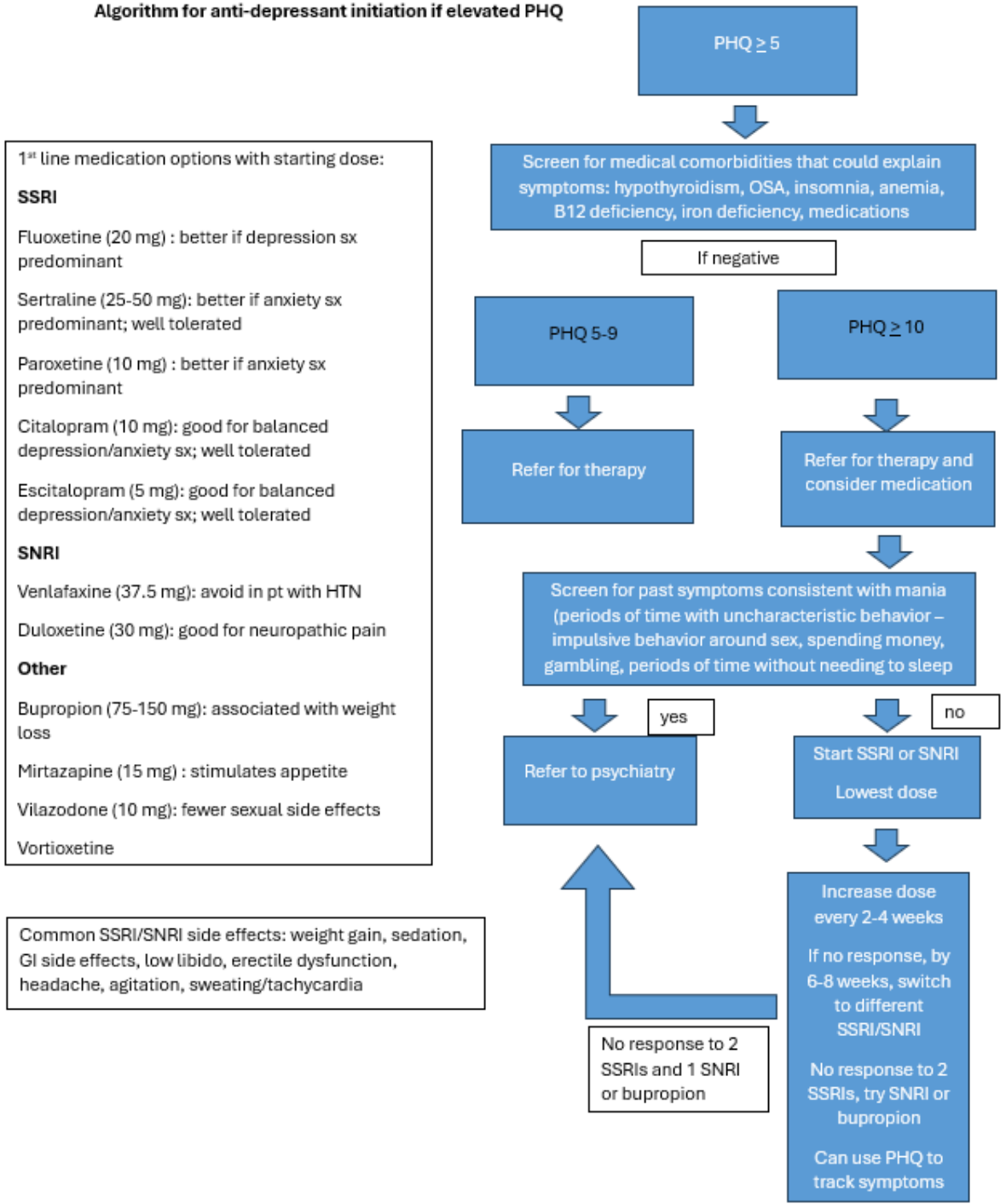
PDSA #3

- 20% of providers were not aware of appropriate screen
  - How to enter
- Concerns with screening included
  - Time
  - Next Steps:
    - Updating list of mental health providers – with insurance info
    - Updated urgent referral or treatment information
    - Education on interpreting results and SSRI prescribing

If PHQ-2 positive, then complete PHQ-9.

Follow flowchart

Algorithm for anti-depressant initiation if elevated PHQ



1st line medication options with starting dose:

SSRI

Fluoxetine (20 mg) : better if depression sx predominant

Sertraline (25-50 mg): better if anxiety sx predominant; well tolerated

Paroxetine (10 mg) : better if anxiety sx predominant

Citalopram (10 mg): good for balanced depression/anxiety sx; well tolerated

Escitalopram (5 mg): good for balanced depression/anxiety sx; well tolerated

SNRI

Venlafaxine (37.5 mg): avoid in pt with HTN

Duloxetine (30 mg): good for neuropathic pain

Other

Bupropion (75-150 mg): associated with weight loss

Mirtazapine (15 mg) : stimulates appetite

Vilazodone (10 mg): fewer sexual side effects

Vortioxetine

Common SSRI/SNRI side effects: weight gain, sedation, GI side effects, low libido, erectile dysfunction, headache, agitation, sweating/tachycardia

Next Steps

- Resource for how to enter screening
  - Video
- Outpatient Task Force Meeting Time

Thank You

Center Presentation

GRADY MEMORIAL HOSPITAL

January 2025 | Adult QI Collaborative Update

Clinic, QI & Research Team

Georgia M. Davis, MD
Associate Professor of Medicine

Francisco J. Pasquel, MD, MPH
Associate Professor of Medicine

Alisha Virani, MS, RD, CDCES, LD
Clinical Dietician Lead
Grady Health System

Kristi Quairoli, PharmD, BCACP, CDCES
Clinical Pharmacist Specialist
Grady Health System

LeChe Williams, CPhT
Patient Navigator

Rohit Parab, MD
Post Doctoral Fellow

Laya Chadalawada, MD
Post Doctoral Fellow

Omolade Oladejo, M.B.B.S. MPH
Assoc. Academic Research Scientist

Sabeena Usman,
Program Coordinator

Clinic Population Overview

Dec 2203 - Dec 2024

Age

31 – <50	109	55.3%
50 – <65	37	18.8%
26 – <31	20	10.2%
18 – <26	19	9.6%
≥65	12	6.1%

Gender

Male	100	51.5%
Female	94	48.5%

Race

Black/African Am.	171	88.1%
White	11	5.7%
Other Race	6	3.1%
Unknown	2	1.0%
Asian	3	1.5%

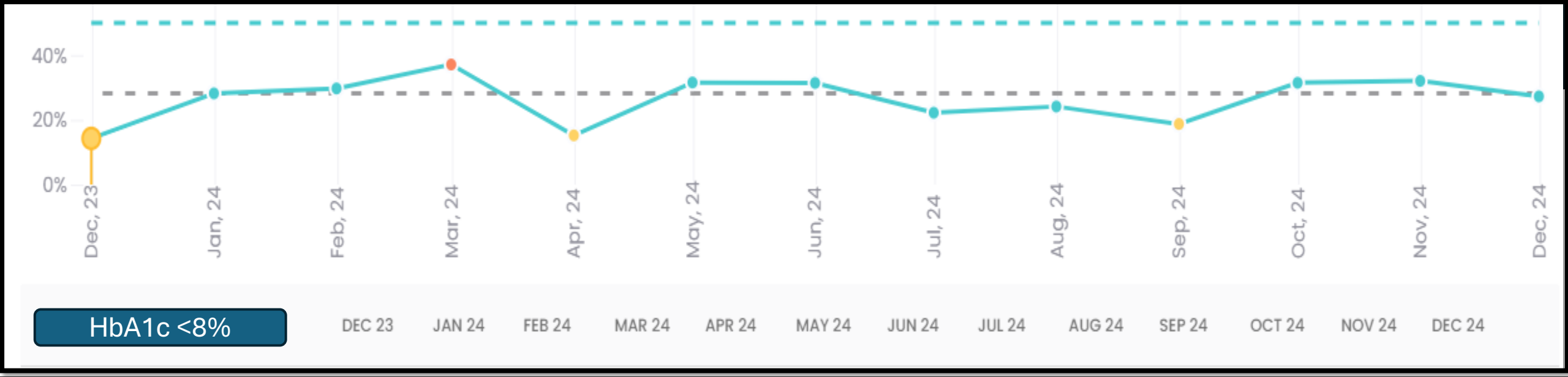
Insurance

Medicaid	73	33.6%
Private	82	37.8%
Medicare	34	15.7%
None, self pay	23	10.6%
Other	5	2.3%

Ethnicity

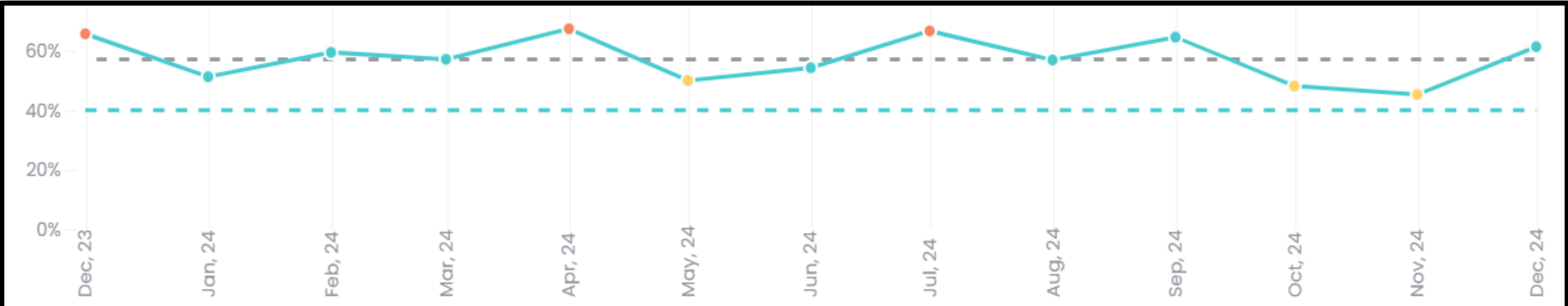
NonHispanic or Latino	185	95.4%
Hispanic or Latino	7	3.6%
Unknown	2	1.0%

Clinic Metrics



HbA1c <8%

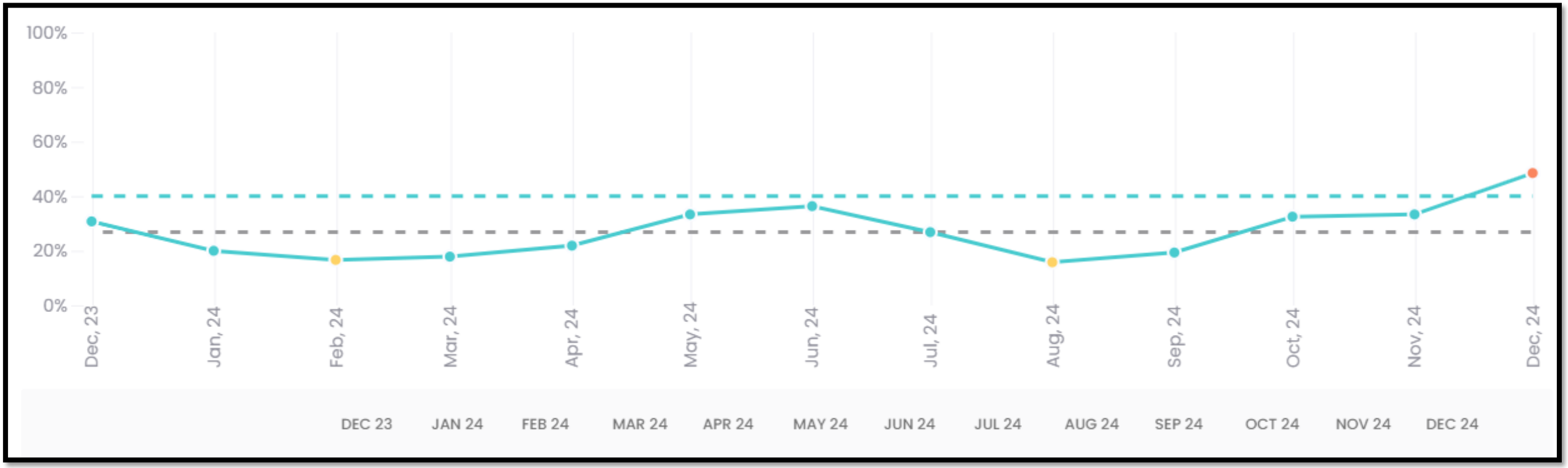
DEC 23 JAN 24 FEB 24 MAR 24 APR 24 MAY 24 JUN 24 JUL 24 AUG 24 SEP 24 OCT 24 NOV 24 DEC 24



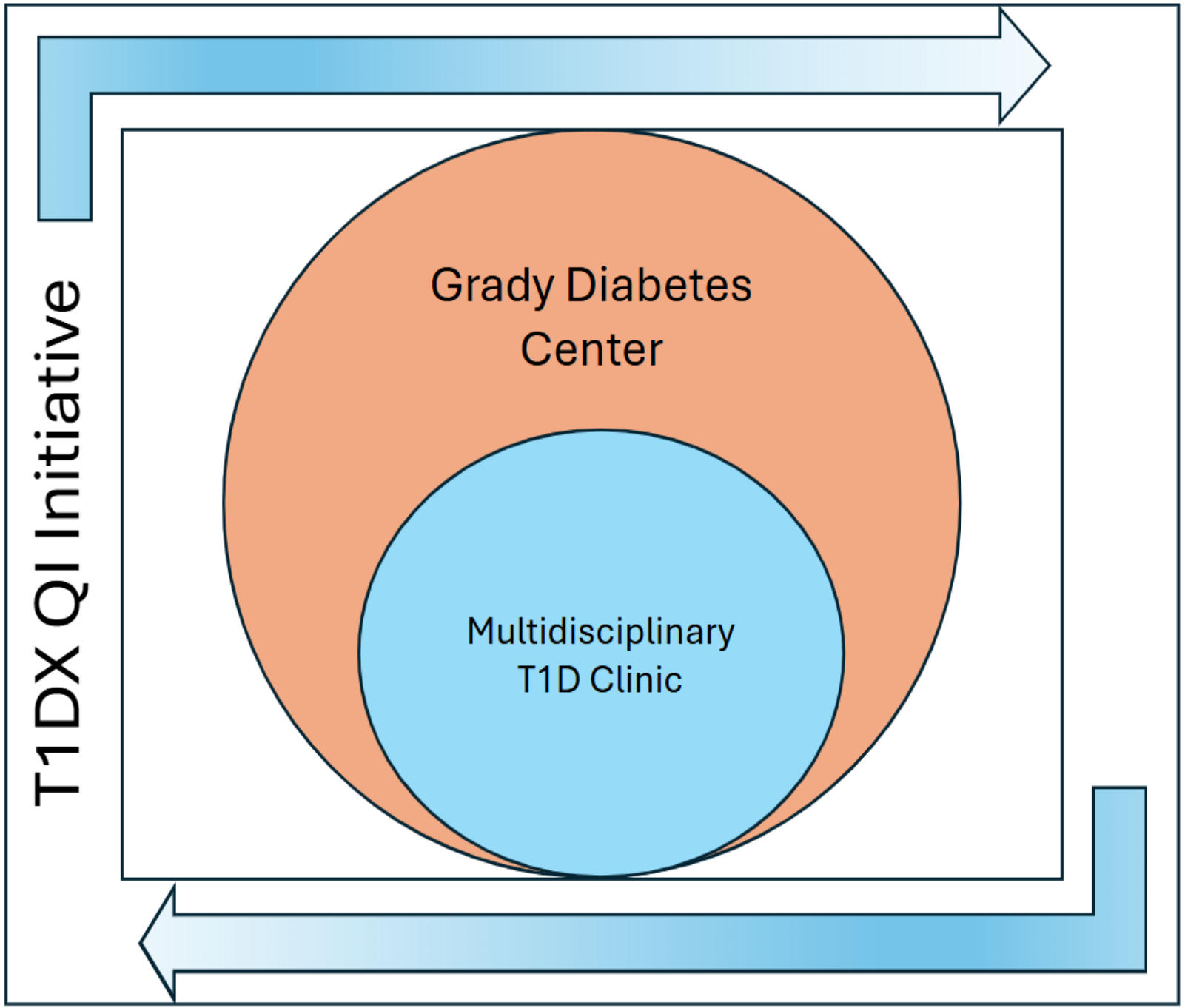
HbA1c >9%

DEC 23 JAN 24 FEB 24 MAR 24 APR 24 MAY 24 JUN 24 JUL 24 AUG 24 SEP 24 OCT 24 NOV 24 DEC 24

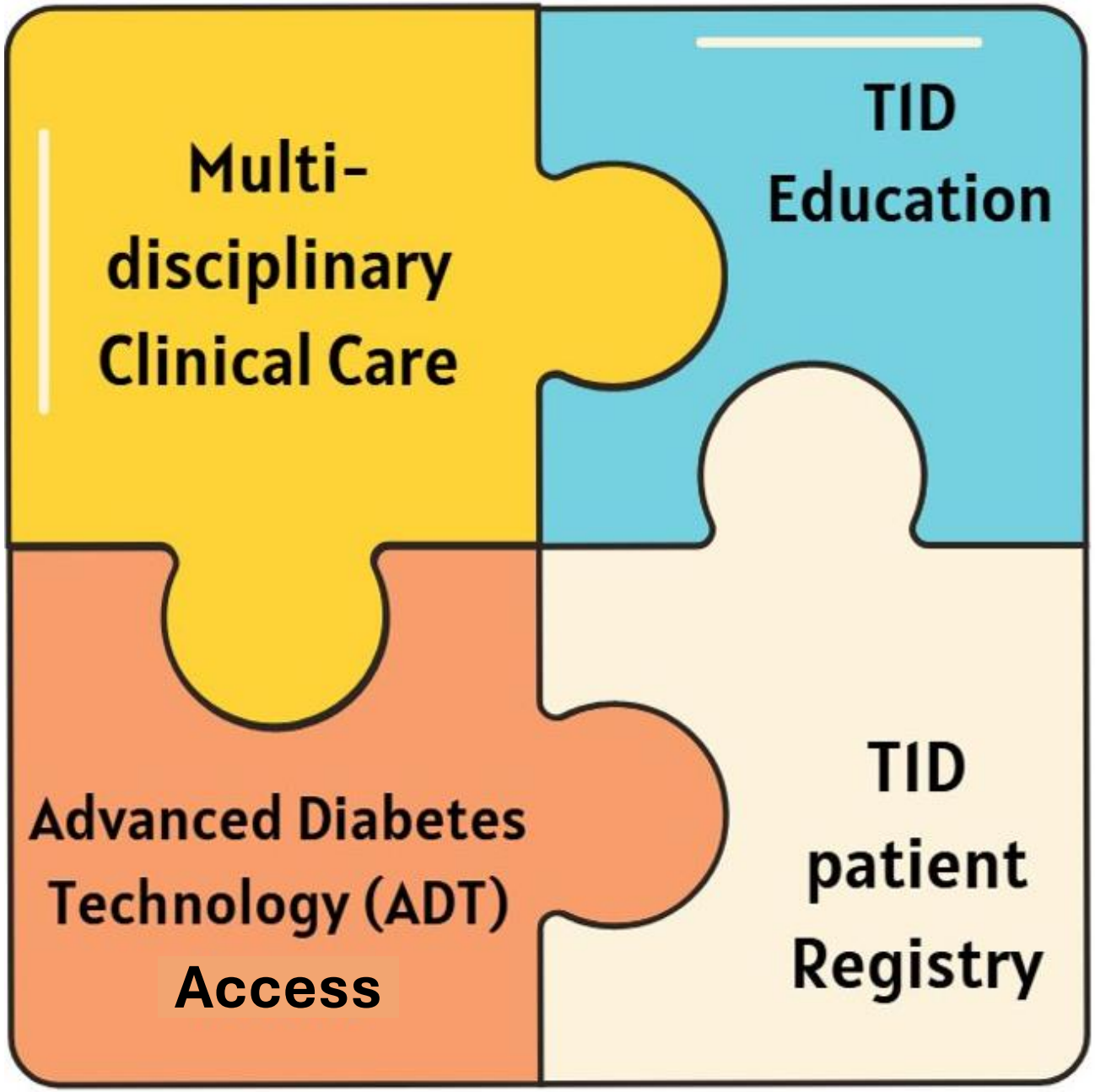
Clinic Metrics: HbA1c Improvement ≥0.5%



GHS Diabetes Center: Clinic Structure

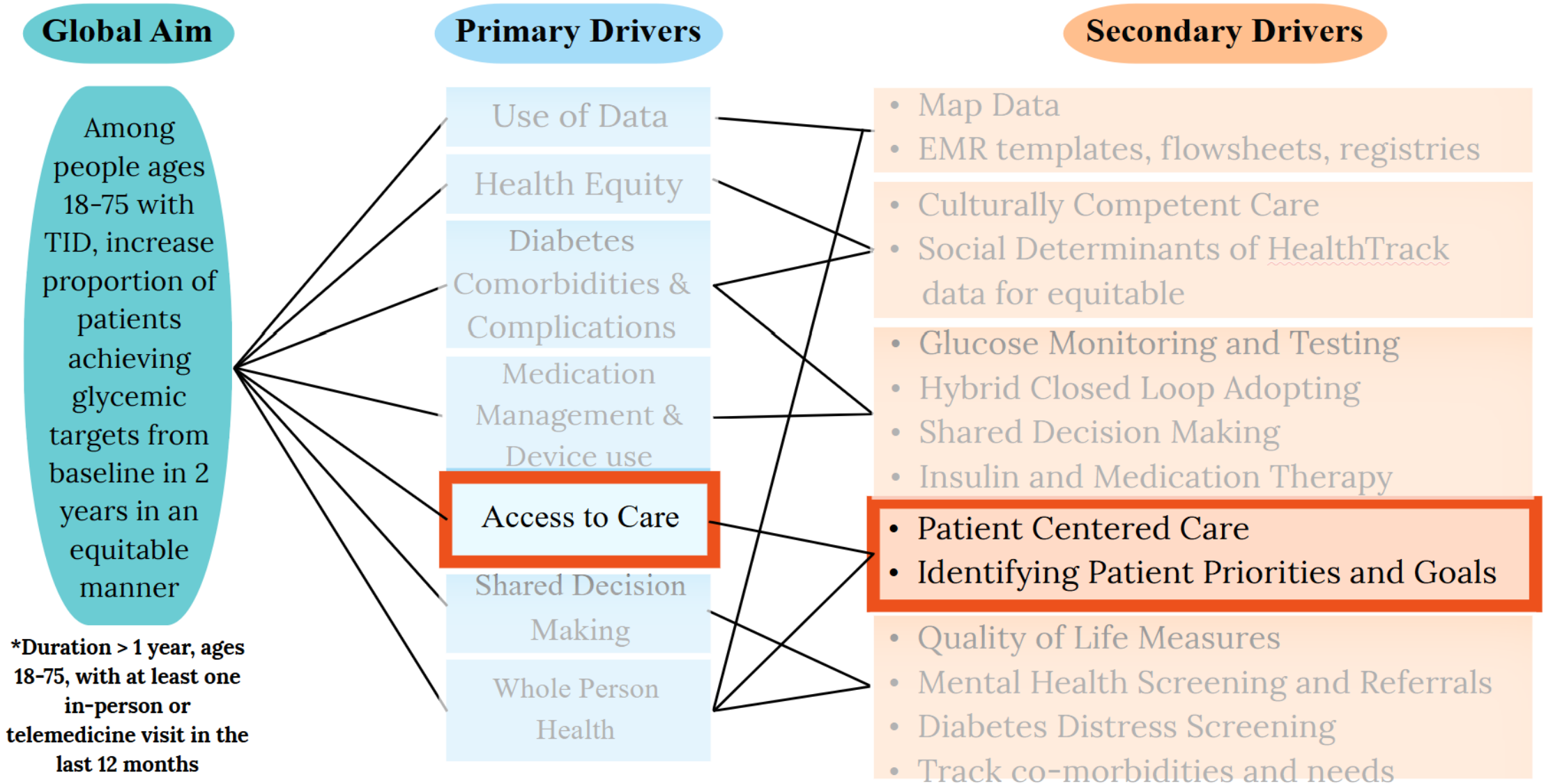


Quality Improvement Initiatives

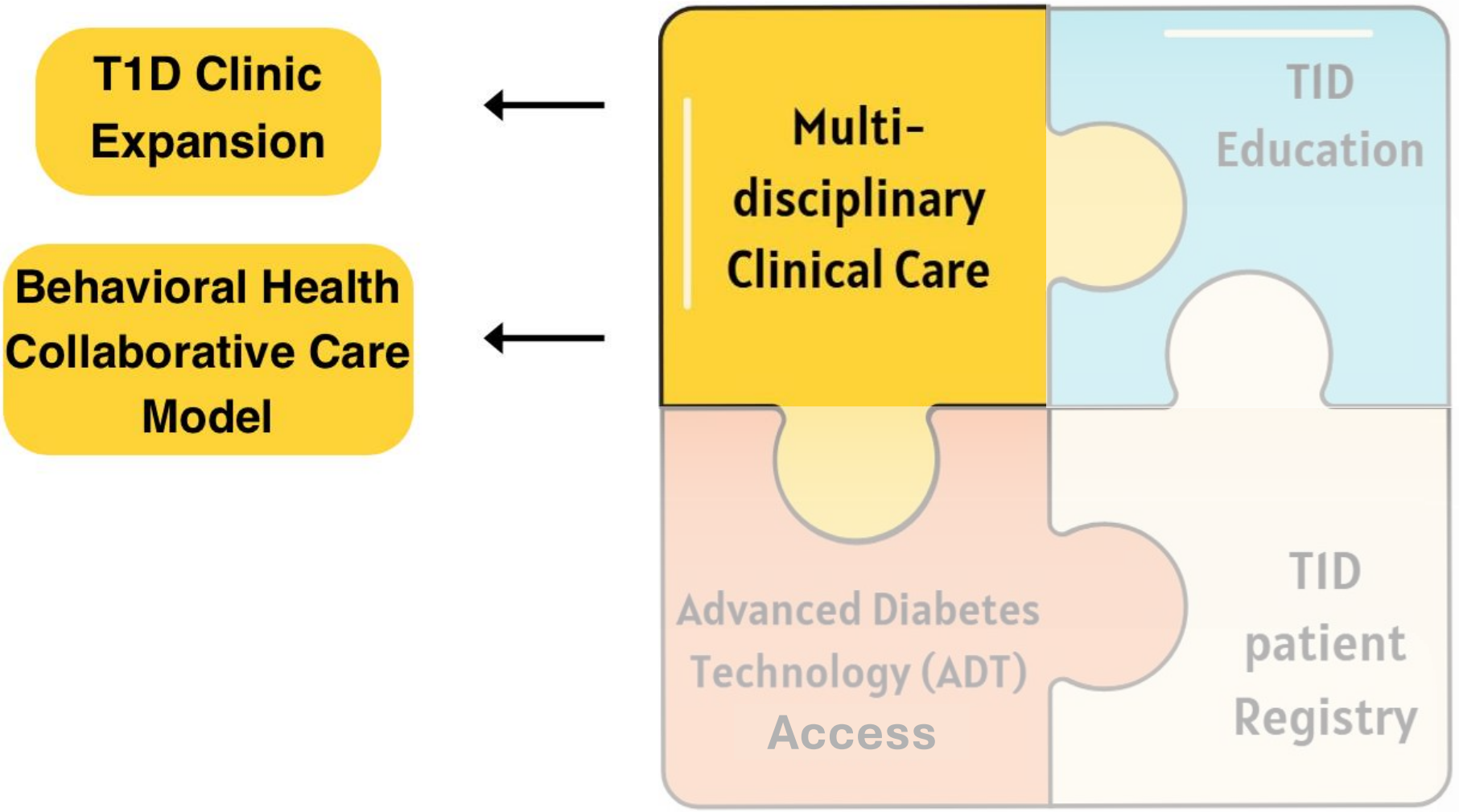


Access to T1D Multidisciplinary Care

Key Driver Diagram



Quality Improvement Initiatives:
Multidisciplinary Clinical Care



Who we are	**Grady T1D Clinic**			
What we do	**Multidisciplinary Clinical Team**	**Advanced Diabetes Technology (ADT) Access**	**Clinical Research and Quality Improvement**	**Medical Education**
How we work	**Endocrinologists** **Diabetes Educators** **Clinical Pharmacists** **Nutritionists** **Behavioral Scientists**	**Identify barriers to equitable access** **Device initiation and continued use**	**Clinical Trials Outcomes Research** **T1D Exchange QI Collaborative**	**Students, Residents, Fellows** **Research Involvement**
Our programmatic mission	Reduce Care Fragmentation and Inequities in T1D Management			

T1D Clinic Expansion

[1]Diabetes Center (40-50% diabetes center T1D population)

2 half day clinics/month

[1]Diabetes Center (all patients with T1D)

[2]High-Risk OB (on technology and/or with A1c >9%)

4-5 half day clinics/month

CURRENT EXPANSION

[1]Diabetes Center(all patients with T1D)

[2]High Risk OB (on technology and/or with A1c >9%)

[3]Inpatient Referrals

[4]Primary Care Referrals

8-9 half day clinics/month

[1]Diabetes Center(all patients with T1D)

[2]High Risk OB (on technology and/or with A1c >9%)

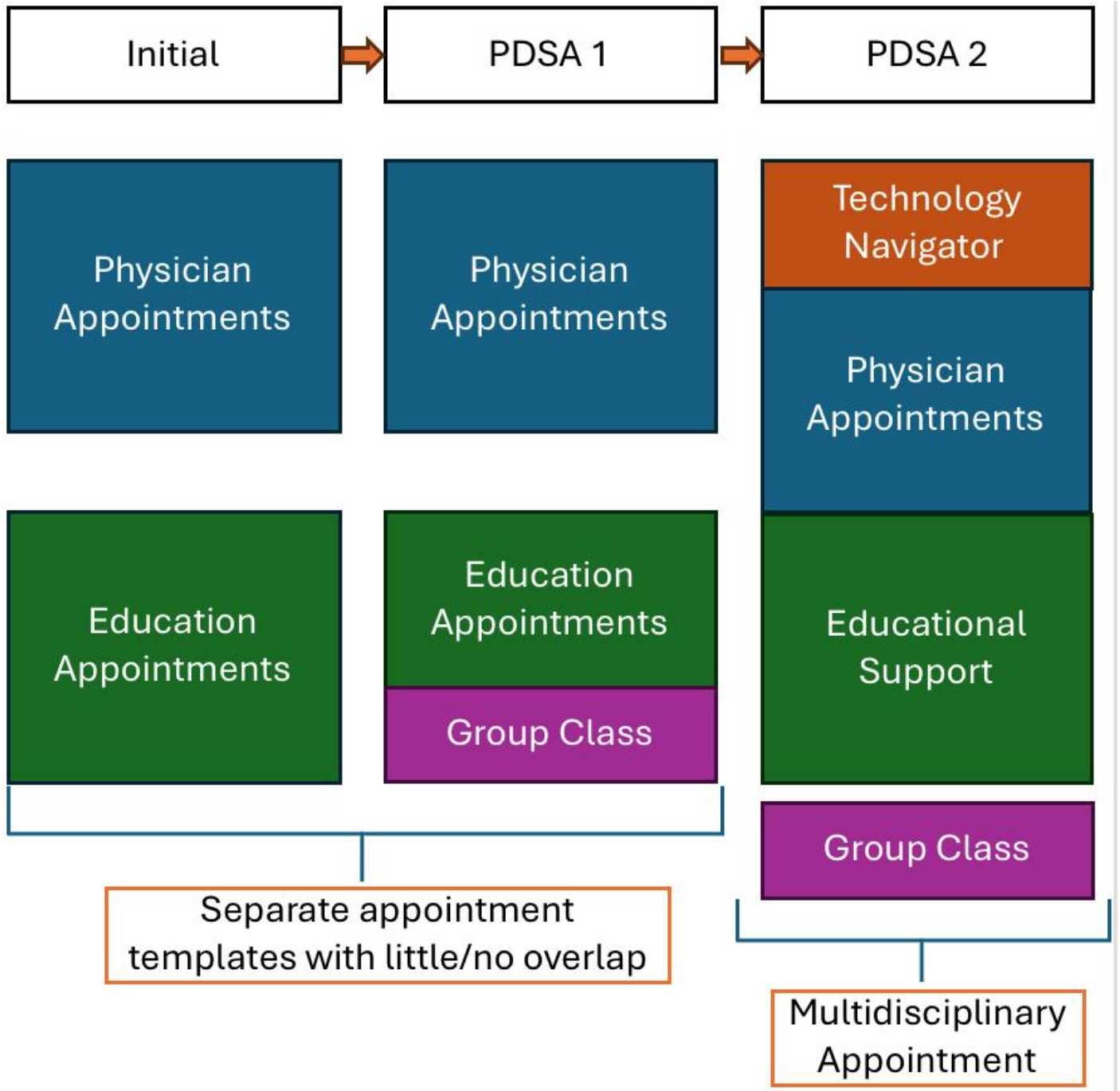
[3]Inpatient Referrals

[4]Primary Care Referrals

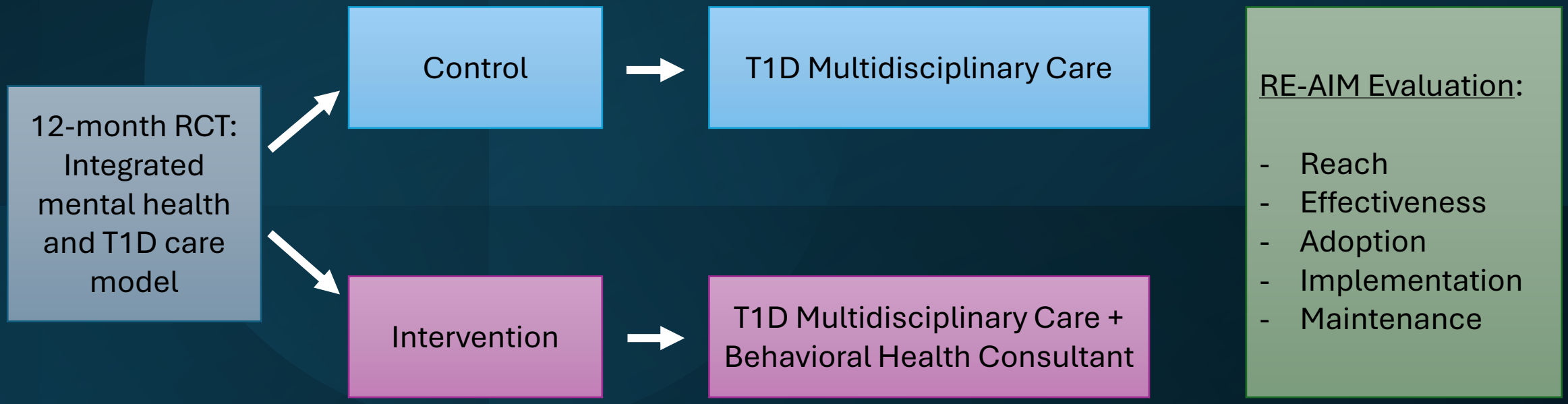
[5]Outside Referrals

10-12 half day clinics/month

Clinic Scheduling: Process Improvements

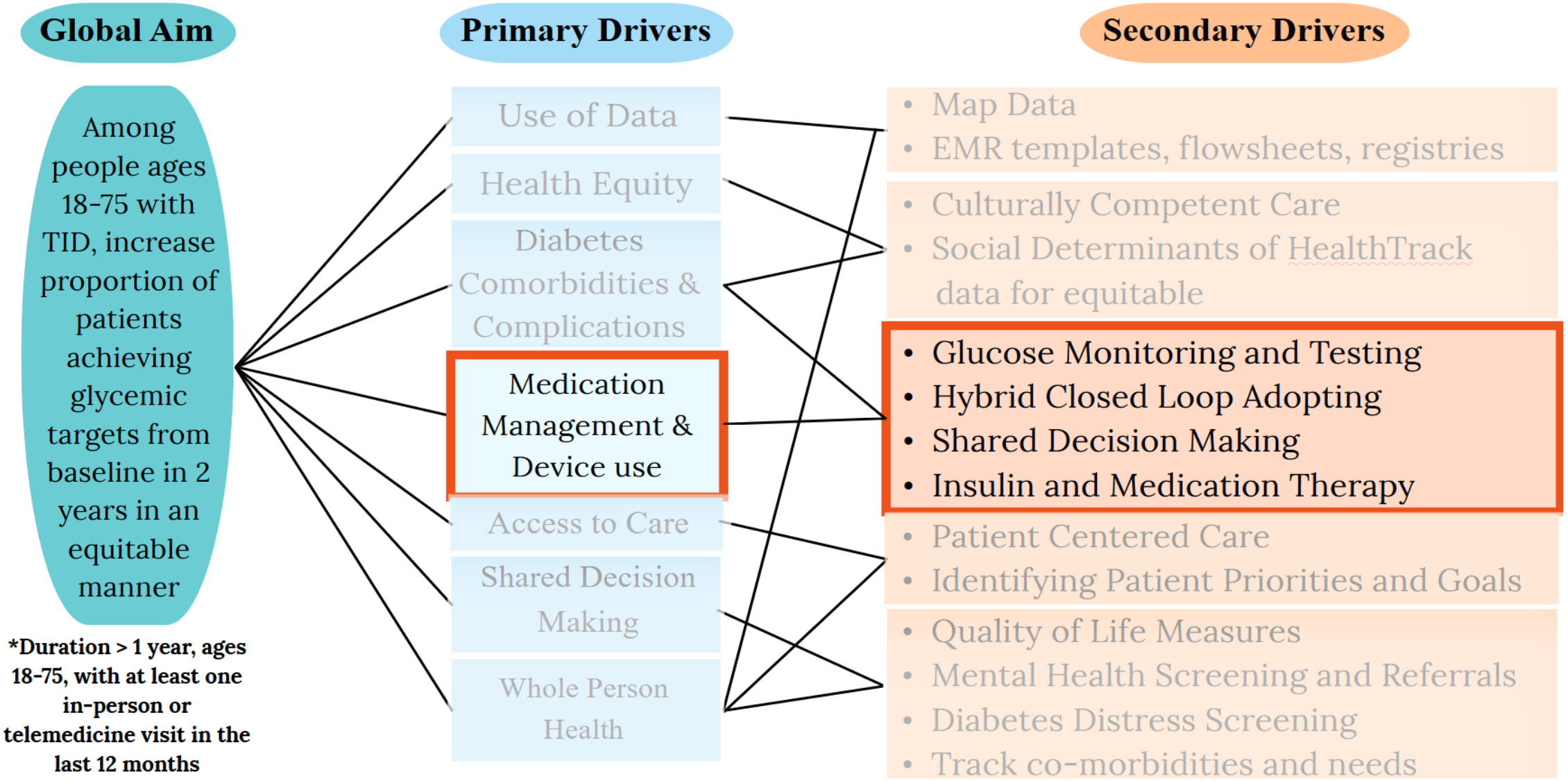


Collaborative Care Model: Addressing Behavioral Health Needs in T1D

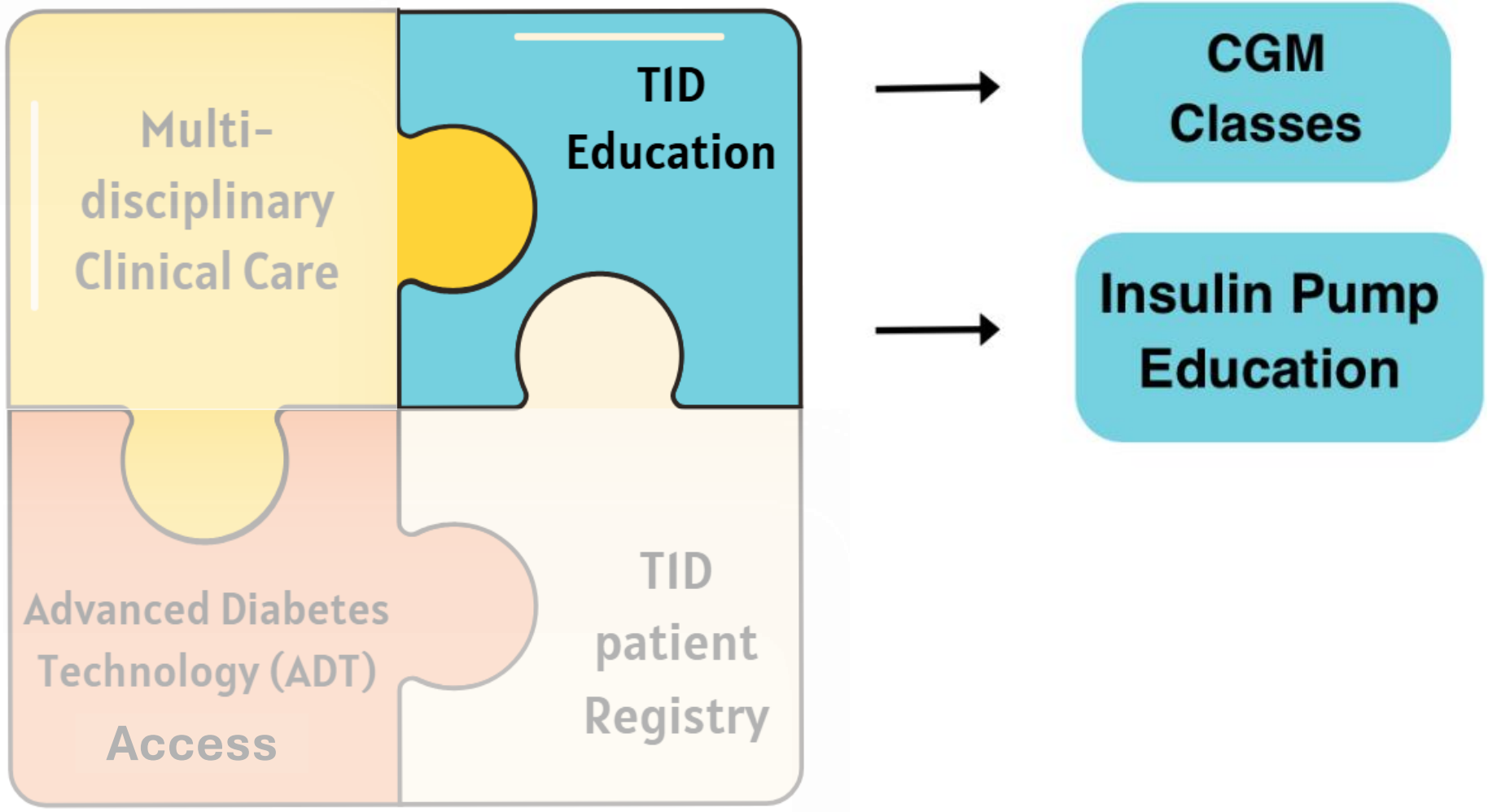


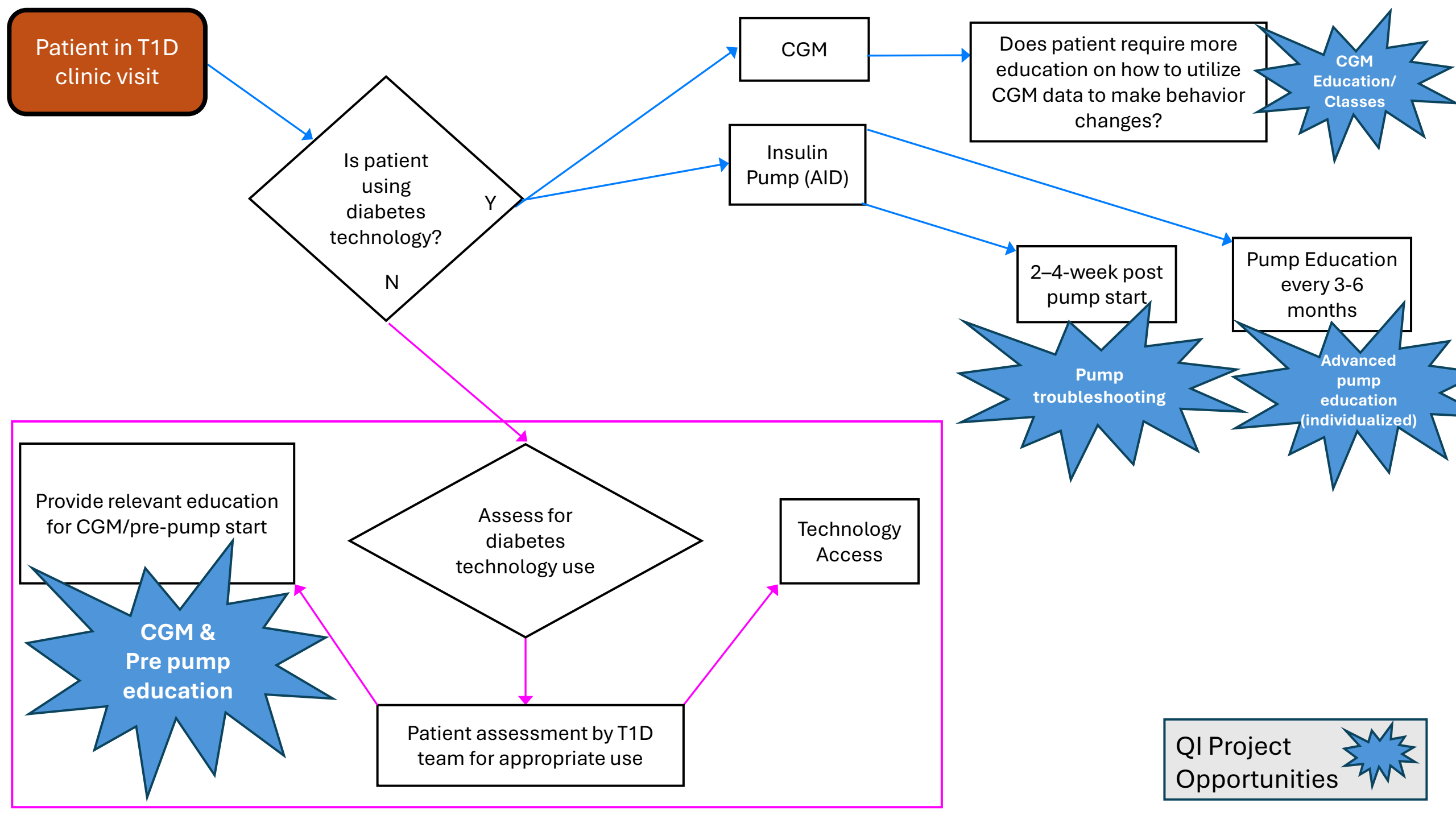
Type 1 Diabetes Education

Key Driver Diagram

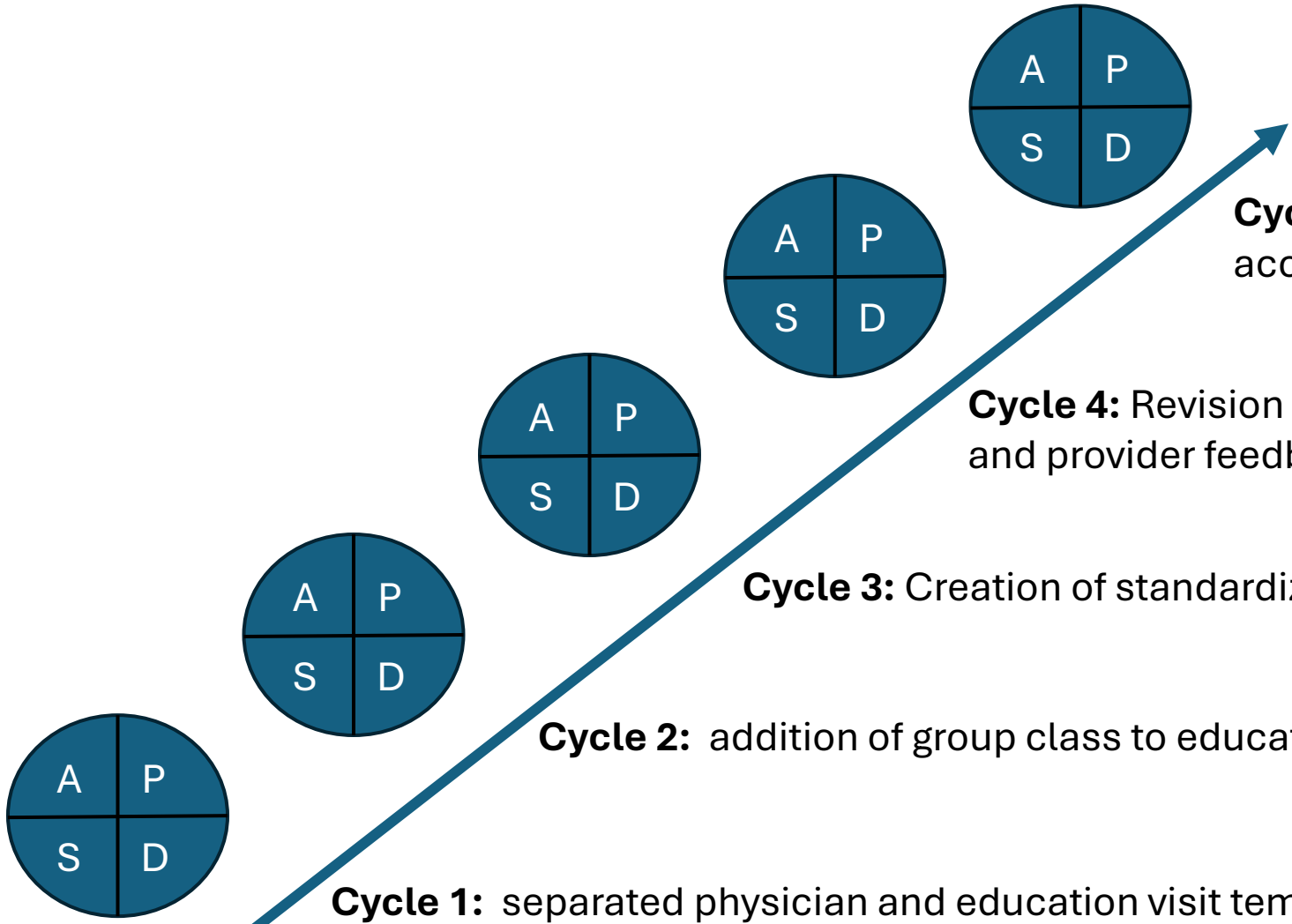


Quality Improvement Initiatives:
Type 1 Diabetes Education




Patient in T1D clinic visit
Is patient using diabetes technology?
Y
N
CGM
Insulin Pump (AID)
Does patient require more education on how to utilize CGM data to make behavior changes?
CGM Education/ Classes
2–4-week post pump start
Pump Education every 3-6 months
Pump troubleshooting
Advanced pump education (individualized)
Provide relevant education for CGM/pre-pump start
Assess for diabetes technology use
Technology Access
CGM & Pre pump education
Patient assessment by T1D team for appropriate use
QI Project Opportunities

CGM Classes



Cycle 5: Revision of presentation of content to accommodate health literacy needs

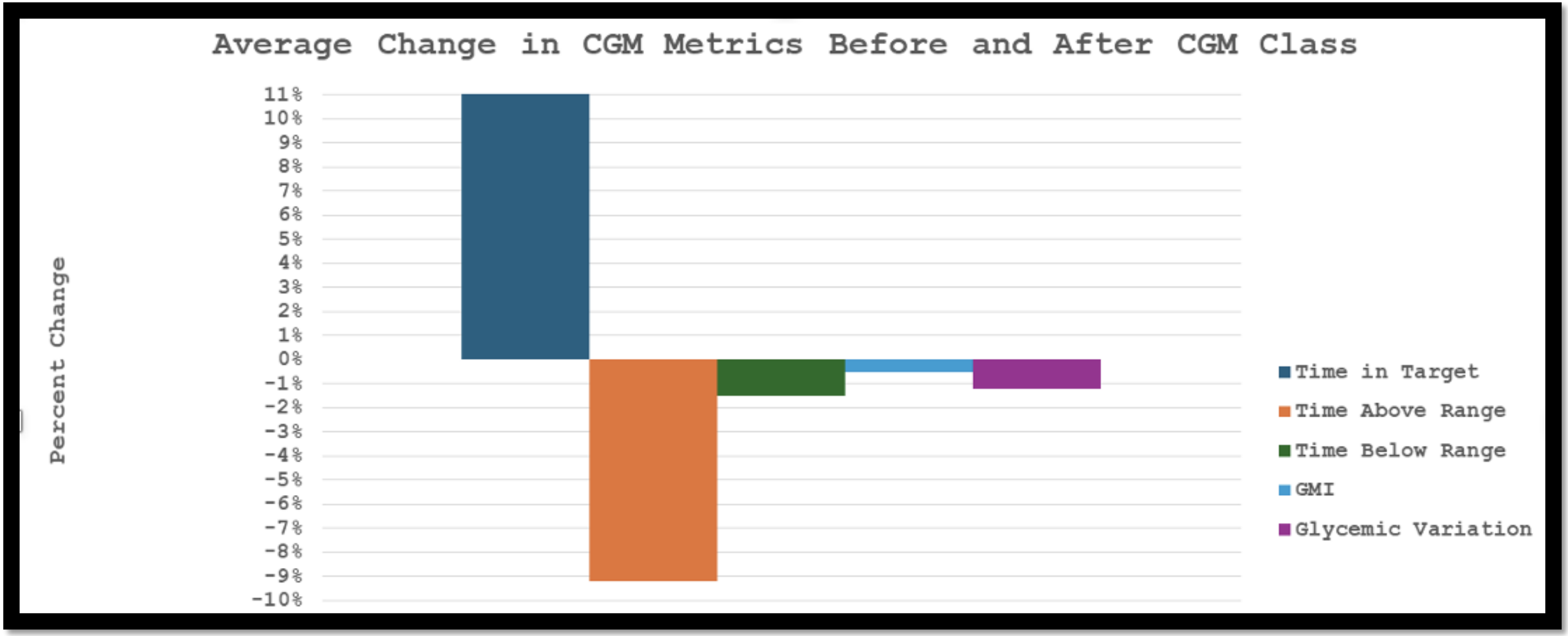
Cycle 4: Revision of curriculum and case studies following patient and provider feedback

Cycle 3: Creation of standardized curriculum with applied case studies

Cycle 2: addition of group class to education template to accommodate more patients

Cycle 1: separated physician and education visit templates to dedicate time to CGM education

CGM Classes


Average Change in CGM Metrics Before and After CGM Class
Percent Change
11%
10%
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%
-1%
-2%
-3%
-4%
-5%
-6%
-7%
-8%
-9%
-10%
Time in Target
Time Above Range
Time Below Range
GMI
Glycemic Variation

Pre-Pump Education

Session 1: Prior to pump initiation

- What is an insulin pump/how it works
- AID concept
- Benefits/Risks
- Carb counting
- Handout of the different types of insulin pumps on the market

Session 1a: Group format carb counting

Session 1b: Individualized carb counting with ICR and/or meal size education

Session 2: Pump Start Education

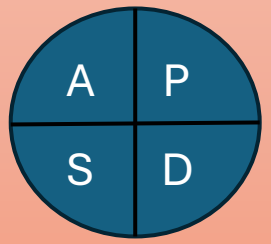
- Pump initiation and training completed with company clinical liaison or clinic CDE
- Glucagon and ketone monitoring prescriptions

Session 3: Pump Troubleshooting

- Skin issues/preventing infections
- Disconnecting and reconnecting pump
- Water activities
- Traveling
- Back up supplies
- Troubleshooting
  - Glucagon review

Session 4: Advanced Pump Education

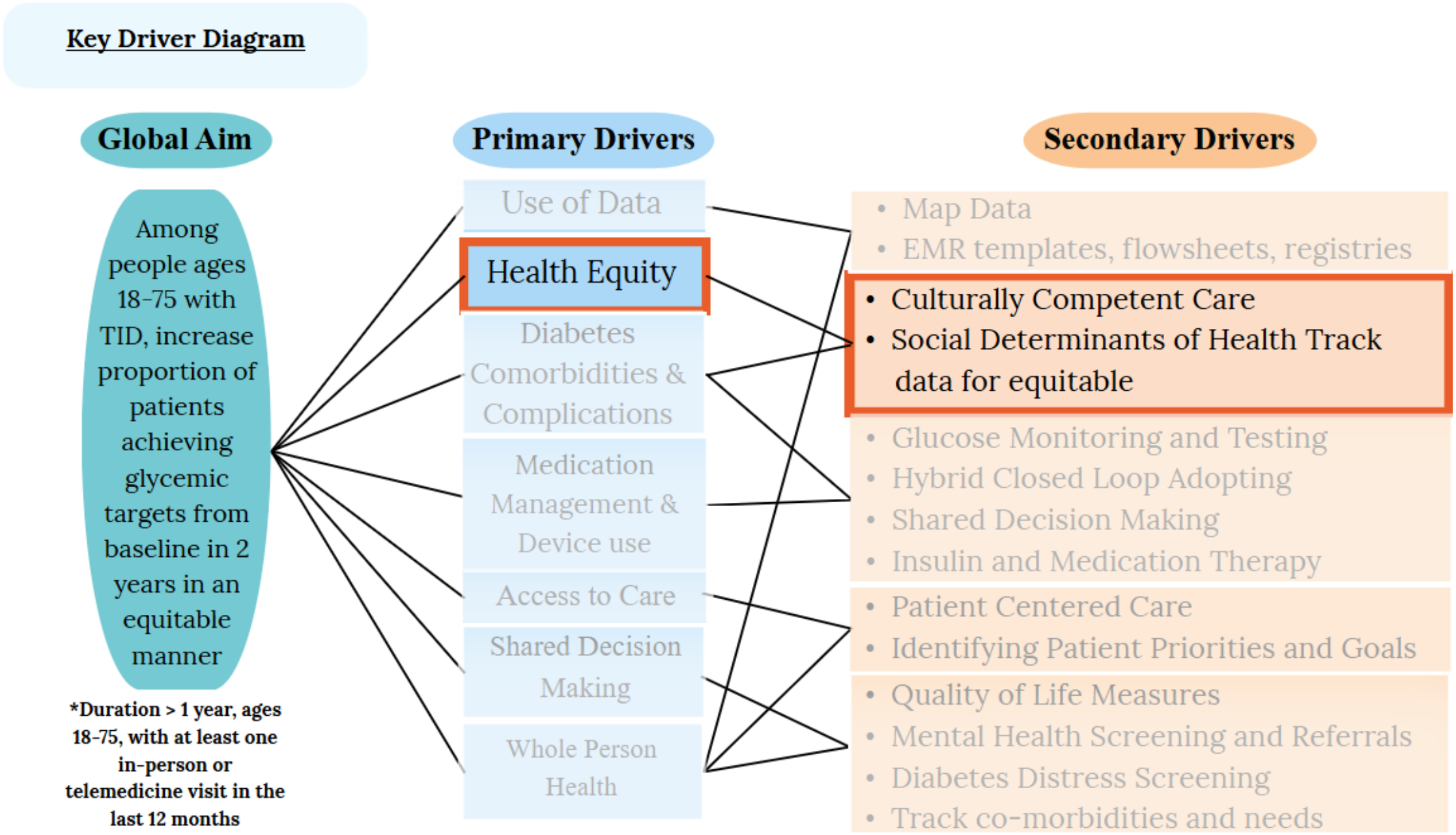
- Ongoing education (every 3-6 months)
- Advanced pump functionality
- Physical activity



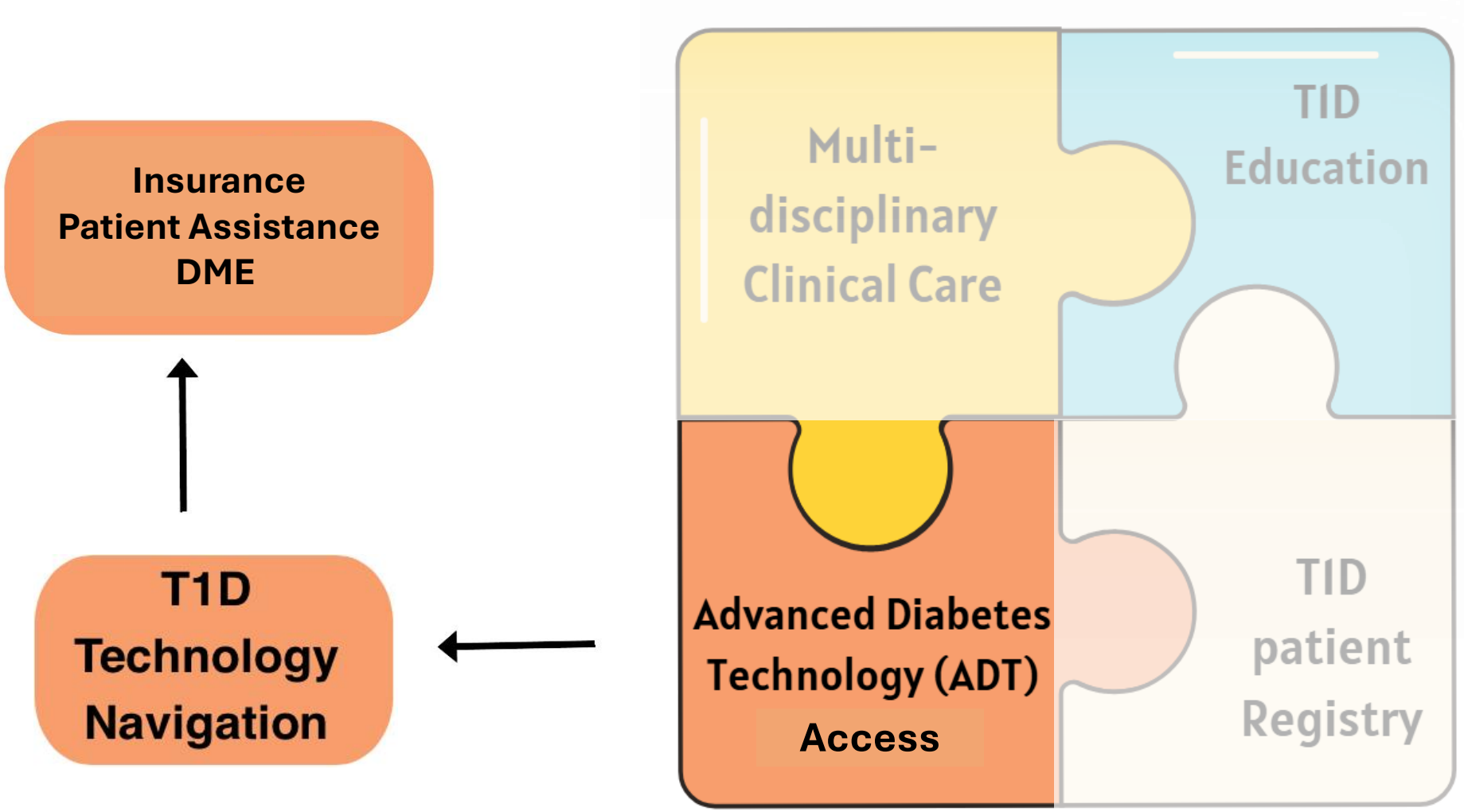
Educational References: trifold brochure for pump troubleshooting

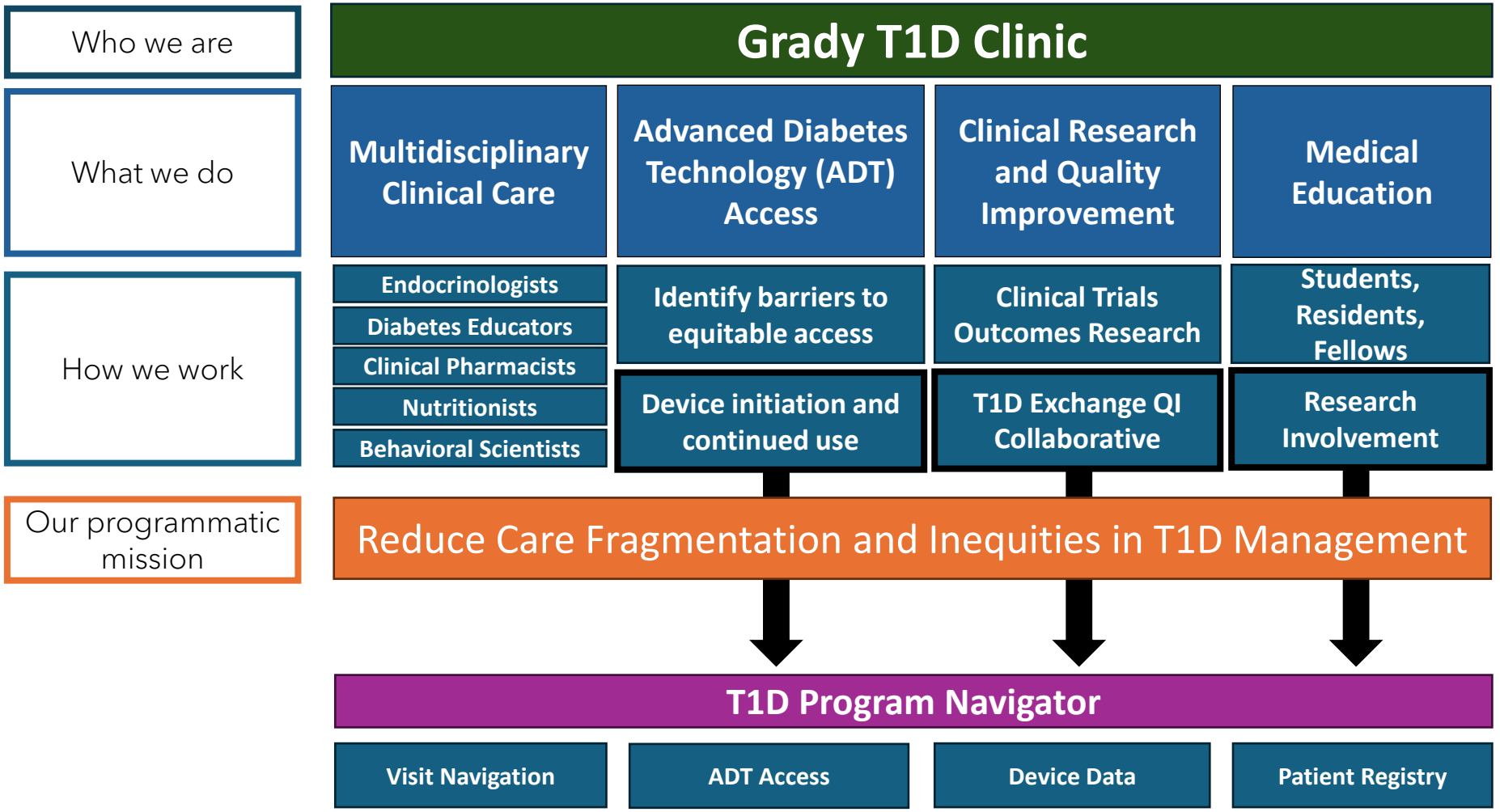
Carb Counting Skill Building: ongoing education for carb and meal estimation entry (individual or group)

Advanced Diabetes Technology Access



Quality Improvement Initiatives:
ADT Access

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Clinical Research and Quality Improvement
Medical Education
How we work
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Diabetes Educators
Clinical Pharmacists
Nutritionists
Behavioral Scientists
Identify barriers to equitable access
Clinical Trials Outcomes Research
Students, Residents, Fellows
Device initiation and continued use
T1D Exchange QI Collaborative
Research Involvement
Our programmatic mission
Reduce Care Fragmentation and Inequities in T1D Management
T1D Program Navigator
Visit Navigation
ADT Access
Device Data
Patient Registry

T1D Program Navigator

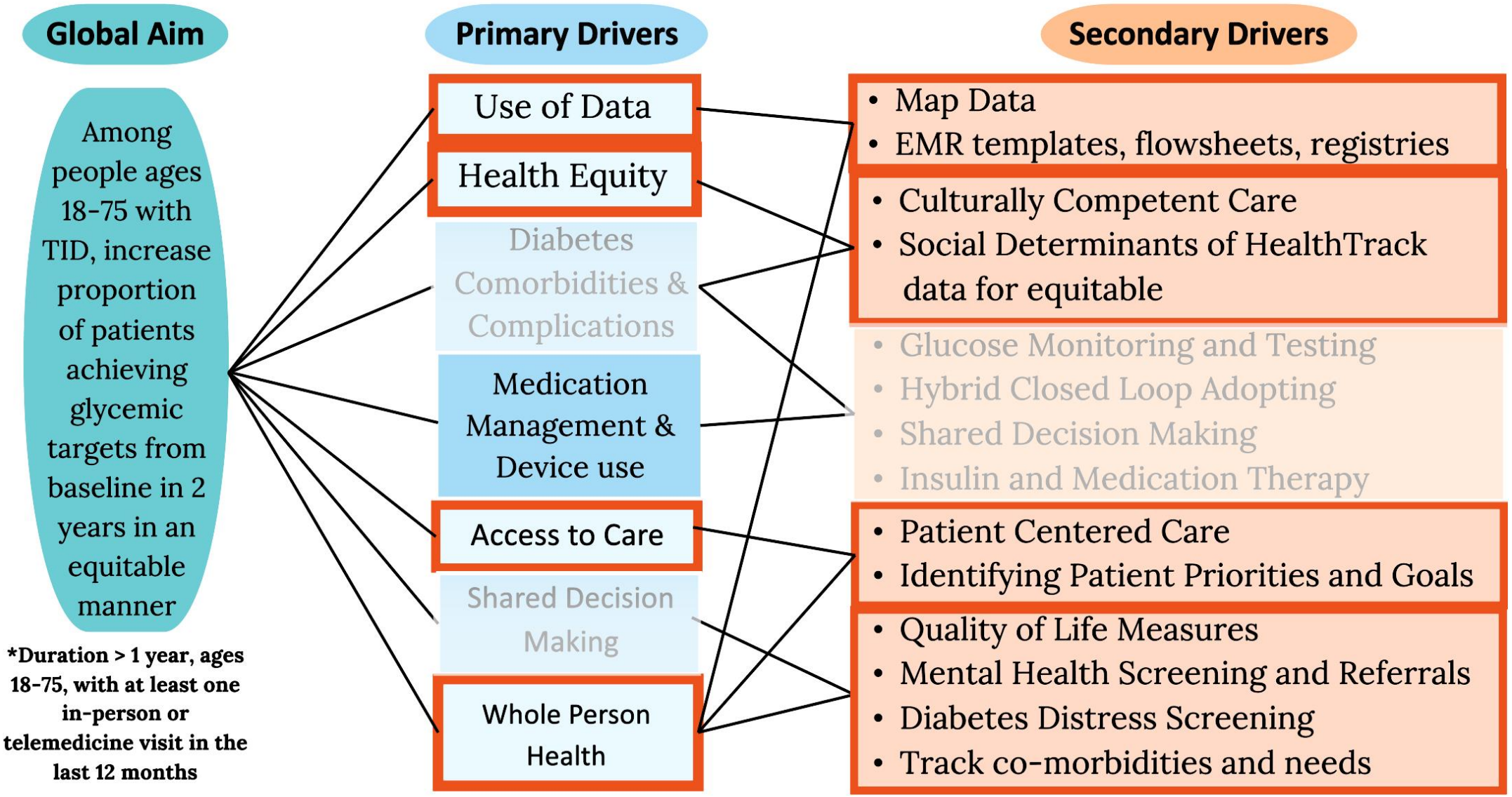
Visit Navigation	ADT Access	Device Data	Patient Registry
- Assessment of current technology use - Patient device and prescription needs - Visit priorities	- Insurance coverage - Patient assistance programs - Approval processes - Order logistics and follow up	- EHR technology use documentation - Population management tools	- Study introduction and integration into clinic flow

<u>Patient and Population-Level T1D Data for support of:</u>

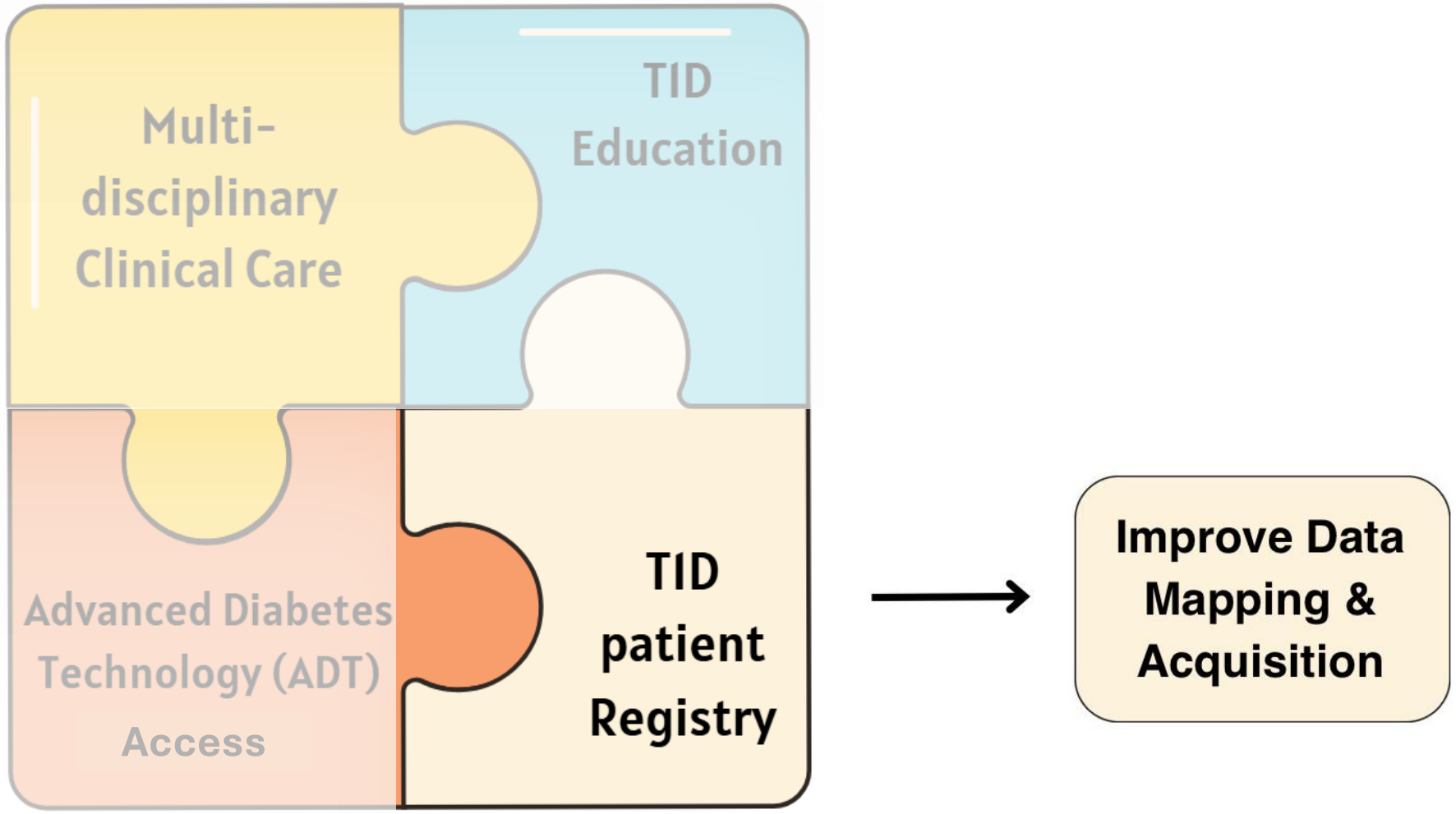
- Ongoing national QI initiatives
- Population management research (local, national)
- Clinical Trials prioritizing high-risk groups

Type 1 Diabetes Registry

Key Driver Diagram



Quality Improvement Initiatives:
Type 1 Diabetes Registry



T1D Registry:

Patient Information & EHR Data

Initial Intake

- Name
- Age
- Sex

Initial Survey

- Diabetes history
  - Duration
  - Diagnosis (T1/T2)
  - DKA/Hypos
- Device use
- Diet & exercise
- Substance use
- Education
- Employment/Income
- Insurance coverage

Follow Up Survey

Longitudinal tracking of events/metrics :

- DKA
- Hypoglycemia
- Glycemic control
- CGM & insulin pump use (gaps)
- Insurance (gaps)

EHR Data

- Vitals
- Anthropometrics
- Lab tests:
  - Glycemic metrics
  - Lipids
  - Ketones
  - Thyroid function
  - Renal function
  - Liver function
  - Vit D
  - Antibodies (T1D-specific and other)

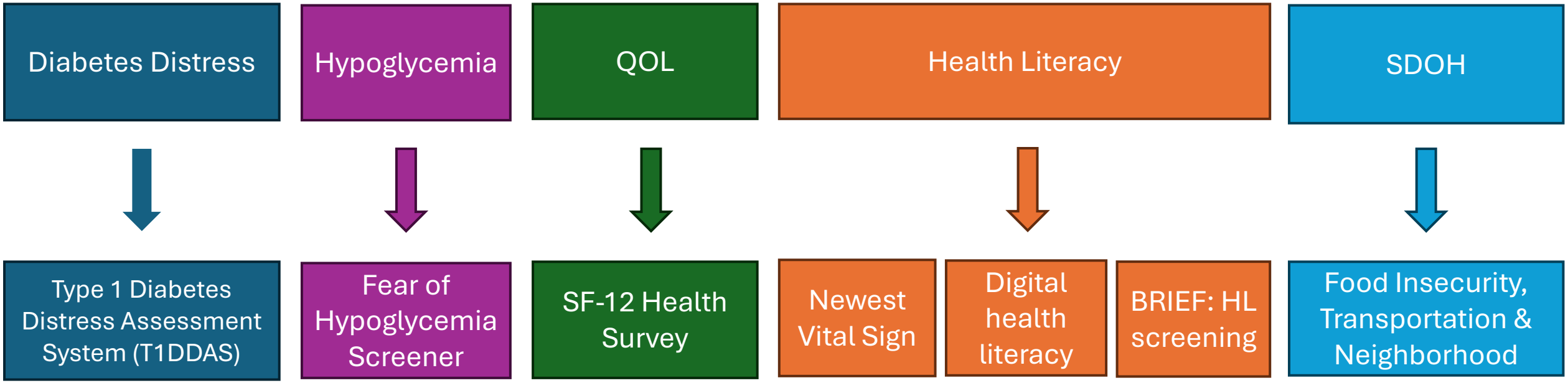
Medical History

- Chronic conditions
- Family history
- Diabetes complications
- Surgeries
- ED visits
- Hospitalizations
- Medications
- Allergies
- Imaging
  - Retinal screening
  - Gastric emptying
  - Echo (EF)

Clinical Encounter & Note Data

- T1D clinic visits
- T1D Education visits
- Diabetes Center encounters

T1D Registry: Surveys



Thank You!

gmdavis@emory.edu

Center Presentation

T2D Exchange
Increasing CGM Prescribing for Adults with T2D

Boston Medical Center
HEALTH SYSTEM

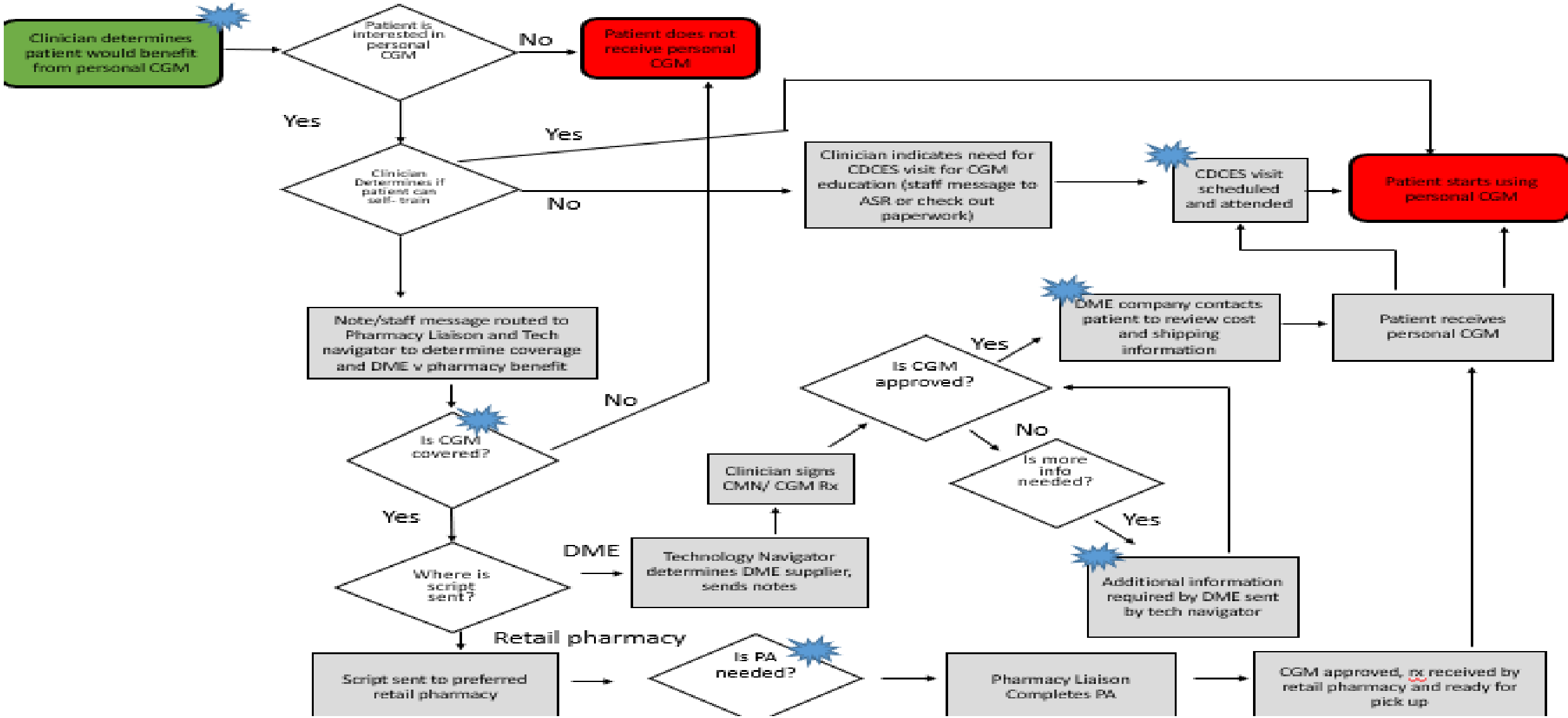
Our Clinic

- 514-bed safety-net hospital in Boston, Massachusetts
- ~75% of patients are publicly insured, ~60% African American, ~10% Hispanic, ~30% non-English language preference
- 8 CDCES (4 RD, 1 RN, 2 PharmD, 1 NP)
- 4 NPs (1 dedicated outpatient)
- 10 Endocrinologists who participate in DM care

Diabetes Population

- -~600 T1D patients/year
- -~4000 T2D patients/year (primary diagnosis billing)

CGM Process Map



CGM KDD

Aim

Increase the use of continuous glucose monitors (CGM) by 10% for people with T2D by 12/31/24. Demonstrate reduction in CGM disparities by 3%

Primary Drivers

- Patient Education
- Provider Education
- Improve Clinic process for CGM
- Address Inequities
- Partner with vendors and payors to support equitable device access

Change Ideas

Patient Education

- FAQ sheet to help families understand CGM usage
- Send educational materials via Mychart
- Peer support discuss benefits and shortfalls with patients.
- Standardize offering of training appointments
- Standardized videos with benefits of CGM
- Create pictorial patient handouts.
- Support patients who have Integration Issues with CGM
- Peer-to-peer opportunities for patients to hear from others about their technology experiences.
- Discuss CGM regularly at appointments

Provider Education

- Train and educate clinical teams on CGM Use
- Run prescribing reports and provide directed outreach and education for providers.

Improve Clinic process for CGM

- Alternate phone or email options for families. Create reminders in mychart for refills
- Discuss CGM regularly at appointments.
- Standardize conversations about technology.
- Use of prior authorization specialist/ Pharm tech.
- Create a better follow up process/Schedule RPM.
- Call/ text patient to know if they received CGM.

Address Inequities

- Patient Barrier Assessment survey
- Community outreach by staff to help families.
- Translate materials in other languages.
- Translators available in clinic/ virtual.
- Comparison chart for CGMs available to patients.
- SDOH Screening and referral
- Coordinate with local PC practices to start CGM
- Limit patient “guidelines” for technology as much as possible to avoid bias.

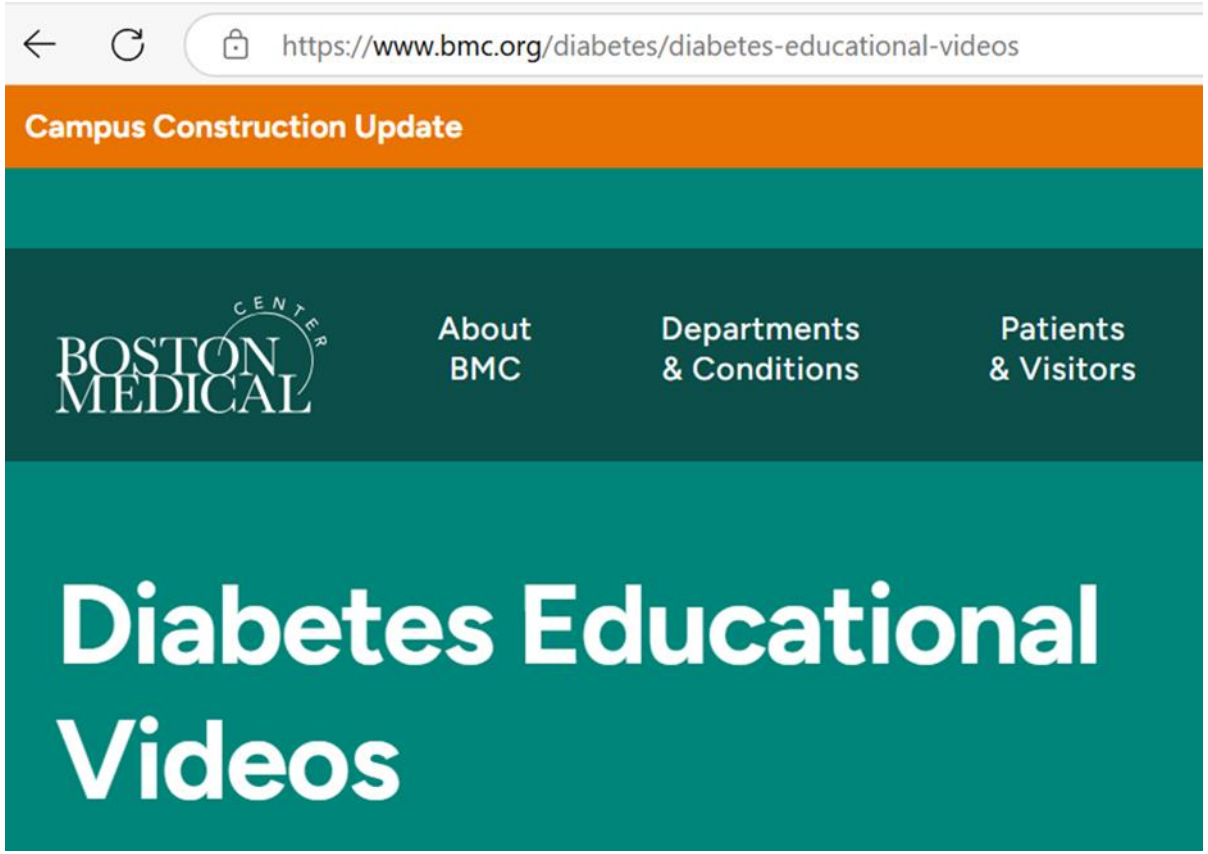
Partner with vendors and payors to support equitable device access

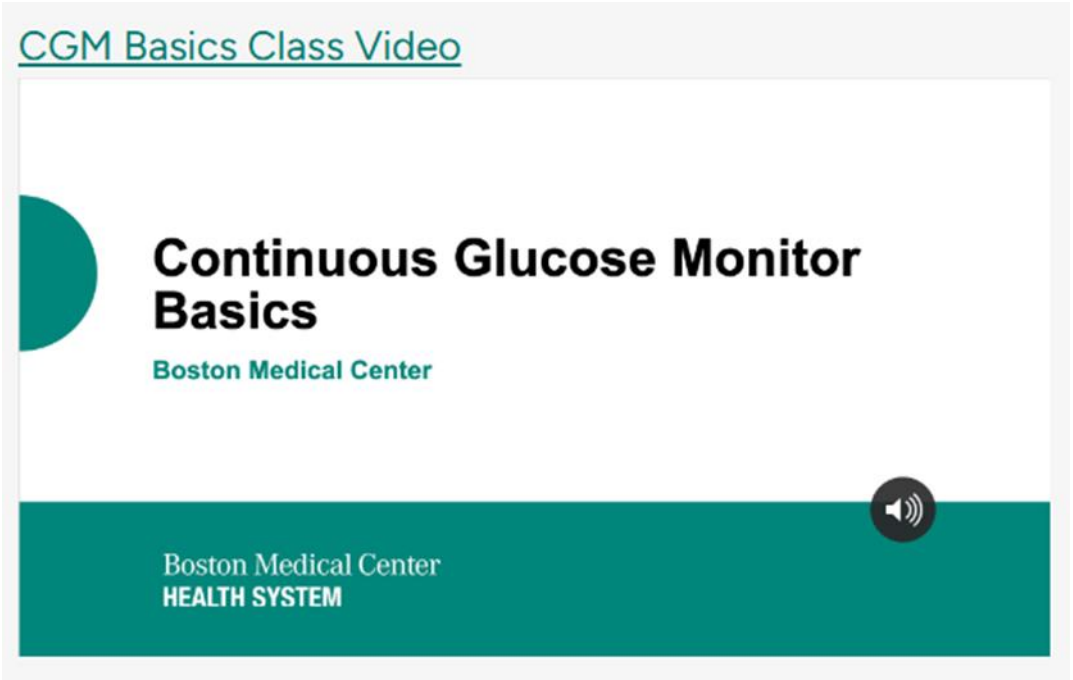
- Advocate with companies about phone compatibility issues.
- Annual DSMES session to address global self-management/ technology needs
- CGM champions to navigate insurance barriers.

Boston Medical Center
HEALTH SYSTEM

Quality Improvement Interventions

Created CGM Basics video with QR code link. CGM video is uploaded to BMC website. August 2023





https://www.bmc.org/diabetes/cgm-basics

Quality Improvement Interventions

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FREE ONLINE CLASS!

CONTINUOUS GLUCOSE MONITORING

A brief, virtual class on the Boston Medical Center website

Use this link below or scan the QR code:

https://www.bmc.org/diabetes/cgm-basics#cgm

Watch video at anytime!

Learn best practices for using your continuous glucose monitor

Answers to common questions you may have!

BOSTON MEDICAL CENTER
732 Harrison Ave
Boston MA, 02118

https://www.bmc.org/diabetes/cgm-basics

Quality Improvement Interventions

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CGM Requirements

MassHealth (and all ACO/Medicaid plans, including Wellsense)	Wellsense QHP (commercial)	Medicare	Commercial Insurances
For a diagnosis of diabetes: -**Testing frequency:** None required -**Insulin frequency:** At least *one daily injection* or insulin pump use -**Additional requirements:** A1c ≥ 7% or doesn't meet target treatment goal (If A1c is ≤ 7%, insurance will consider other factors such as frequent hypoglycemia, hypoglycemic unawareness, dawn phenomenon, pregnancy, or history of DKA) For a diagnosis of hypoglycemia due to a diagnosis other than diabetes: -Clinical rationale for use of CGM instead of glucometer & test strips	*Dexcom G7 is non-preferred and patient must have trial or contraindication to preferred CGMs For a diagnosis of diabetes: -**Testing frequency:** At least QID -**Insulin frequency:** *Multiple daily injections* or insulin pump (unless patient is unable to use insulin d/t physical, visual, or cognitive disability) -**Additional requirements:** A1c ≥ 7% or doesn't meet target treatment goal (If A1c is ≤ 7%, insurance will consider other factors such as frequent hypoglycemia, hypoglycemic unawareness, dawn phenomenon, pregnancy, or history of DKA)	To be eligible for coverage of a CGM and related supplies, the beneficiary must meet all of the following initial coverage criteria (1)-(5): 1. The beneficiary has diabetes mellitus 2. The beneficiary's treating practitioner has concluded that the beneficiary (or beneficiary's caregiver) has sufficient training using the CGM prescribed as evidenced by providing a prescription; and, 3. The CGM is prescribed in accordance with its FDA indications for use; and, 4. The beneficiary for whom a CGM is being prescribed, to improve glycemic control, meets at least one of the criteria below: A) The beneficiary *is insulin-treated (at least one injection per day*, any type of insulin and any amount) or, B) The beneficiary has a history of problematic hypoglycemia with documentation of at least one of the following: • (Recurrent (more than one) level 2 hypoglycemic events (glucose <54mg/dL (3.0mmol/L)) that persist despite multiple (more than one) attempts to adjust medication(s) and/or modify the diabetes treatment plan; or, • A history of one level 3 hypoglycemic event (glucose <54mg/dL (3.0mmol/L)) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia	- The majority of commercial insurances will go through pharmacy benefit. May need PA. They change requirements often but for the most part they require patient to be a T1/T2 and Insulin treated.

Feel free to reach out to me with any questions you may have. Cassie.rehm@bmc.org

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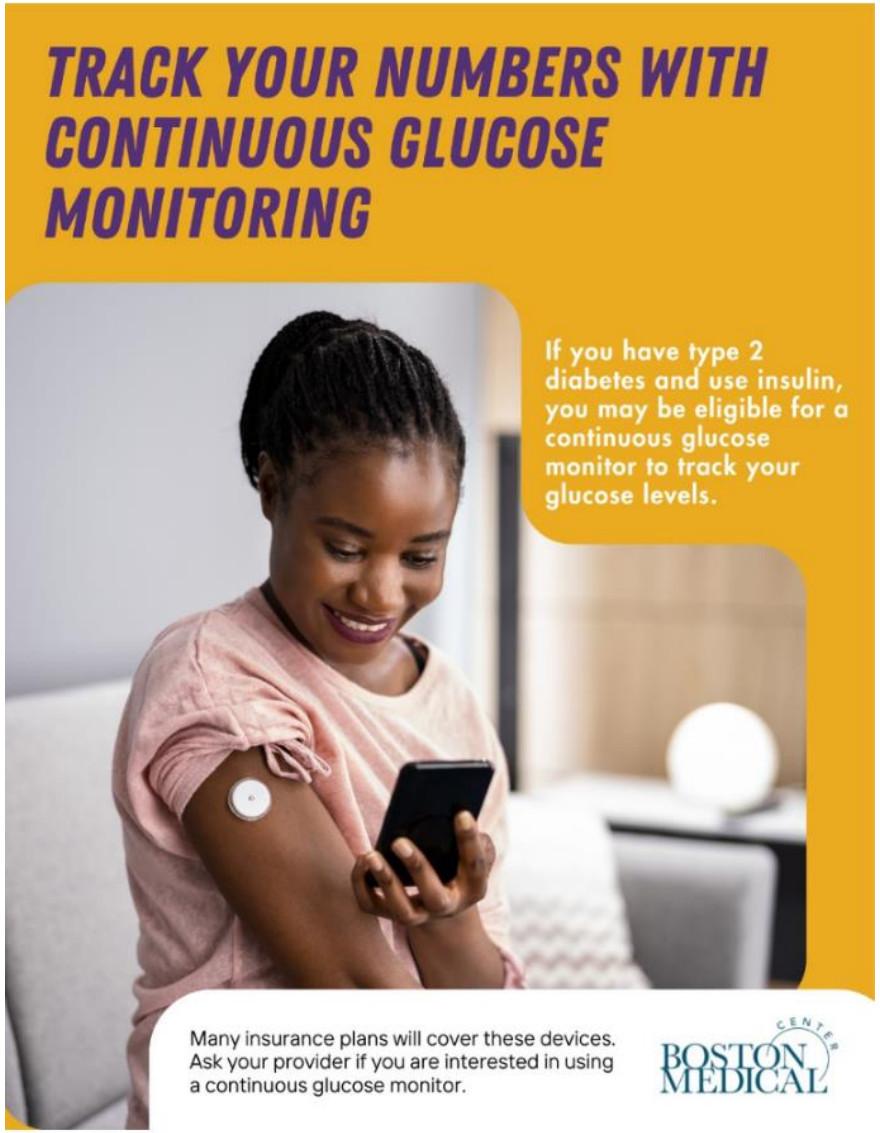
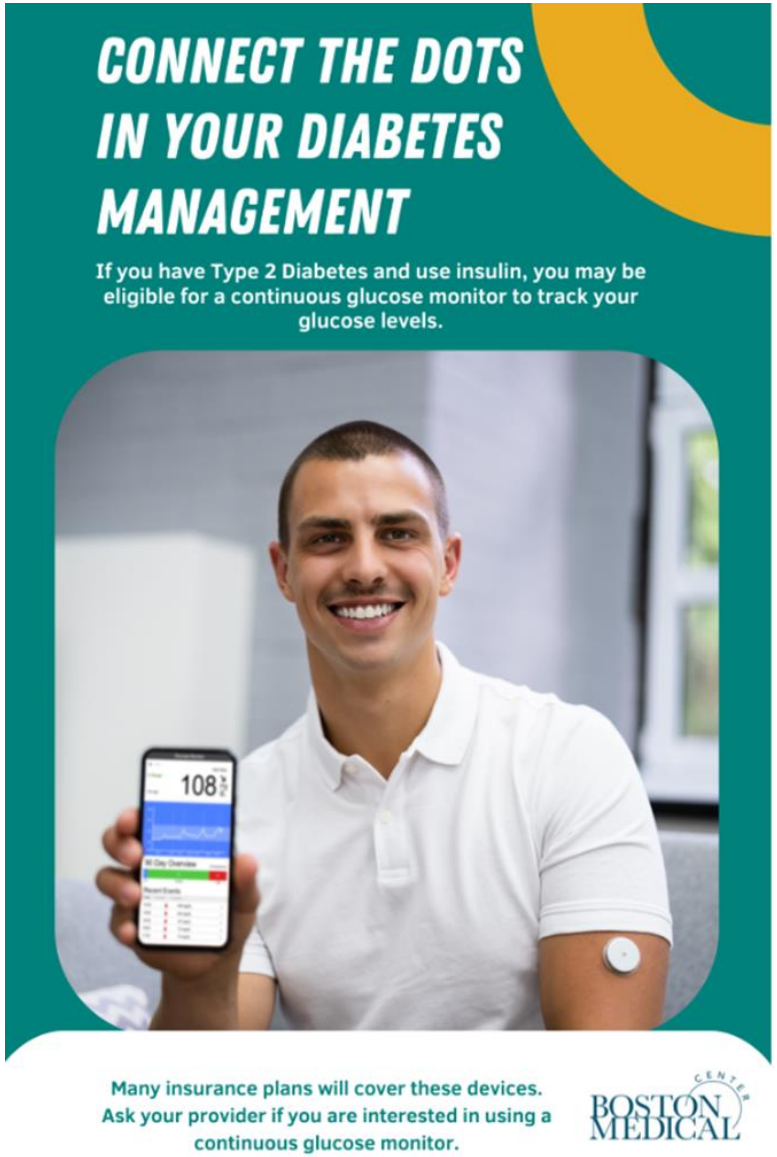
Flyer Placed in Waiting Areas – English & Spanish





CGM Survey Ranking of Barriers

Patients meeting insurance eligibility criteria

Patient preference

Inadequate time to explain CGM during a clinic visit

Inconsistent patient follow up in clinic

Knowledge of insurance eligibility criteria

Insufficient availability of education for CGM use

Difficulty navigating coverage process (PA, DME, etc)

Comfort and confidence in using CGM and interpreting results

Quality Improvement Interventions

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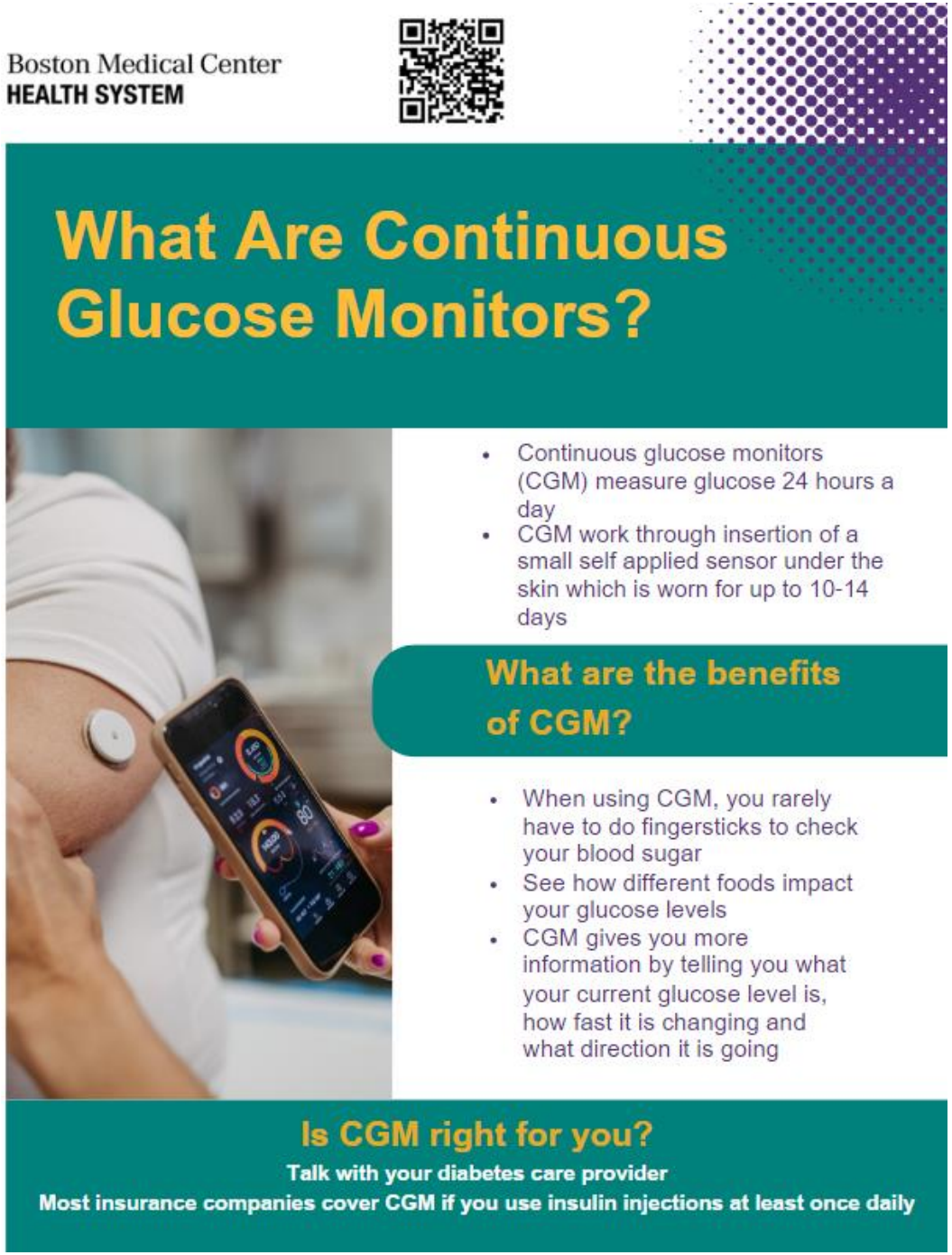
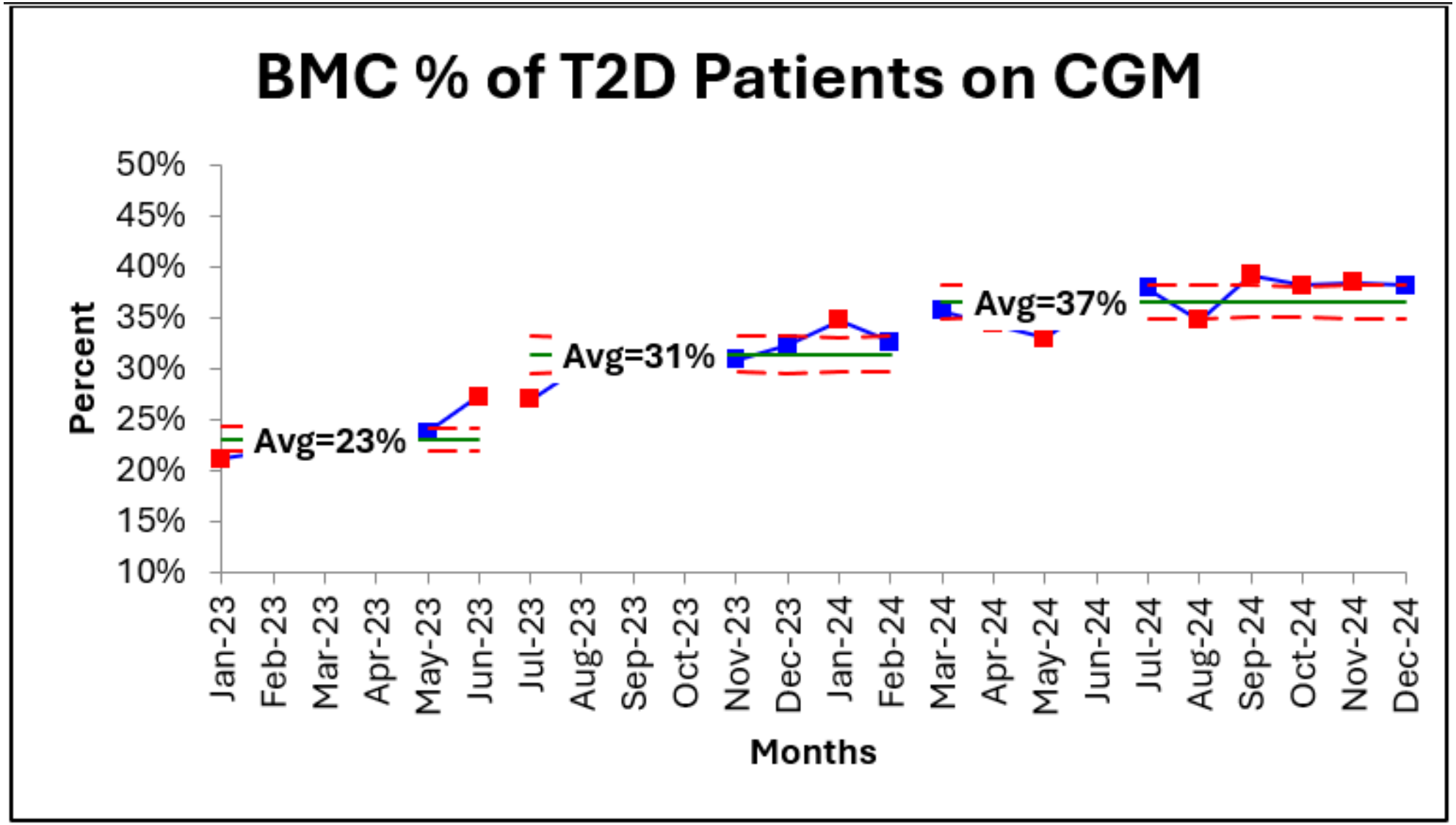
- Created patient facing flyers to post in clinic to encourage CGM conversation with patient and provider. Distributed provider survey to assess barriers. June/July 2024
- CGM eligibility criteria, clinic workflow, resources, and prescribing data reviewed at faculty meeting. October 2024
- Created handout for RD CDCES to use with patients with QR code link to CGM video. November 2024
- CGM Basics video in Spanish and Haitian Creole uploaded to BMC website. December 2024

Thank you to Trevon and UPMC for the idea for this handout!



Ongoing Data



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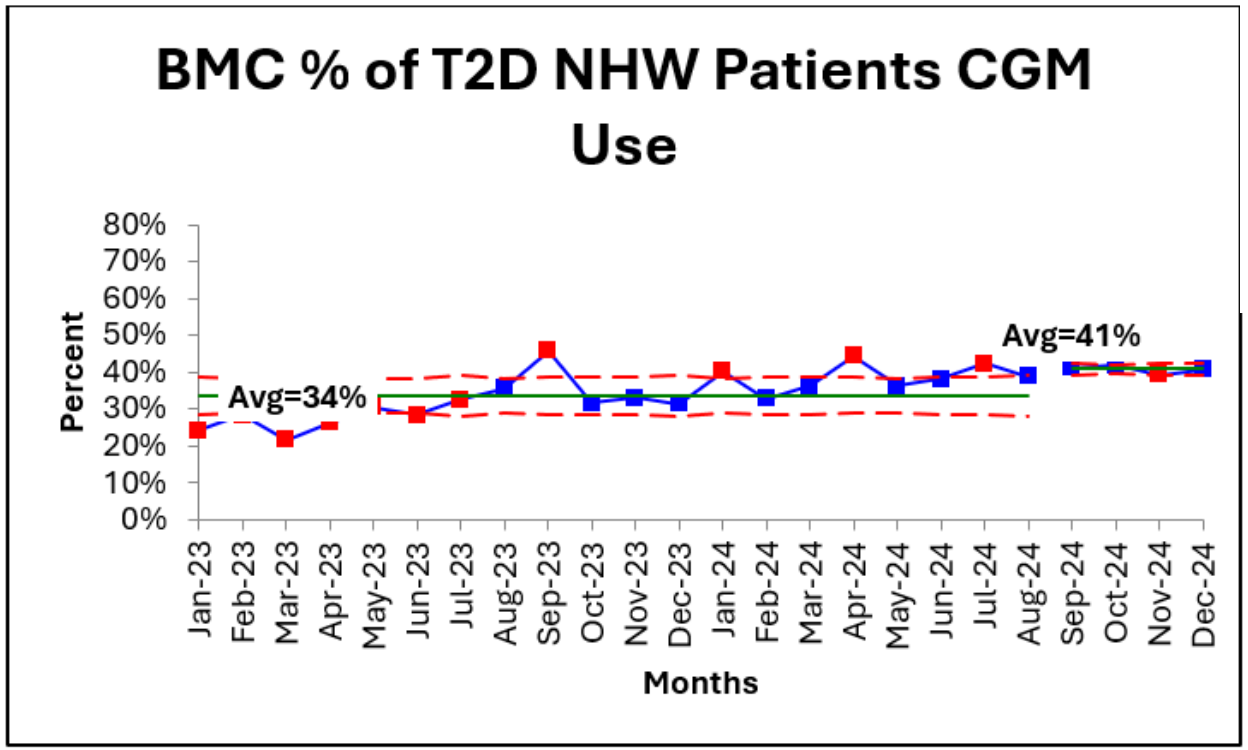

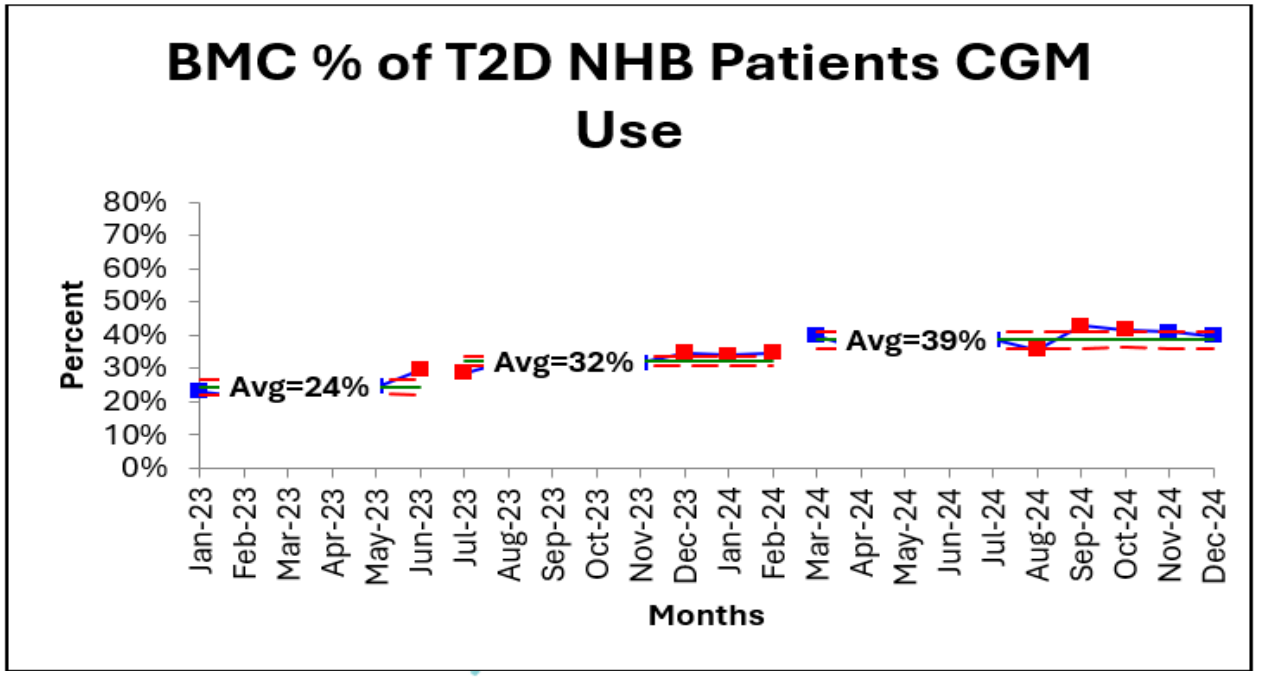

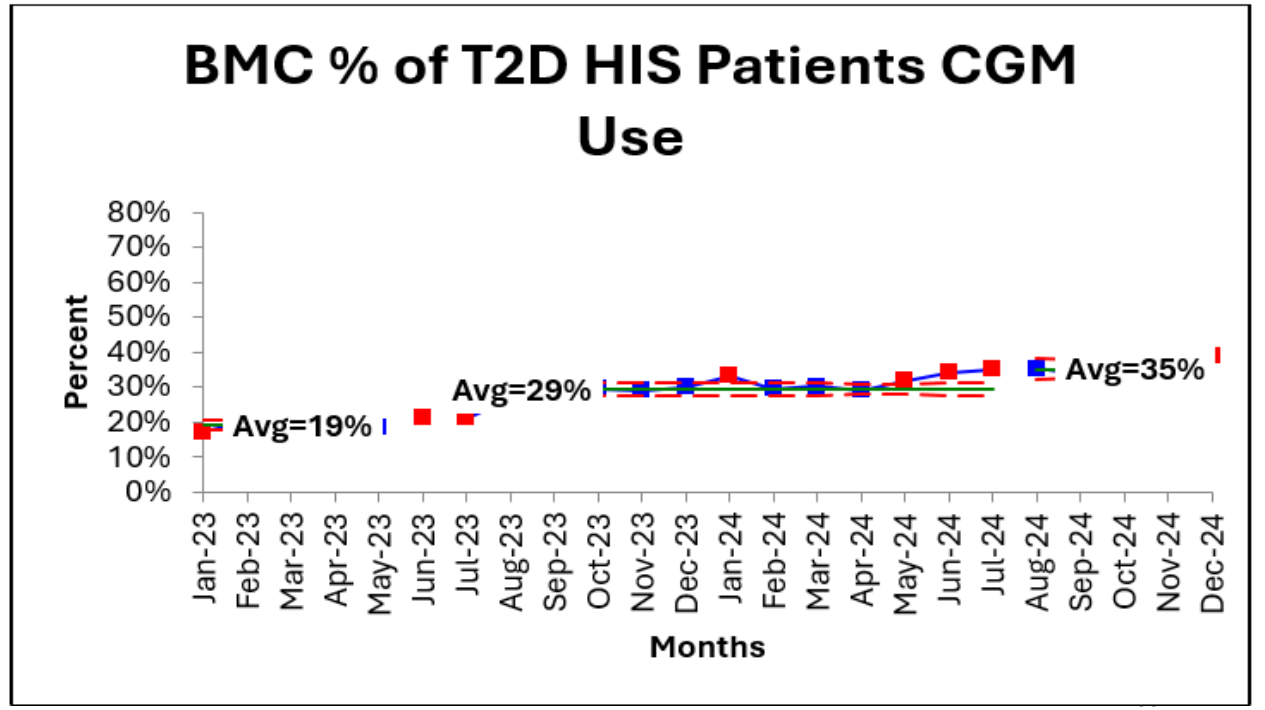

Upcoming PDSA Cycles

- Follow up with RD CDCES' use of the CGM handout
- Continuous Glucose Monitoring in-service for all BMC dietitians
- New monthly CGM classes
  - CGM basics
  - CGM & Nutrition

Lessons Learned

- Involve the broader community
  - Including patient perspectives early helped identify several interventions
  - What is obvious or easy for one person may not be to another
  - Others may have interest in involvement and skills to contribute!
- Data collection and review can help target interventions
  - BMC QI Hub essential to gathering data as data mapping not yet complete at BMC
- One step at a time
  - Avoids overwhelming people and resources and builds momentum
- Shared resources
  - Iteration and adaptation can help fit interventions to context