T1D Exchange

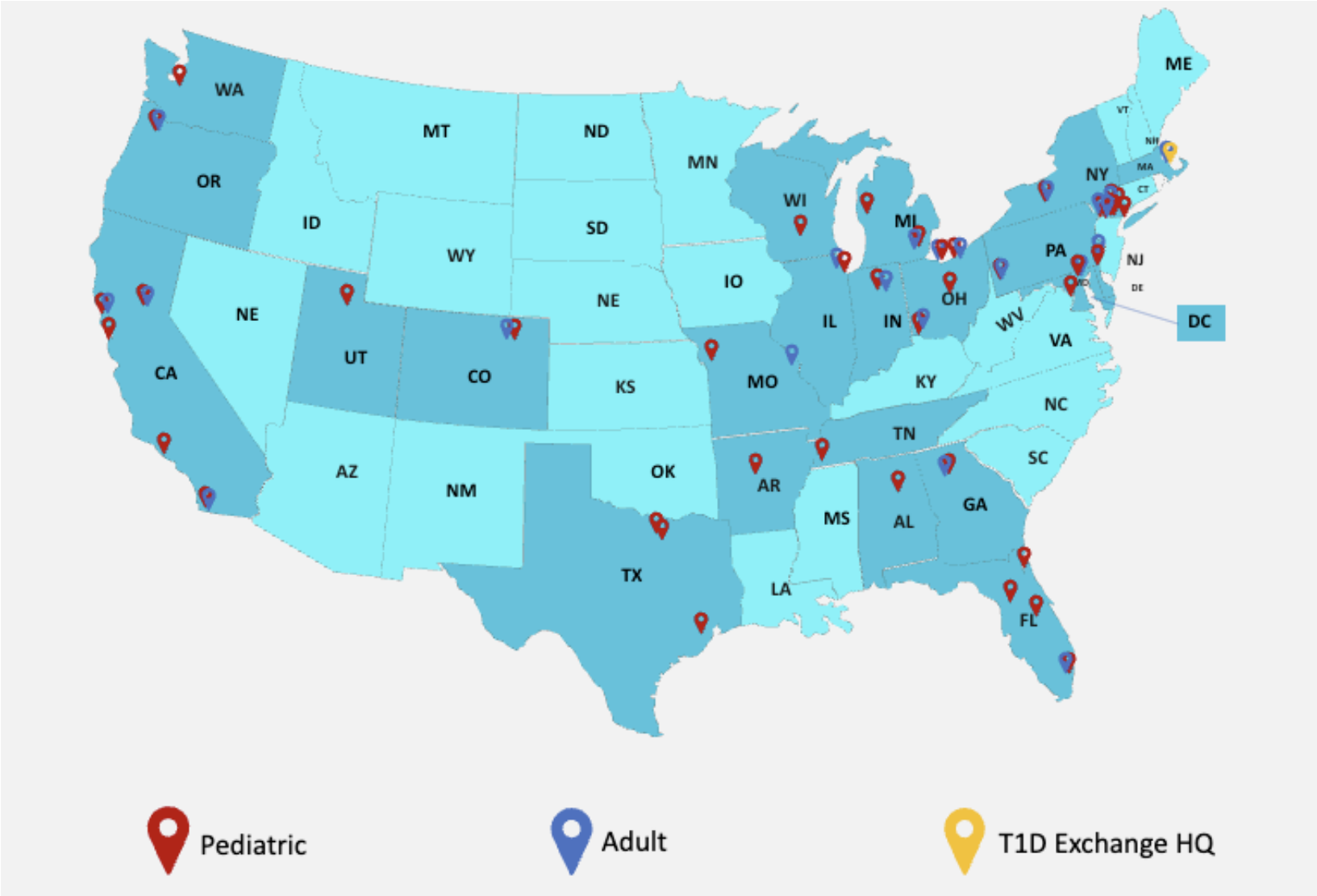
T1DX-QI Collaborative Meeting, Adults

September 25, 2025

Agenda

- Welcome and Introductions
- Updates from the Coordinating Center
  - Annual Survey
  - November Learning Session
  - 2026-2028 Measures
  - Dashboard review
- Clinical center presentation: Northwestern
- Next meeting: Tuesday January 27th 3:30-5:00pm EST

T1DX-QI Collaborative Centers: 41 Pediatric & 21 Adult



You can find more information about the Collaborative on the member website including the details of the list of centers, contacts, publications, committees, and special projects.

You can find more information about the Collaborative data and benchmarking on the QI Portal.

The 2025 Annual Survey

We encourage every center to complete the survey. Why is this important?

- Your responses help us understand the infrastructure and the needs across the centers
- We can better advocate and learn together, understanding opportunities for future projects and priorities
- Publication opportunities in forthcoming abstracts and manuscripts
- If you haven't completed the survey yet, we ask that you submit one survey per center. Please use this link to complete this year's survey on or before **Friday October 4, 2025.**

T1DX-QI Learning Session, November 11-12

Event Highlights

Welcome Reception: Nov. 10, 5-6:30pm

Sessions: Nov. 11-12 at The Whitley Hotel

Collaborate, share strategies, and showcase your work.

Action Items

Register for the event before 10/1/2025.

Reserve your hotel.

Confirm your travel plans —

Arrive by Monday afternoon to join the welcome reception.

We look forward to seeing you in Atlanta!

T1D Exchange

Learning Session Posters and Oral Presentations

- We received 63 abstracts. Thank you for your contributions!
- Accepted will be included in the *Journal of Diabetes*

Abstracts that have been accepted as posters

- Please share your poster by Friday October 17th
- T1D Exchange will print your poster and bring it to Atlanta for the conference. You can take the poster home with you when the conference concludes.
- Time is blocked after Tuesday's lunch for poster presentations

Abstracts that have been accepted as oral presentations

- Please share your slides by Friday October 17th
  - Plan to share 8 slides
  - 10 min presentation plus time for questions

T1DX-QI 2026-2028 Measures

Collaborative measures for 2022-2025 period end on 12/31/2025

Review period for new measures

- The T1DX-QI coordinating center will share proposed measurement definitions before 10/1/2025
- We as for your feedback by 10/24/2025
- We will share back the final definitions by 11/3/2025

New 2026-2028 Measures go live on 1/1/2026

- New Smartsheets for the new measurement period will be shared with teams by 1/1/2026
- Data reporting for the new period is requested by 3/1/2026 to begin reporting data for the 1/1/2026+ period

2023-2025 Data Overview

T1D Exchange

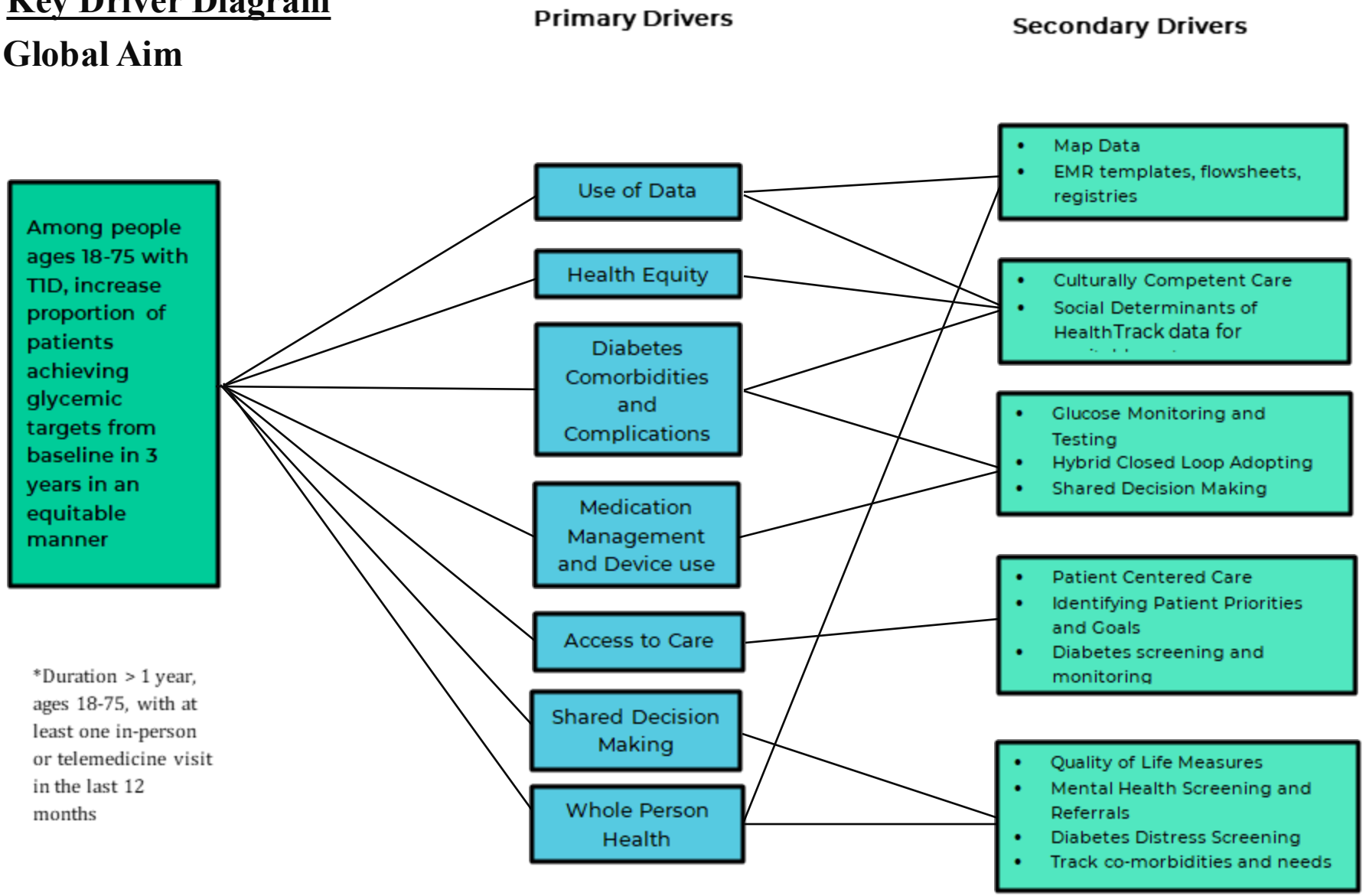
QI Collaborative Adult Centers Dashboard Review

September 2025

21 adult clinics – caring for 20,000+ patients with T1D

Key Driver Diagram

Global Aim



*Duration > 1 year, ages 18-75, with at least one in-person or telemedicine visit in the last 12 months

How we receive data at T1D Exchange?

Data Mapping

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

Smartsheets

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

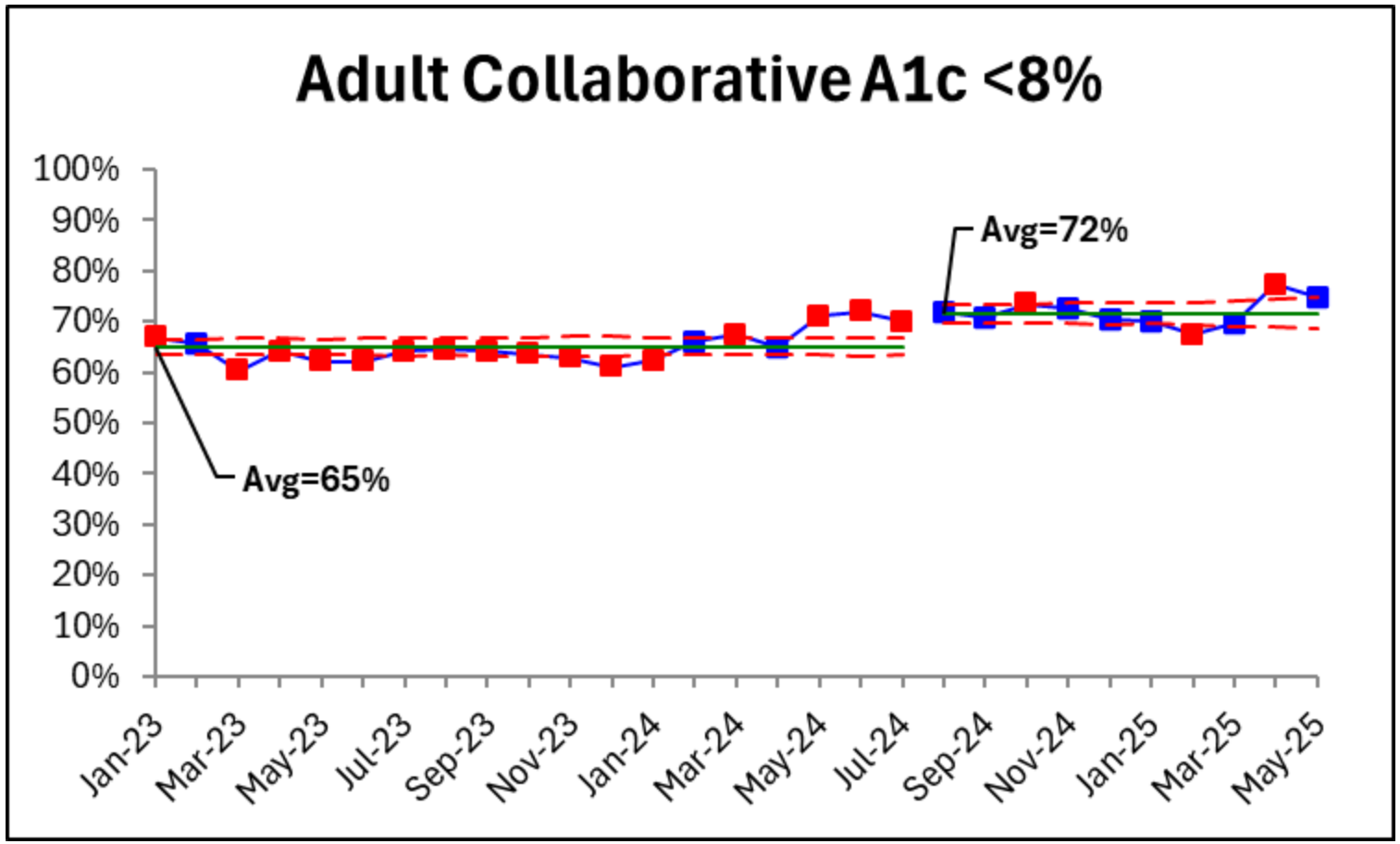
Core QI Measures – Adult clinics

January 2023 – Sep 2025

Measures reported as of Sep 2025	Measure	# of Adult clinics reporting
Outcome Measures	HbA1c >8%	**14 clinics**
	HbA1c >9%	**14 clinics**
Process Measures	CGM use	**12 clinics**
	Pump use	**13 clinics**
	HCL [AID] use	**8 clinics**
	DKA events	**12 clinics**
Other Measures	Time in Range	**2 clinics**
	Social Determinants of Health screening	**2 clinics**

T1D Exchange

Adult Clinics - HbA1c <8%



Increase by 8%

Run chart favorable direction

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	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	Jan-25	Feb-25	Mar-25	Apr-25	May-25
3447	3317	2928	3161	3264	2631	2154	2590	2117	2215	2054	1726	2719	2685	2405	2636	2665	2287	3067	2668	2874	2802	2138	1985	2283	1714	1402	1237	947
2306	2181	1766	2028	2026	1633	1383	1671	1357	1410	1291	1055	1694	1772	1620	1717	1895	1646	2146	1920	2036	2058	1555	1398	1598	1156	975	957	707

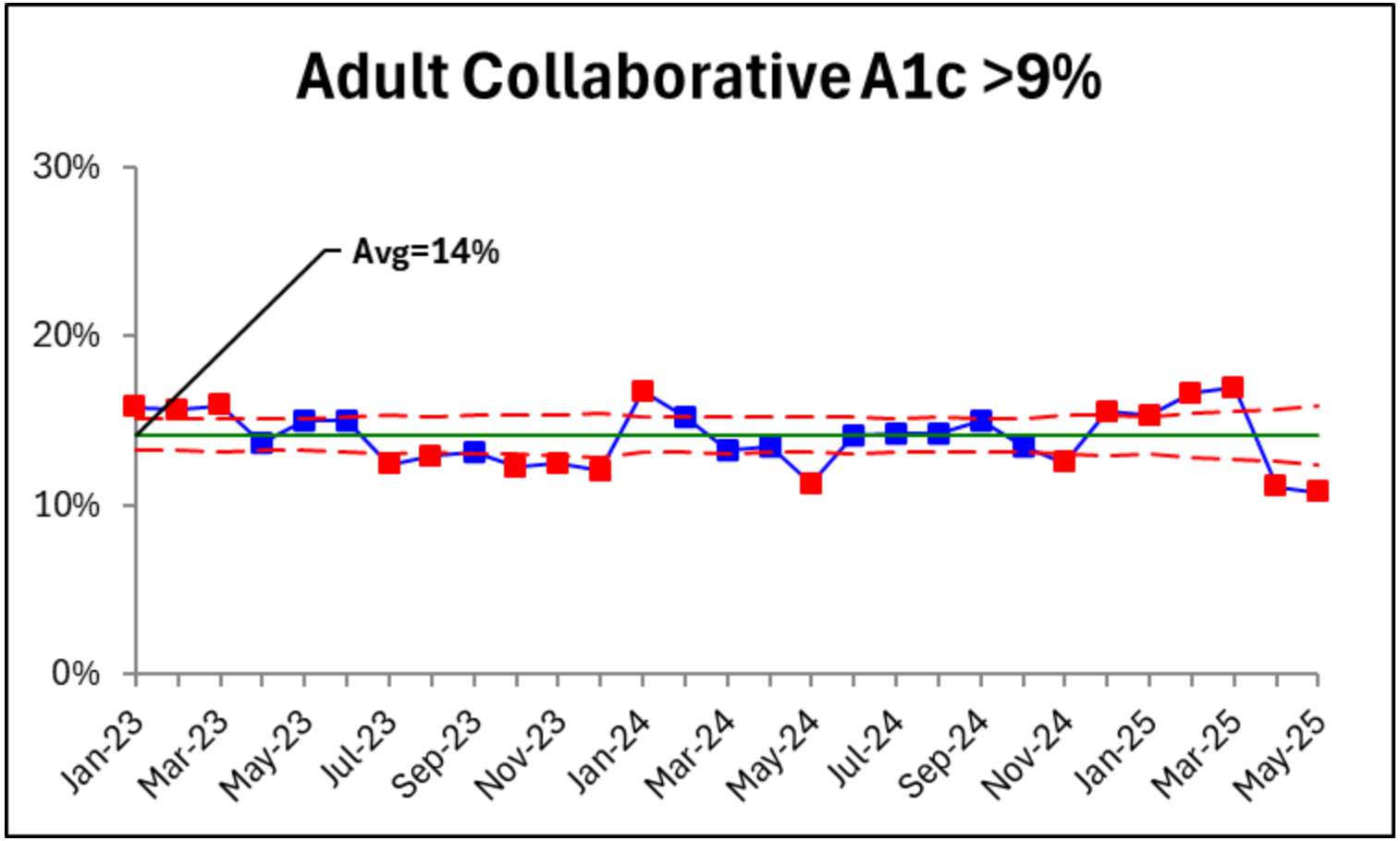
Adult Clinics - HbA1c < 8% Summary

- **QI Collaborative Goal: 50%**
- **QI Collaborative Average: 72%**
- **Improvement Range: 27% to 82%**

- **Centers that meet goal: 10/14**
- **Top performers:**

1. Barbara Davis 82%
2. Mt. Sinai 78%
3. Northwestern 77%
4. UC Davis 72%

Adult Clinics - HbA1c >9%



Run chart favorable direction

QI Collaborative Goal: 25%
QI Collaborative Average: 29%

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	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	Jan-25	Feb-25	Mar-25	Apr-25	May-25
3447	3317	2928	3161	3264	2631	2154	2590	2117	2215	2054	1726	2719	2685	2405	2636	2665	2287	3067	2668	2874	2802	2138	1985	2283	1714	1402	1237	947
543	518	465	431	488	395	267	333	277	271	256	207	454	407	317	354	300	322	435	378	429	377	267	308	349	284	237	137	102

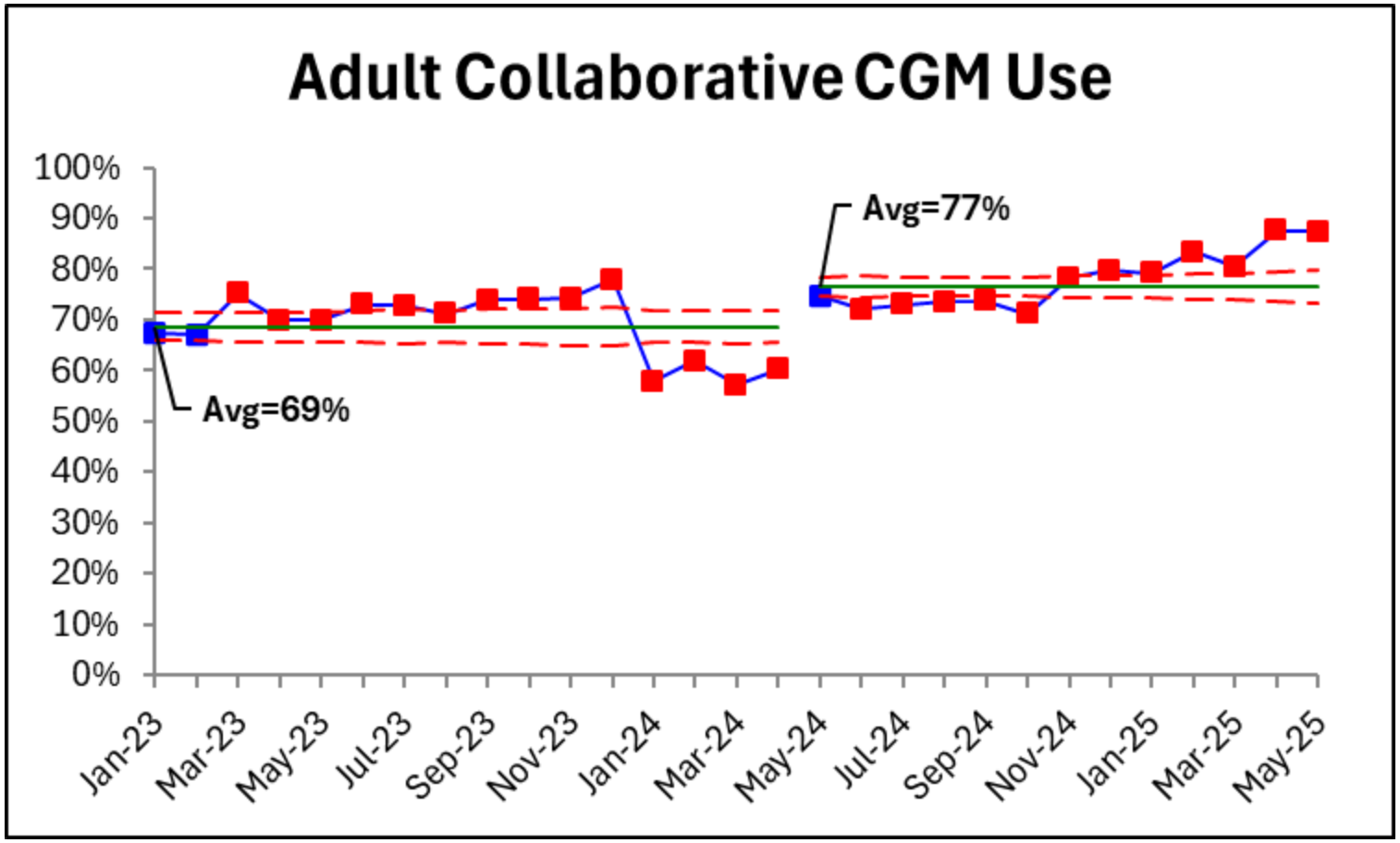
Adult Clinics - HbA1c > 9% Summary

- **QI Collaborative Average: 14%**
- **Improvement Range: 41% to 5%**

- **Centers that meet goal: 10/14**
- **Top performers:**

1. Barbara Davis 5%
2. UPenn 7%
3. Mt. Sinai 9%
4. Northwestern 9%

Adult Clinics - CGM Use



Increase by 8%

Run chart favorable direction

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	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	Jan-25	Feb-25	Mar-25	Apr-25	May-25
3447	3317	2928	3161	3264	2631	2154	2590	2117	2215	2054	1726	2719	2685	2405	2636	2665	2287	3067	2668	2874	2802	2138	1985	2283	1714	1402	1237	947
2318	2230	2200	2211	2279	1921	1569	1841	1563	1642	1527	1346	1575	1661	1375	1586	1992	1648	2239	1964	2117	1996	1672	1583	1806	1428	1128	1083	827

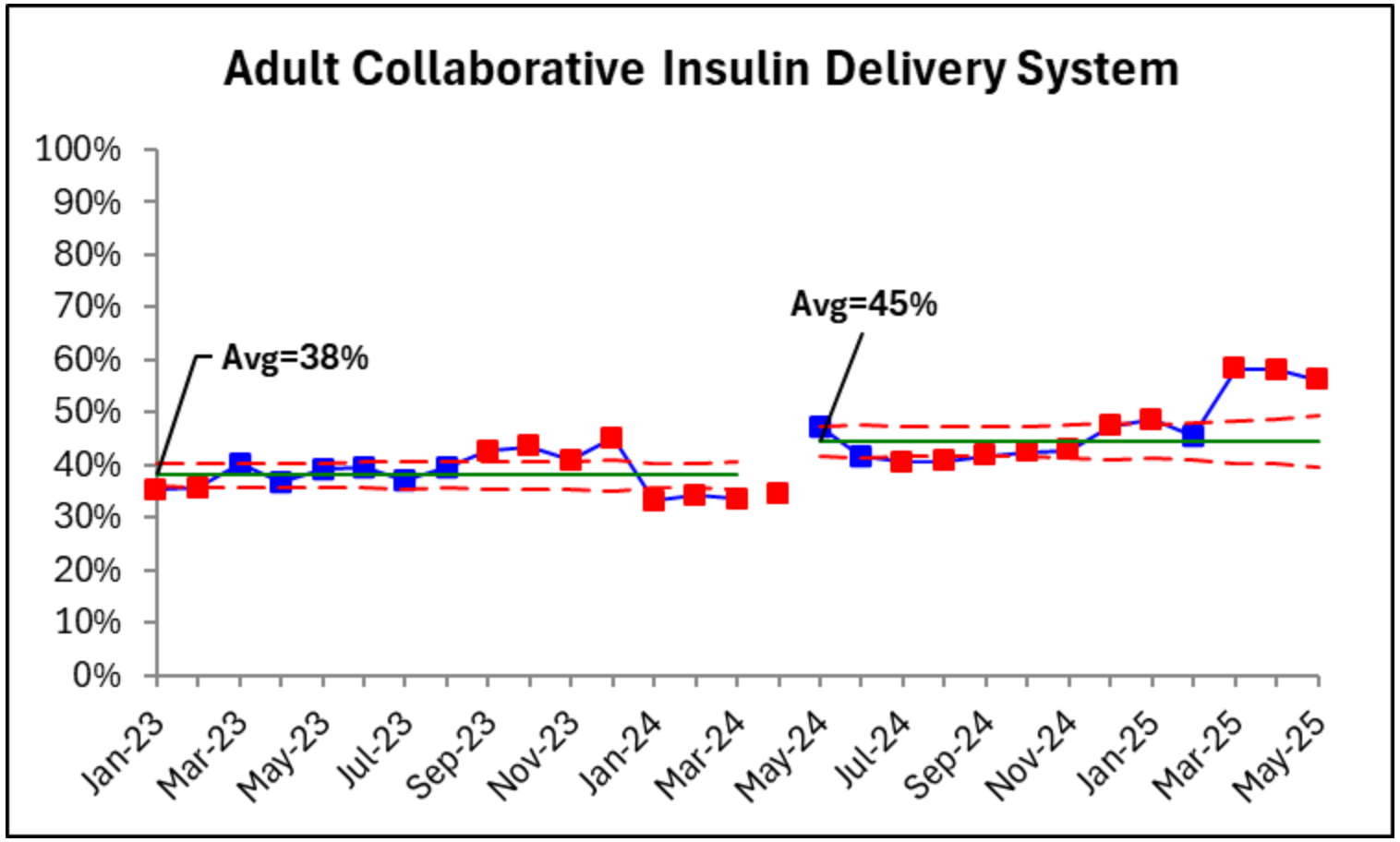
Adult Clinics – CGM Use

- **QI Collaborative Goal: 70%**
- **QI Collaborative Average: 77%**
- **Improvement Range: 48% to 98%**

- **Centers that meet goal: 9/12**
- **Top performers:**

1. Northwestern 98%
2. Johns Hopkins 97%
3. UC Davis 90%
4. Mt. Sinai 90%

Adult Clinics – Insulin Delivery System



Increase by 7%

Run chart favorable direction

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	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	Jan-25	Feb-25	Mar-25	Apr-25	May-25
3447	3317	2928	3161	3264	2631	2154	2590	2117	2215	2054	1726	2719	2685	2405	2636	2665	2287	3067	2668	2874	2802	2138	1985	2283	1714	1402	1237	947
1213	1179	1175	1164	1277	1038	795	1026	903	965	840	778	900	917	806	911	1256	952	1242	1083	1197	1188	913	940	1111	781	817	718	532

Adult Clinics – Insulin Delivery System

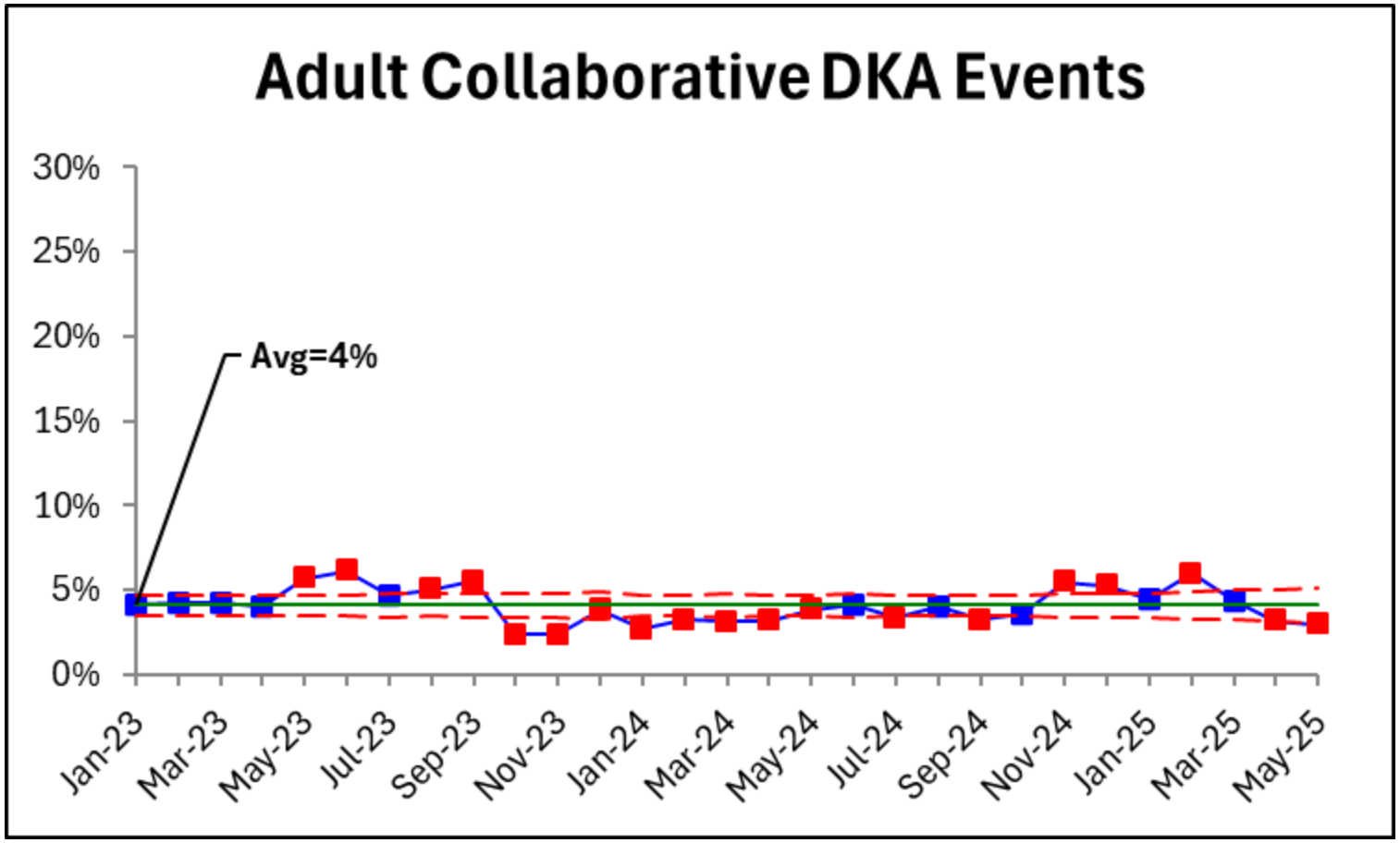
- **QI Collaborative Goal: 65%**
- **QI Collaborative Average:45**%
- **Improvement Range: 18% to 76%**

Centers that meet goal: 3/13

- **Top performers:**

1. UC Davis 76%
2. Johns Hopkins 70%
3. Mt. Sinai 65%
4. UPenn 64%

Adult Clinics – DKA Events



Decrease by 1%

Run chart favorable direction

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	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	Jan-25	Feb-25	Mar-25	Apr-25	May-25
3447	3317	2928	3161	3264	2631	2154	2590	2117	2215	2054	1726	2719	2685	2405	2636	2665	2287	3067	2668	2874	2802	2138	1985	2283	1714	1402	1237	947
141	140	123	128	186	161	102	130	117	52	48	66	73	87	75	84	102	94	103	108	93	102	117	104	103	102	61	39	28

Adult Clinics – DKA Events

- **QI Collaborative Goal: 5%**
- **QI Collaborative Average: 4%**
- **Improvement Range: 0.5 to 7%**

- **Centers that meet goal: 11/12**
- **Top performers:**

1. Mt. Sinai: 0.5%
2. SUNY: 1%
3. BMC: 1%
4. Northwestern: 1%

68% of Centers Meeting T1DX-QI Goals

Adult Improvement Scorecard							
Number Key	A1c less than 8%	A1c greater than 9%	CGM	Insulin delivery system	DKA	Time In Range >50%	SDOH Screening
Goals	>50%		>70%	>65%	<5%	>50%	>10%
QIC Status	72%	14%	77%	45%	4%	48%	21%
1	#2 [82%]	#2 [5%]	#7 [98%]	#11 [76%}	#6 [0.5%]	#2 [56%]	#13 [43%]
2	#14 [82%]	#14 7%	#5 [97%]	#5 [70%]	#9 [0.5%]	#3 [40%]	#12 [2%]
3	#6 [78%]	#6 [9%]	#9 [91%]	#14 69%	#7 [1%]		
4	#7 [77%]	#7 [9%]	#6 [90%]	#6 [65%]	#3 [1%]		
5	#5 [75%]	#13 [11%]	#11 [90%]	#13 [64%]	#2 [2%]		
6	#8 [72%]	#5 [12%]	#13 [90%]	#9 [61%]	#11 [2%]		
7	#10 [72%]	#10 [12%]	#3 [81%]	#2 [60%]	#12 [2%]		
8	#11 [72%]	#8 [13%]	#2 [79%]	#7 [47%]	#5 [2%]		
9	#12 [69%]	#11 [15%]	#4 [71%]	#10 [39%]	#8 [3%]		
10	#9 [61%]	#9 [16%]	#12 [69%]	#3 [36%]	#4 [4%]		
11	#3 [52%]	#12 [17%]	#8 [60%]	#8 [29%]	#10 [6%]		
12	#13 [49%]	#3 [30%]	#10 [48%]	#1 [25%]	#13 [7%]		
13	#1 [48%]	#1 [34%]		#12 [18%]			
14	#4 [27%]	#4 [41%]					


T1D
Exchange

Center Presentation

Northwestern Medicine®
Feinberg School of Medicine

Screening for Liver Fibrosis in T1D

Northwestern Medicine
T1DX-QI Update

Sept 25, 2025

Jared Friedman, MD, Grazia Aleppo, MD

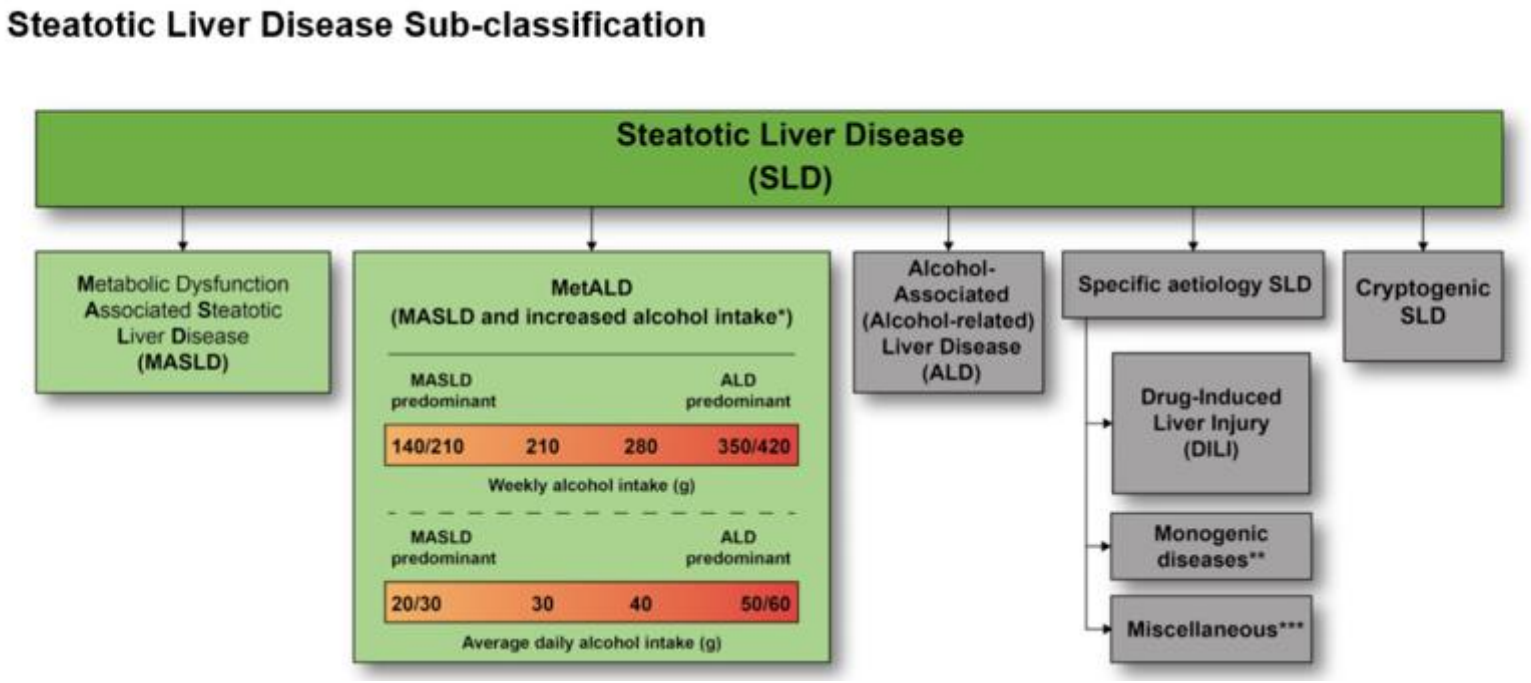
MASLD and MASH

2023: New terminology to describe NAFLD and NASH by consensus of liver organizations as a way of directly linking the disease to the underlying metabolic dysfunction and to decrease stigmatization

SLD= Steatotic Liver Disease

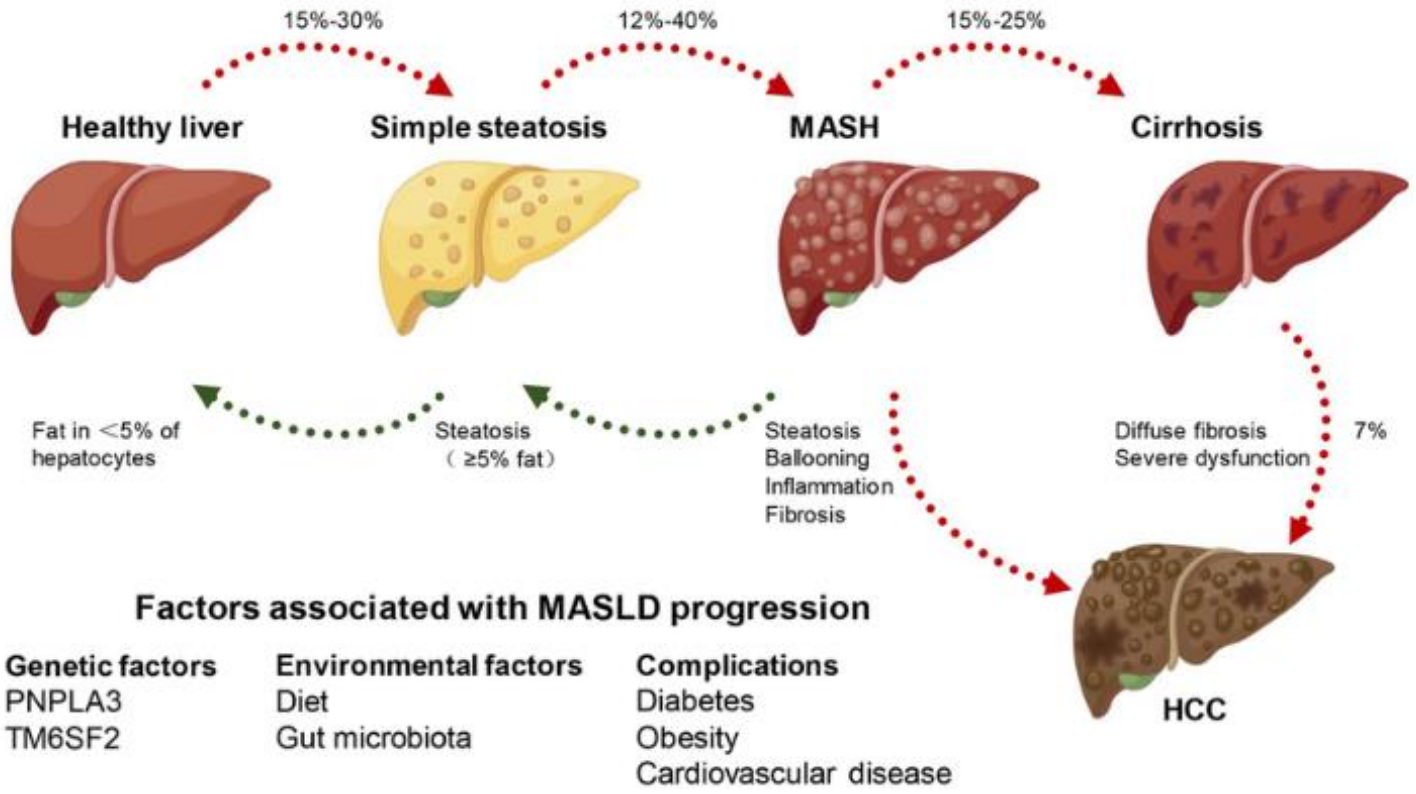
MASLD= Metabolic-Dysfunction Associated Steatotic Liver Disease

MASH= Metabolic-Dysfunction Associated Steatohepatitis



Rinella ME, Lazarus JV, Ratziu V, et al. A multi-society Delphi consensus statement on new fatty liver disease nomenclature. *Hepatology*. Jun 24 2023;doi:10.1097/hep.0000000000000520; https://www.aasld.org/new-masld-nomenclature

Progression of MASLD



- 20-30% of individuals with MASLD will later develop MASH[1]
- MASH is the most common indication for liver transplant in women and in people over 54 years old[2]

1 Chalasani N, Younossi Z, Lavine JE, et al. The diagnosis and management of nonalcoholic fatty liver disease: Practice guidance from the American Association for the Study of Liver Diseases. *Hepatology*. 2018;67(1):328-357. doi:10.1002/hep.29367
2 Stepanova M, Kabbara K, Mohess D, et al. Nonalcoholic steatohepatitis is the most common indication for liver transplantation among the elderly: Data from the United States Scientific Registry of Transplant Recipients. *Hepatol Commun*. 2022;6(7):1506-1515. doi:10.1002/hep4.1915

MASLD Risk Factors

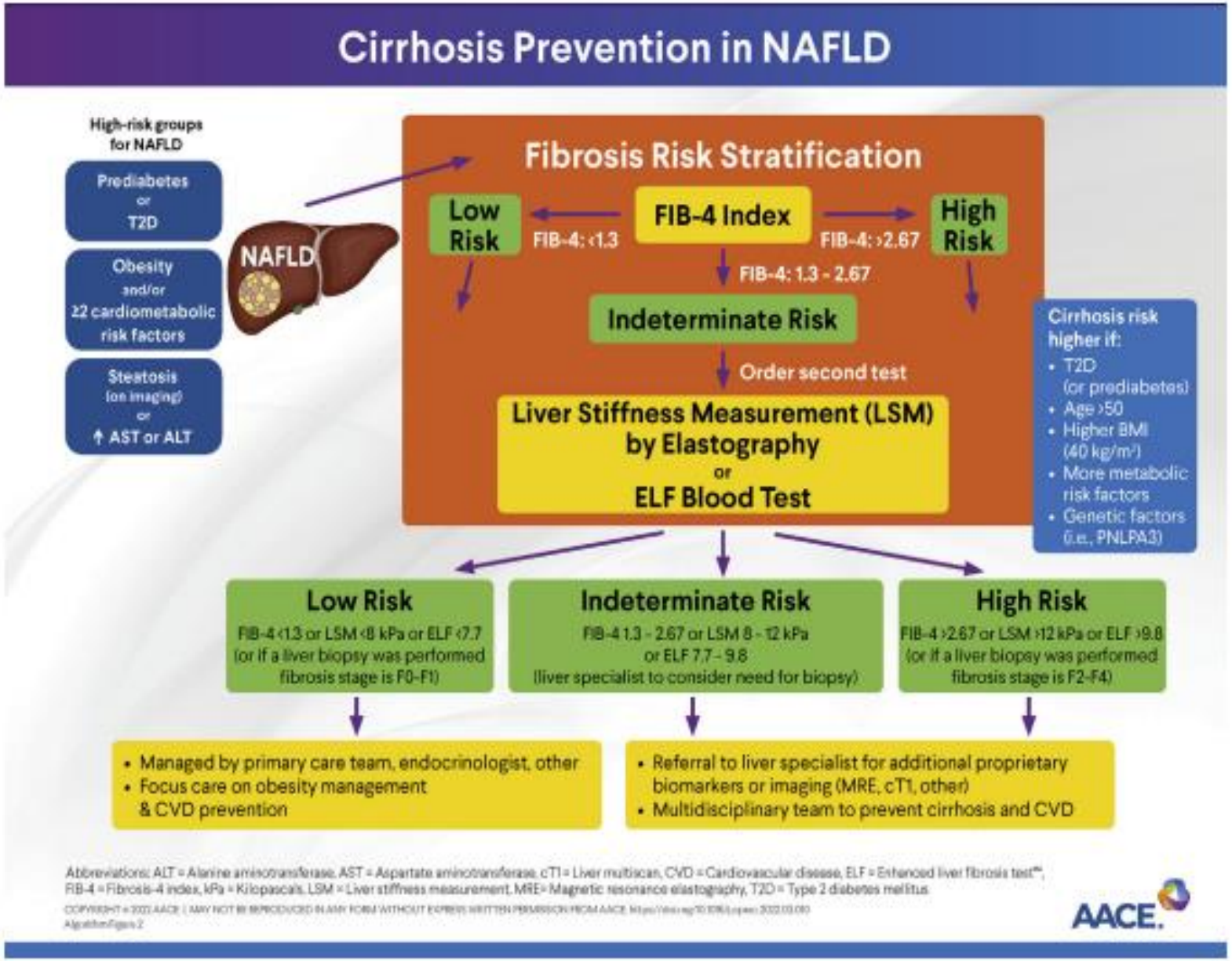
- Obesity is a risk factor for MASLD; it is thought to promote inflammation and oxidative stress at the liver
- There is a well-established link between T2D and MASLD. T2D → risk factor for onset and progression of liver disease
- MASLD impairs metabolic pathways involved in insulin secretion and sensitivity

Fibrosis-4 Index (FIB-4)

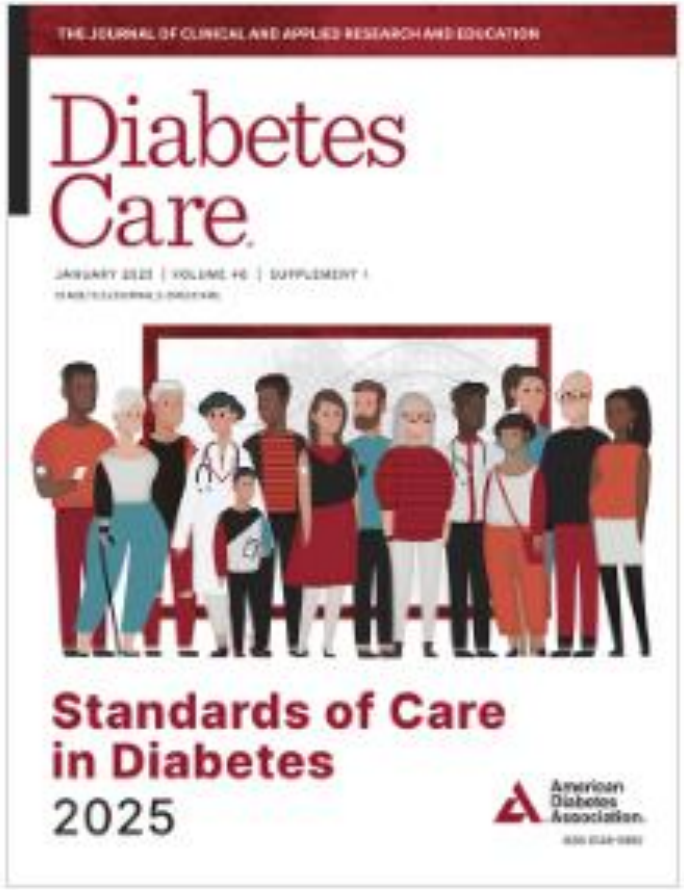
$$\text{FIB-4} = \frac{\text{Age (years)} \times \text{AST (U/L)}}{\text{Platelet Count } (10^9/\text{L}) \times \sqrt{\text{ALT (U/L)}}}$$

Calculation validated in ages 35-65 (initial study population)

- While liver biopsy is the gold standard for diagnosing liver fibrosis, it comes with procedural risks
- A non-invasive screening test allows for initial risk stratification



Cusi K, Isaacs S, Barb D, et al. American Association of Clinical Endocrinology Clinical Practice Guideline for the Diagnosis and Management of Nonalcoholic Fatty Liver Disease in Primary Care and Endocrinology Clinical Settings: Co-Sponsored by the American Association for the Study of Liver Diseases (AASLD). *Endocr Pract*. 2022;28(5):528-562. doi:10.1016/j.eprac.2022.03.010



Metabolic Dysfunction–Associated Steatotic Liver Disease and Metabolic Dysfunction–Associated Steatohepatitis

Screening

Recommendations

4.22a Screen adults with type 2 diabetes or with prediabetes, particularly those with obesity or other cardiometabolic risk factors or established cardiovascular disease, for their risk of having or developing cirrhosis related to metabolic dysfunction–associated steatohepatitis (MASH) using a calculated fibrosis-4 index (FIB-4) (derived from age, ALT, AST, and platelets [mdcalc.com/calc/2200/fibrosis4-fib-4-index-liver-fibrosis]), even if they have normal liver enzymes. **B**

American Diabetes Association Professional Practice Committee. 4. Comprehensive Medical Evaluation and Assessment of Comorbidities: Standards of Care in Diabetes-2025. *Diabetes Care*. 2025;48(1 Suppl 1):S59-S85. doi:10.2337/dc25-S004

But What About T1D?

T1D and MASLD Risk

- It is estimated that 1 in 3 adults with T1D lives with obesity[1]
- When DCCT started in 1983, only 1% of individuals enrolled had BMI >30 kg/m2 however that had increased to 31% by year 10 of the EDIC study[2]
- We are still learning about how obesity affects insulin resistance and associated metabolic complications in this population

1 Fang M, Jeon Y, Echouffo-Tcheugui JB, Selvin E. Prevalence and Management of Obesity in U.S. Adults With Type 1 Diabetes. *Ann Intern Med*. Mar 2023;176(3):427-429. doi:10.7326/m22-3078
2 Nathan DM, Zinman B, Cleary PA, et al. Modern-day clinical course of type 1 diabetes mellitus after 30 years' duration: the diabetes control and complications trial/epidemiology of diabetes interventions and complications and Pittsburgh epidemiology of diabetes complications experience (1983-2005). *Arch Intern Med*. Jul 27 2009;169(14):1307-16. doi:10.1001/archinternmed.2009.193

Screening Using Fib-4

- We completed a retrospective review of individuals with T1D age 35-65 at our practice with relevant FIB-4 labs
- FIB-4 was calculated to stratify patients into low-risk and intermediate/high-risk categories
- Demographics and glycemic status-related variables (HbA1c, device use, glucometric data from continuous glucose monitoring (CGM), and total daily insulin) were obtained and compared between FIB-4 risk categories

Friedman, J, et al. Diabetes 2025;74(Supplement_1):1426-P

Characteristic	Overall, N = 354[1]	Low risk, N = 293[1]	Intermediate and high risk, N = 61[1]	P-value (low vs intermediate/high risk)[2]
age				<0.001
Mean (SD)	48.1 (9.1)	46.5 (8.5)	55.7 (7.9)	
Median (IQR)	46.0 (40.0, 56.0)	44.0 (40.0, 53.0)	58.0 (51.0, 62.0)	
legal sex				0.3
F	176 (50%)	149 (51%)	27 (44%)	
M	178 (50%)	144 (49%)	34 (56%)	
race (recoded into 4 categories)				0.13
White	248 (70%)	201 (69%)	47 (77%)	
Black or African American	30 (8.5%)	27 (9.2%)	3 (4.9%)	
Asian	12 (3.4%)	8 (2.7%)	4 (6.6%)	
Other	64 (18%)	57 (19%)	7 (11%)	

Friedman, J, et al. Diabetes 2025;74(Supplement_1):1426-P

ethnicity (recoded into 3 categories)				0.4
Hispanic	34 (9.6%)	28 (9.6%)	6 (9.8%)	
Non-Hispanic	286 (81%)	234 (80%)	52 (85%)	
Patient declined	34 (9.6%)	31 (11%)	3 (4.9%)	
latest bmi				0.006
Mean (SD)	28.4 (6.1)	28.8 (6.1)	26.5 (5.3)	
Median (IQR)	27.0 (24.1, 32.0)	27.4 (24.3, 32.3)	25.9 (23.3, 28.3)	
current insurance (recoded into 2 categories)				0.008
Private	304 (86%)	258 (88%)	46 (75%)	
Public	49 (14%)	34 (12%)	15 (25%)	
Unknown	1	1	0	

Friedman, J, et al. Diabetes 2025;74(Supplement_1):1426-P

latest hba1c				0.2
Mean (SD)	7.1 (1.3)	7.2 (1.3)	6.8 (1.1)	
Median (IQR)	6.9 (6.4, 7.7)	6.9 (6.4, 7.7)	6.8 (6.3, 7.5)	
Unknown	1	1	0	
received CGM				0.3
Yes	352 (99%)	292 (100%)	60 (98%)	
No	2 (0.6%)	1 (0.3%)	1 (1.6%)	
received insulin pump				>0.9
Yes	351 (99%)	290 (99%)	61 (100%)	
No	3 (0.8%)	3 (1.0%)	0 (0%)	
fib4				<0.001
Mean (SD)	1.0 (0.5)	0.8 (0.2)	1.8 (0.7)	
Median (IQR)	0.8 (0.7, 1.1)	0.8 (0.6, 1.0)	1.6 (1.4, 1.8)	

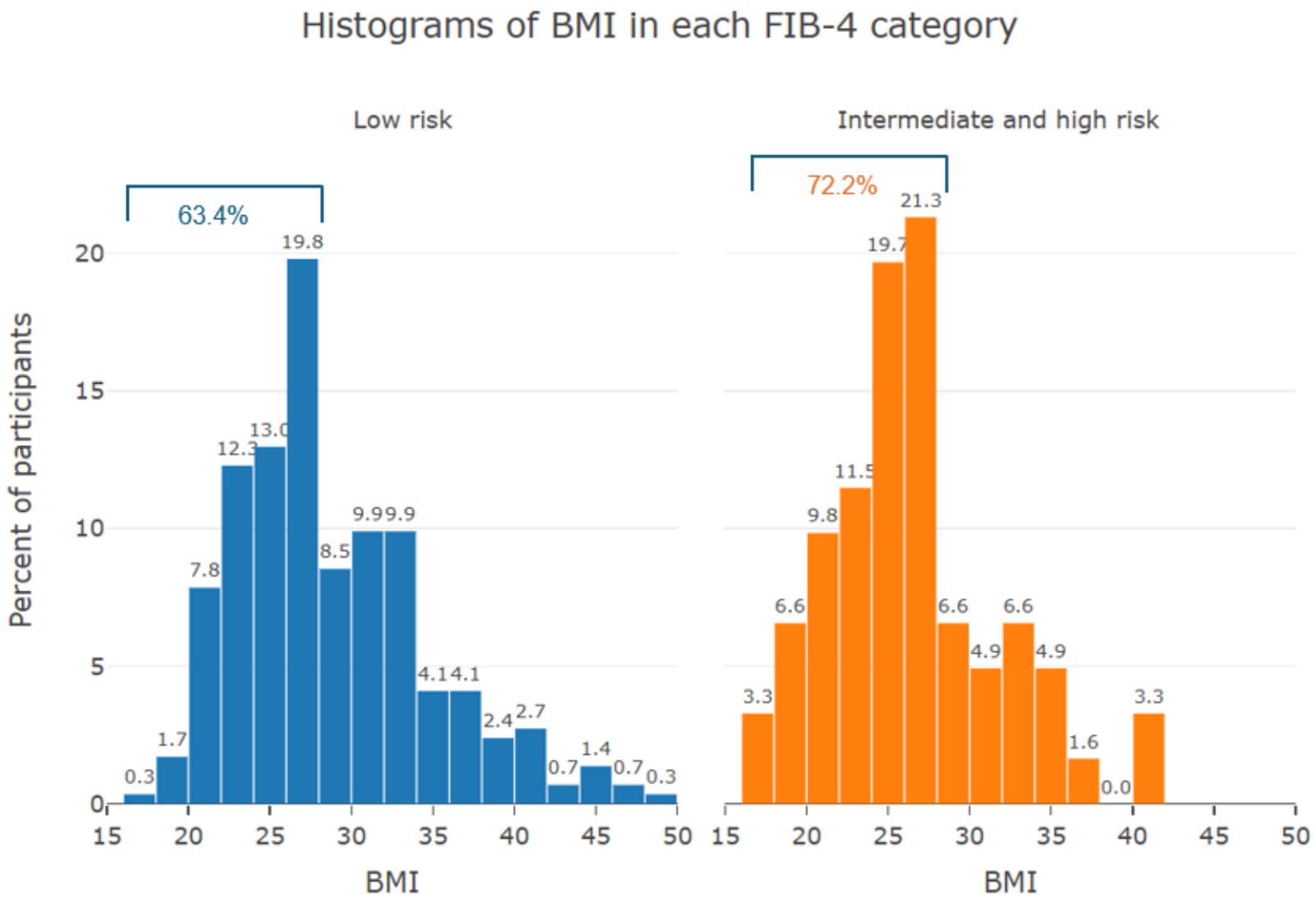
Friedman, J, et al. Diabetes 2025;74(Supplement_1):1426-P

GMI				0.2
Mean (SD)	7.2 (1.0)	7.2 (1.0)	7.1 (0.8)	
Median (IQR)	7.1 (6.7, 7.6)	7.1 (6.7, 7.6)	7.0 (6.6, 7.3)	
Unknown	93	73	20	
% time CGM glucose was >250 mg/dL				0.3
Mean (SD)	10.9 (14.3)	11.2 (14.5)	9.6 (12.9)	
Median (IQR)	6.0 (2.0, 13.0)	6.0 (2.0, 13.0)	4.0 (2.0, 12.0)	
Unknown	88	68	20	
% time CGM glucose was >180 mg/dL (includes >250 mg/dL)				0.2
Mean (SD)	32.7 (19.8)	33.4 (20.0)	29.1 (18.5)	
Median (IQR)	29.0 (19.0, 44.0)	29.0 (19.0, 46.0)	24.0 (16.0, 40.0)	
Unknown	88	68	20	
% time CGM glucose was at target 70-180 mg/dL				0.2
Mean (SD)	65.1 (19.2)	64.6 (19.4)	68.2 (17.9)	
Median (IQR)	68.0 (54.0, 78.8)	68.0 (54.0, 78.0)	75.0 (55.0, 82.0)	
Unknown	88	68	20	

Friedman, J, et al. Diabetes 2025;74(Supplement_1):1426-P

Results

The bracketed region represents total percent of participants with BMI < 28 kg/m^2



Friedman, J, et al. Diabetes 2025;74(Supplement_1):1426-P

Discussion

- A total of 354 individuals were included in the study. Of them, 61 (17.2%) were deemed intermediate/high-risk for fibrosis by FIB-4.
- The intermediate/high-risk group had a significantly lower BMI (mean±SD 26.5±5.3 vs 28.8±6.1 kg/m^2) and higher likelihood of being on public insurance (25% vs 12%) compared to the low-risk group.
- No significant differences by FIB-4 risk category were observed in the other variables assessed including HbA1c and CGM metrics.

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Conclusion

Individuals with T1D with lower BMI or on public insurance may be at higher risk for an abnormal FIB-4, and therefore, at higher risk for the presence of liver fibrosis.

It may be worthwhile to screen for liver fibrosis in individuals with T1D using FIB-4 irrespective of BMI or glycemic status.

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Next Steps/Future Direction

- Deep dive into demographics of the “lean” T1D patient with liver fibrosis; we will be writing a manuscript and look at addl variables (kidney function, medication use, total daily insulin use)
- Evaluate what % of patients at high risk by Fib-4 proceed with Elastography—possible role for QI to enhance outcomes
- Use of EMR embedded Fib 4 Calculation dotphrase

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Next Steps/Future Direction

- Possible opportunity for pooling data from other T1DX Adult sites to better understand incidence of liver fibrosis in adults with T1D
- Together we can inform screening guidelines, improve treatment pathways, and preserve the liver health for individuals with T1D

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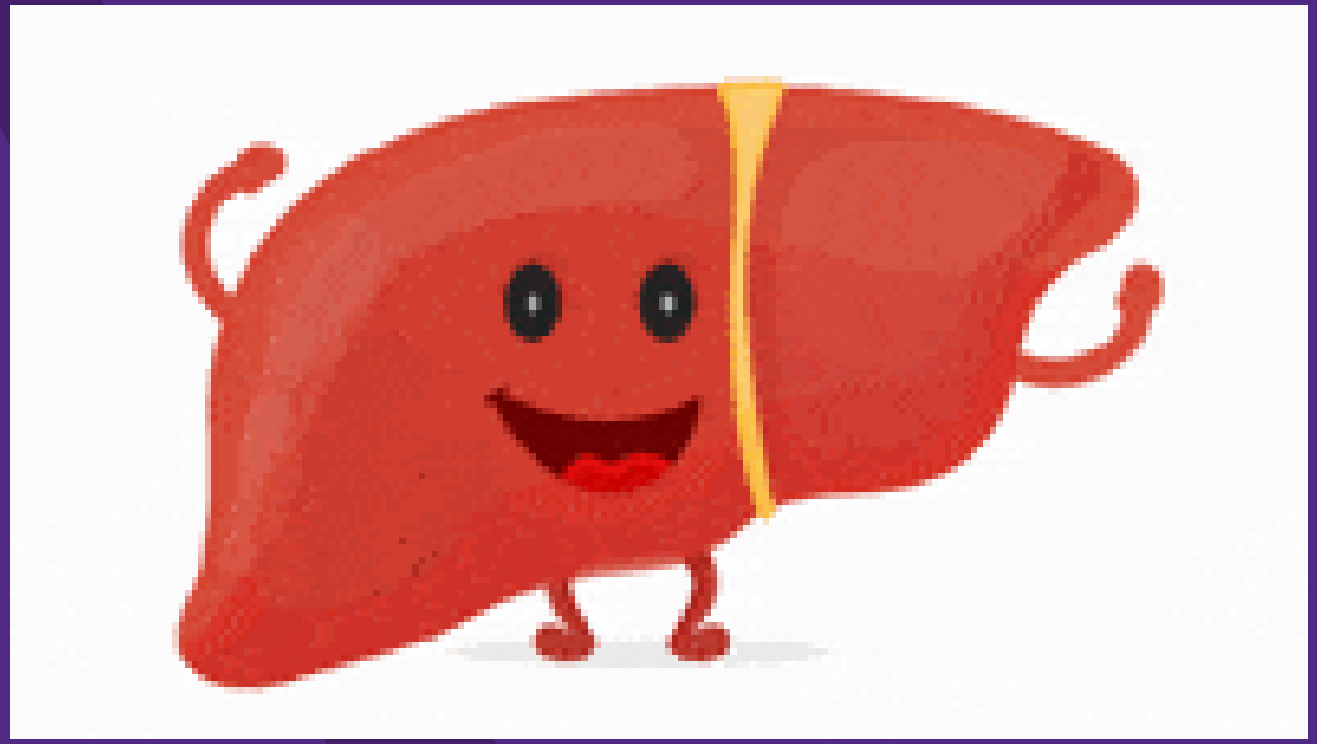
Questions?



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Next meeting

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T1D
Exchange