Department of Pediatrics Meeting
February 23, 2021 @ noon

CMIO update: Digital Health, Patient Data Sharing and IS Strategic Planning
Natalie Pageler, MD, Med / Erin Ballard

Type 1 Diabetes Care: Leading the Way in the Ambulatory Transformation
David Maahs, MD, PhD & Lisa Chamberlain, MD
Department Faculty Meeting Cadence and Topics

• Vaccine Governance
• Finance stabilization and mitigation
• Plans and strategies to re-open clinics and resume elective procedures
  o Procedural Operations Ramp-up Team (PORT)
  o Ambulatory Transformation Team (ATT)
  o Respond, Recover and Re-Open Team (R3)
• Scientific developments and lessons learned
• New clinical research and trials underway
• Wellness
• Plans to ramp-up clinical and basic science research
• Advocacy updates
• Education updates
• Academic Affairs and HR (e.g. hiring and search freezes)
• Real and potential Impact of COVID on patient safety and quality of care
COVID-19 IN CHILDREN SEMINAR SERIES

Sessions will be held monthly starting in March.

Scan QR code to view session recordings on YouTube.

tinyurl.com/covidinchildrenvideos

Covid and the Role of Telehealth and Clinical Informatics

February 25 | Thursday | 12 - 1pm | Zoom

Christopher Longhurst, MD - Chief Information Officer and Associate Chief Medical Officer, UC San Diego Health

Natalie Pageler, MD - Chief Medical Information Officer, Stanford Children’s Health

Rajdeep Pooni, MD - Instructor, Pediatric Rheumatology, Stanford School of Medicine

pediatrics.stanford.edu/covidinchildren
3 Day Virtual Event

**Day 1**
**MONDAY, APRIL 19**
- 09:00am - 09:10am: Welcome
- 09:10am - 09:55am: Keynote
- 09:55am - 10:00am: Break
- 10:00am - 11:00am: Poster Session 1
- 11:00am - 11:10am: Break
- 11:10am - 11:50am: Trainee Talks & Q&A
- 11:50am - 12:00pm: Day 1 Wrap Up

**Day 2**
**WEDNESDAY, APRIL 21**
- 1:00pm - 1:10pm: Day 2 Welcome
- 1:10pm - 1:55pm: Faculty Talks & Q&A
- 1:55pm - 2:00pm: Break
- 2:00pm - 3:00pm: Poster Session 2
- 3:00pm - 3:10pm: Break
- 3:10pm - 3:50pm: Trainee Talks & Q&A
- 3:50pm - 4:00pm: Day 2 Wrap Up

**Day 3**
**THURSDAY, APRIL 22**
- 09:00am - 09:10am: Day 3 Welcome
- 09:10am - 09:55am: Faculty Talks & Q&A
- 09:55am - 10:00am: Break
- 10:00am - 11:00am: Poster Session 3
- 11:00am - 11:05am: Break
- 11:05am - 11:45am: Trainee Talks & Q&A
- 11:50am - 12:00pm: Retreat Wrap Up & Awards
12TH ANNUAL PEDIATRICS RESEARCH RETREAT

3 Day Virtual Event

Day 1  MONDAY, APRIL 19
Michelle Monje-Deisseroth, MD, PhD  Faculty - Keynote
Jessica Klein, PhD  Postdoctoral Scholar
Dipankan Bhattacharya, MD, PhD  Resident
Alma-Martina Cepika, MD, PhD  Instructor
Pablo Domizi, PhD  Postdoctoral Scholar
Yuntao Xia, PhD  Postdoctoral Scholar

Day 2  WEDNESDAY, APRIL 21
Tanja Gruber, MD  Faculty
Danny Chou, PhD  Faculty
Katherine Travis, PhD  Faculty
Dessi Zaharieva, PhD  Postdoctoral Scholar
Ayelet Rosenthal, MD  Fellow
Ashley Jowell  Medical Student
Julia Raney, MD  Resident

Day 3  THURSDAY, APRIL 22
Jason Yeatman, PhD  Faculty
Lance Prince, MD  Faculty
Charles Gawad, MD  Faculty
Esmond Lee  Graduate Student
Fangfei Qu, PhD  Postdoctoral Scholar
Debopam Ghosh, PhD  Postdoctoral Scholar
Alison Vander Roest, PhD  Postdoctoral Scholar
Wui Ip, MD  Fellow
Program Committee

Gary Shaw, DrPH
Co-Chair
Neonatal & Developmental Medicine

Anna Gloyn, DPhil
Co-Chair
Endocrinology

Manuel Amieva, MD, PhD
Infectious Diseases

Justin Crest, PhD
Research Development

Elizabeth Egan, MD, PhD
Infectious Diseases

Allison Guerin, EdD, MEd
Education

Bonnie Halpern-Felsher, PhD
Adolescent Medicine

Mark Kay, MD, PhD
Genetics

Mary Leonard, MD, MSCE
Department Chair

David Maahs, MD
Endocrinology

Elizabeth Mellins, MD
Human Gene Therapy

Julien Sage, PhD
Hematology/Oncology

Clea Sarnquist, DrPH, MPH
Infectious Diseases

John Whitin, PhD
Research

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Clea Sarnquist, DrPH, MPH
Infectious Diseases

John Whitin, PhD
Research
Dr. Philip Pizzo

Recognized with a Lifetime Achievement Award from the International Immunocompromised Host Society
Invited Commentary | Pediatrics

Improving Value in Bronchiolitis Care

Alan R. Schroeder, MD; Julia A. Marlow, MD; Chris P. Bonafide, MD, MSCE
2nd Annual Teaching Cannabis Awareness & Prevention Virtual 2021 Conference
A Focus on the Triangulum of Cannabis, Tobacco and E-cigarettes
April 27-28, 8am-12pm PST

This conference is for educators, TUPE Coordinators, community-based organizations, school administrators, healthcare providers, school resource officers, parents, and anyone else working with youth to learn about the latest research on youth and cannabis, including products being used, reasons for use, health effects, and the latest available lessons for teaching cannabis education and prevention to middle school and high school aged youth.

Keynote Speakers

"Protecting Public Health and Safety in an Era of Cannabis Legalization: Implications for Youth Health"
Gillian L. Schauer, PhD, MPH
Research Scientist, Alcohol & Drug Abuse Institute
University of Washington

"How Structural Racism Influences Adolescent Cannabis Use and Harms Associated with Use"
Renee M. Johnson, PhD, MPH
Associate Professor
Johns Hopkins Bloomberg School of Public Health

Registration waived for SPAARC participants and trainees
## Vaccine Clinical Development: Children

<table>
<thead>
<tr>
<th>Platform/Design</th>
<th>Biontech/Pfizer</th>
<th>Moderna</th>
<th>Janssen</th>
<th>AstraZeneca</th>
</tr>
</thead>
<tbody>
<tr>
<td>mRNA: encodes stabilized spike; lipid NP</td>
<td>mRNA: encodes 2P-stabilized spike; lipid NP</td>
<td>Replication incompetent Ad26; stabilized spike</td>
<td>Replication incompetent ChAdOx1 chimp Ad; wild type spike</td>
<td></td>
</tr>
</tbody>
</table>

| Dose/Schedule Adults | IM 2 doses X 30 μg 21 days apart | IM 2 doses 100 μg 28 days apart | IM 1 dose at 5 x 10^{10} vp (also testing 2 doses (0, 56 days)) | IM 2 doses at 5 x 10^{10} vp, (0, 28 days) |

| Current Status | EUA ages 16 and up | EUA ages 18 and up | Phase 3 adults | Phase 3 adults |

| Adolescents | Fully enrolled | TeenCOVE | Start 4-6wks after results from adult trials | Begin Early 2021 |

| Younger Children | Planning early 2021 | Planning early 2021 | Planning early 2021 | Planning early 2021 |

| Comments | Platform used widely in teens, infants, children |

Others supported by USG: Novavax (Ph3 enrolling), Sanofi
Advocacy Updates

- Received $100k from LPCH to support the community
- Donated 28,000 masks & 2,184 bottles of hand sanitizers delivered to 7 community partners
- Advocacy call to contact legislators supporting school reopening
- Continue to look for action alerts – food bag collection, BGCP opportunities still active
  - Email melanie.ramirez@Stanford.edu to join if you haven’t already!
SPAARCC Action Team Members by Division

Hospital Medicine

Peds ID

Kim Hoang  Francisco Alvarez  Amit Singh  Becky Blankenburg  Sarah Hilgenberg  Carrie Rassbach  Nata Li  Xin She  Andrew Saunders  Kathleen Boyd

Grace Lee  Linda Lambert

Allison Guerin  Tiyasha De Pinto  Kristi Townsend  Mary Riordan  Erica Delgado  Earlene Stuzendi  Erica Okamura  Caroline Okorie  Kathleen Lee  Esmeralda Morales

Pulmonary

Neonatology

75 faculty and staff engaged through SPAARCC!

Caroline Okorie  Lana Henthorn  Esmeralda Morales  Weichen Ling  Meera Sankar  Meghan Stawitcke  Henry Lee  Caroline Toney-Newland  Erin Crew  Anjali Chowla  Elizabeth Talley  Cynthia Wong  Jill Krissberg  Kyla Kent  Alison Holzer-Speed

STEM Cell Transplant

Hospital Medicine

Peds ID

Allison Guerin  Tiyasha De Pinto  Kristi Townsend  Mary Riordan  Erica Delgado  Earlene Stuzendi  Erica Okamura  Caroline Okorie  Kathleen Lee  Esmeralda Morales

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STEM Cell Transplant
Accomplishments to Date

- Adopted formal **sponsorship initiative** to support junior faculty
- **Grand Rounds Committee** added assessments on: (1) diversity of speakers; (2) speaker evaluation of racial/ethnic health disparities
- Piloted **medical racism training** for 20 faculty, staff, learners
  - Collaborating with LPCH re: unconscious bias training
- Mentored **89 URM high school students** on health professions careers
- Delivered health equity in research lecture to 100 dept members
- Staff Engagement Team established and posted **DEI Staff Event Coordinator** position
Event Announcement: Discussion on Anti-Asian Sentiment

- Hosted by Asian Staff Forum & Filipino American Community at Stanford (FACS)

Featuring Dion Lim of ABC7 News & Mayor Lily Mei of Fremont

Join us in this important conversation with ABC-7’s Dion Lim and Fremont Mayor Lily Mei about the rise of anti-Asian American sentiment during the pandemic and the recent increase in attacks against Asian Americans in the Bay Area. Submit questions for the speakers at https://tinyurl.com/ASFEventQA.
Next Steps

- Assoc Chair of DEI search halfway though, to be announced April
- Next town hall mid-spring
- Any questions email lyemane@Stanford.edu or lchamberlain@Stanford.edu
Ambulatory Transformation Team: An Update

Department of Pediatrics Faculty Meeting
Lisa Chamberlain, MD, MPH
David Maahs, MD, PhD
Task Force Charge

The Ambulatory Transformation Team [ATT] is charged with developing plans for how we prepare for a different future and reimagine our clinical ambulatory practice in a post-COVID-19 world.

<table>
<thead>
<tr>
<th>Develop standards for home virtual visits</th>
<th>Assess resulting downstream procedural capacity</th>
</tr>
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<tbody>
<tr>
<td>Propose volume target for virtual visits</td>
<td>Make recommendations or suggestions for opportunities to improve telehealth tools to enhance visits and provider workflow</td>
</tr>
<tr>
<td>Identify resources needed for new models of care</td>
<td>Ensure patient experience and impact on satisfaction, care coordination, including access to ancillary services</td>
</tr>
<tr>
<td>Redesign ambulatory clinics staffing, reviewing APP and MA roles</td>
<td>Analyze referral network and assess ramp-up capabilities</td>
</tr>
<tr>
<td>Analyze changes and modifications to the existing ambulatory footprint and subsequent creation of on-site capacity</td>
<td>Leverage and partner with advocacy groups to inform county, state, and national directives</td>
</tr>
</tbody>
</table>
Timeline

- **Phase 1** – Short term immediate activation of ambulatory locations to support incremental ramp up services
  
  - May 18 – Jun 30 2020

- **Phase 2** – Re-energizing our practices, highlighting and sharing best practices and supporting creativity in planning for the future
  
  - Jul 1 – Dec 31 2020

- **Phase 3** – Reimagine the future of delivering ambulatory care across SHC, UHA, and SCH
  
  - Jan + 2021

- **Phase 4** – Post-COVID-19
  
  - TBD
Six ATT Teams

• Phase 1: “Return from COVID”
  • Bring awareness to the issues

• Phase 2: Achieving FY2021 Operation Plans Goals
  • Identify examples of equity issues

• Phase 3: Design & implement transformational models
  • Build attention to HE in everything we do
  • Normalize HE in tracking and reporting processes
Incorporating innovations in digital health, Stanford Medicine will drive increased health equity via transforming ambulatory care.
Questions we will answer

Is the ambulatory transformation increasing or decreasing health disparities?

Where are our most significant equity gaps?

What are the solutions to close the gaps?
Opportunities and Metrics

**The salient opportunities**

Ensure work done by each ATT workstream uses lens of racial equity
Develop dashboard to measure racial equity across Stanford Medicine
Convened data summit
Working with allied groups

**Metrics**

Defining metrics based on national standards AND local relevance
Race/ethnicity, Language, Payer, Zip, Pre/post 2020
Quality: Standard quality & service metrics
Access: Compare in-person visits & telehealth
Operational

- Specialty
- FPO/PCHA (SHC/UHA/VC)
- Vaccine Manufacturer

Demographic

Gender

- Male
- Female

Patient Age

- 0-4
- 5-9
- 10-14
- 15-19
- 20-24
- 25-29
- 30-34
- 35-39
- 40-44
- 45-49
- 50-54
- 55-59
- 60-64
- 65-69
- 70-74
- 75+

Ethnicity

- Hispanic
- Non-Hispanic

Equity

% of Our Patients Vaccinated by Zip Code COVID Rates

% of Our Patients Vaccinated by Insurance Type

% of Our Patients Vaccinated by Preferred Language

- English
- Spanish
- Chinese
- Other
Telehealth and Care Delivery Adaptation in Diabetes
Acknowledgements: Teamwork, Targets, Technology and Tight Control in Newly Diagnosed Pediatric T1D: 4T Study

• Priya Prahalad, MD, PhD
• David Scheinker, PhD
• Manisha Desai, PhD
• Korey Hood, PhD
• Ananta Addala, DO
• Dessi Zaharieva, PhD – PI of exercise sub-study

• Victoria Ding, MS
• Natalie Pageler, MD
• Alex Freeman, NP
• Jeannine Leverenz, RN, CDE
• Piper Sagan, RN, CDE
• Anjoli Martinez-Singh, RD, CDE
• Franziska Bishop, MS, CDE
• Brianna Leverenz
• Annette Chmielewski, RD, CDE
• Barry Conrad, RD, CDE
• Julie Senaldi, RN, CDE
• Molly Tanenbaum, PhD

• R18DK122422
• SDRC
• LPCH Auxiliaries
• Helmsley Charitable Trust, Exercise Ancillary study
Telehealth adaptation with Covid

a) Provider Dependent Access
- Up to 3 months before visit: Provider recommends patient for telehealth visit.
- 1 week before visit: Patient obtains venipuncture HbA1c from lab if not using CGM.
- 1 day before visit: Patient/caregiver uploads diabetes devices.
- Time of the visit: Physician connects to visit and asks patient for the location of diabetes downloads.
- CDE may join visit if needed.

No Workflows Developed for:
- Interpreters
- Registered Dietitians
- Social workers

b) Provider Independent Access – open to all patients with internet access
- 1 day before visit: Patient or Caregivers contacted to convert visit to telehealth.
- 15 minutes before visit: CDE contacts family to assist with downloads.
- Time of the visit: Provider joins the visit.
- CDE, Registered Dietitian, Social Worker, and/or Interpreter may join visit.

Telehealth Visits by individuals with public insurance

- Pre-COVID-19: 24.1%
- During COVID-19: 39.9%

p < 0.001

Telehealth visits by non-English speakers

- Pre-COVID-19: 3.1%
- During COVID-19: 13.5%

p < 0.001
Steps to a Closed-Loop System

Glucose Monitoring

1977 Blood Glucose Meter
1983 First Minimed Pump-502
1999 First Animas Pump-R1000
2000 First CGM system
2005-2007 Real-time CGM
2006 1st Dexcom
2005 First Omnipod pump
2006 Medtronic combine Pump and CGM
2013 Suspend on low pump
2016 Commercial Hybrid artificial pancreas
2016 Dexcom G5 treatment decisions
2016 Advanced Hybrid Closed Loop
2020 Artificial Pancreas

1920s Insulin Injections
1978 First Insulin Pump

Insulin Delivery
A glucose sensor and insulin pump are attached to a person's stomach. The system includes an algorithm for improved insulin kinetics, delayed insulin absorption (30-100 min), individual delay factors (20 min periphery, 100 min liver), and a need for compensation for delays, errors, and noise. The algorithm adjusts insulin dosing based on glucose fluctuations. The system includes safeguards against insulin overdose and underdose and appreciates patient characteristics (e.g., exercise, behaviors).
A Decade of Disparities in Diabetes Technology Use and HbA1c in Pediatric Type 1 Diabetes: A Transatlantic Comparison

N=51,111 US & Germany

Disparities in Diabetes Technology use worse in US than Germany and increasing

Disparities in A1c worse in US than Germany and increasing
Racial and Socioeconomic Disparities in Pediatric Type 1 Diabetes: Time for a Paradigm Shift in Approach

Lipman & Hawkes, Diabetes Care, ‘21
Teamwork, Targets, Technology and Tight Control in Newly Diagnosed Pediatric T1D: 4T Study

1) Implement 4T education and care program to reduce rise in HbA1c trajectory.

2) Systematic approach to monitor psychosocial and patient reported outcomes (PROs).

3) Develop and test automated system to identify need for insulin dose adjustments between quarterly visits.
Previous State of New Onset T1D Education

- Attend & fellow discuss the diagnosis
- CDE + RD deliver 4-6 hours outpatient education
- Fellow calls Youth/family daily until recent onset visit
- 1-2 weeks post-diagnosis: Recent Onset Visit with MD/NP ± CDE, RD, SW
- 1 month follow up visit
- q3 month follow up

Youth started on technology (months to years)
Methods
4T Pilot study
Methods

• Youth with newly diagnosed T1D are provided routine new onset education

• Offered opportunity to start on Dexcom G6 with CDE
  – 1 month starter pack (1 transmitter, 3 sensors, and a receiver) provided by Dexcom
  – Ongoing coverage applied for through the youth’s insurance

• Offered the opportunity for remote monitoring

• Youth who elect to start on the Dexcom have a 1 week follow up with a NP by telehealth

• Those in the remote monitoring study have weekly CGM review by care team
Inclusion Criteria

• Within 1\textsuperscript{st} month of diabetes diagnosis (all ages)

• Plan to have ongoing follow up with our practice
Recruitment - CGM Initiation (July ‘18-June ‘20)

136 Youth with New Onset T1D

123 Approached
- 119 Initiated on CGM
  - 1 started CGM
- 4 Declined CGM
  - 1 started CGM

13 Excluded
- 11 with Public Insurance*
  - 11 eventually started CGM
- 2 traveling internationally
  - 2 eventually started CGM

11 with Public Insurance*
- 11 eventually started CGM
Recruitment – Remote Monitoring

133 Initiated On CGM

85 Approached

- 84 Consented to Remote Monitoring
- 1 Declined Remote Monitoring

48 Excluded
**HbA1c in Pilot vs. Historic Controls**

**Figure.** LOESS plot of HbA1c trajectory in patients initiated on CGM in the new onset period (blue line) compared to historic controls (black line).

**Adjusted Analysis**

<table>
<thead>
<tr>
<th>Months Post-Diagnosis</th>
<th>Estimated Difference (95% CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 months</td>
<td>-0.81 (0.019)</td>
<td></td>
</tr>
<tr>
<td>9 months</td>
<td>-1.43 (0.013)</td>
<td></td>
</tr>
<tr>
<td>12 months</td>
<td>-2.5 (0.013)</td>
<td></td>
</tr>
</tbody>
</table>

Adjusted for: age at onset, Hispanic ethnicity, insurance type
## Unadjusted HbA1c Differences between the Pilot and Historic Cohorts

<table>
<thead>
<tr>
<th>4T vs. Standard (HbA1c only)</th>
<th>Pilot 4T</th>
<th>Standard</th>
<th>Difference*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes onset</td>
<td>122</td>
<td>272</td>
<td>1.37</td>
</tr>
<tr>
<td>3 months</td>
<td>120</td>
<td>262</td>
<td>0.10</td>
</tr>
<tr>
<td>6 months</td>
<td>107</td>
<td>255</td>
<td>-0.65</td>
</tr>
<tr>
<td>9 months</td>
<td>96</td>
<td>250</td>
<td>-0.53</td>
</tr>
<tr>
<td>12 months</td>
<td>73</td>
<td>244</td>
<td>-0.62</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Average HbA1c (%)</th>
<th>Average HbA1c (%)</th>
<th>Average HbA1c (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>n</td>
<td>n</td>
</tr>
</tbody>
</table>

### Notes
- *Difference* is calculated as Standard - Pilot 4T.
Remote Monitoring
What is Remote Monitoring?

• Review of data by a care team member (CDE) at frequent intervals to provide education or make dose changes

• Occurring asynchronously (MyChart messaging)

• Integration of data into the EMR to build EMR-based tools to facilitate the process
GluVue Platform

Figure 1. Diagram of GluVue Platform

Automated integration of continuous glucose monitor data in the electronic health record using consumer technology

Rajiv B. Kumar, M.D. Ph.D., Nina O. Goren, David E. Stork, Dennis P. Wolf, and Christopher A. Longhurst

Stanford Medicine

Stanford Children’s Health

Lucile Packard Children’s Hospital

Stanford
Phase 3: TIDE – Population Level
Phase 3: TIDE – Patient Level

![Graph showing glucose levels and malaria incidence over time]

- **Avg Glucose mg/dL**: 110.5
- **Very Low**: 1.2%
- **Low**: 8.4%
- **In Target Range**: 81.9%
- **High**: 8.8%
- **Very High**: 0.0%
- **Coefficient of Variation**: 34.8%
- **SD mg/dL**: 38.4
- **% Time CGM Active**: 75.0%

Date Range: Monday - Sunday

- **Monday**: 11
- **Tuesday**: 12
- **Wednesday**: 13
- **Thursday**: 14
- **Friday**: 15
- **Saturday**: 16
- **Sunday**: 17
Phase 4: Epic Based Platform – Message Flags
Scalability: Time per Patient

• Phase 1: Dexcom Clarity alone
  – 5 min per patient, all patients reviewed

• Phase 2: R-based Tool
  – 5 min per patient, 40% decrease in # reviewed/week

• Phase 3: TIDE Tool
  – 4.2 min per patient

• Phase 4: Epic Based Platform
  – TBD
HbA1c in Remote Monitoring vs. No-Remote Monitoring

Adjusted Analysis*

<table>
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<tr>
<th>Months Post-Diagnosis</th>
<th>Estimated Difference (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 months</td>
<td>-0.45</td>
</tr>
<tr>
<td>9 months</td>
<td>-0.07</td>
</tr>
<tr>
<td>12 months</td>
<td>-0.52</td>
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</tbody>
</table>

Adjusted for: age at onset, Hispanic ethnicity, insurance type

p = 0.004
## Unadjusted A1c Differences
### Remote Monitoring vs. None

<table>
<thead>
<tr>
<th>GluVue vs. No GluVue (HbA1c only)</th>
<th>GluVue</th>
<th>No GluVue</th>
<th>Difference**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average</td>
<td>Average</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>HbA1c (%)</td>
<td>n</td>
</tr>
<tr>
<td>Diabetes onset</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 months</td>
<td>76</td>
<td>11.42</td>
<td>46</td>
</tr>
<tr>
<td>6 months</td>
<td>75</td>
<td>6.87</td>
<td>44</td>
</tr>
<tr>
<td>9 months</td>
<td>67</td>
<td>6.43</td>
<td>39</td>
</tr>
<tr>
<td>12 months</td>
<td>55</td>
<td>7.19</td>
<td>38</td>
</tr>
</tbody>
</table>

*Difference calculated as GluVue HbA1c - No GluVue HbA1c.*
Current State of New Onset T1D Education

1. Attendings & fellow discuss the diagnosis
2. CDE + RD deliver 4-6 hours outpatient education
3. Fellow calls Youth/family daily until next visit (avg. 10 ± 8 days)
4. 3 days to 2 weeks post-diagnosis - CDE visit for CGM initiation
5. Telehealth visit w/ NP to review CGM data & provide additional education (~1 week post-CGM initiation)
6. 1-2 weeks post-diagnosis - Recent onset visit with MD or NP + rest of the care team
7. 1 month follow up visit
8. q3 month follow up

Remote CGM Data Review by the Care Team
"I was ready for it at the beginning": Parent experiences with early introduction of continuous glucose monitoring following their child’s Type 1 diabetes diagnosis.
↓ HbA1c
↑ TIR ↑ QOL
↓ Hypoglycemia
Acknowledgements: Teamwork, Targets, Technology and Tight Control in Newly Diagnosed Pediatric T1D: 4T Study

• Priya Prahalad, MD, PhD
• David Scheinker, PhD
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