Together2Goal
AMGA Foundation
National Diabetes Campaign

Monthly Campaign Webinar
January 18, 2018
John W. Kennedy, M.D.

President, AMGA Foundation
Chief Medical Officer, AMGA

Andrea L. Cherrington, M.D., M.P.H.

Associate Professor at the Nutrition Obesity Research Center at University of Alabama Birmingham
• **January 19:** AMGA’s Annual Conference early bird registration deadline
  
  www.amga.org/ac18

• **January 31:** Deadline to apply for the Johnson & Johnson CORE Program

• **February 15:** Monthly campaign webinar on Geisinger’s Fresh Food Pharmacy program

• **March 7-10:** AMGA 2018 Annual Conference in Phoenix, AZ
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<th>Date</th>
<th>Topic</th>
<th>Presenter(s)</th>
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<td>Jan. 18, 2018</td>
<td>American Diabetes Association (ADA) 2018 Standards of Care</td>
<td>Andrea L. Cherrington, M.D., M.P.H. (University of Alabama, Birmingham)</td>
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<td>Feb. 15, 2018</td>
<td>An Rx for Good Health: Geisinger’s Fresh Food Pharmacy</td>
<td>Andrea Feinberg, M.D. (Geisinger)</td>
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<td>March 15, 2018</td>
<td>Addressing Health Disparities in Latino Populations with Diabetes</td>
<td>David Marrero, Ph.D. (University of Arizona)</td>
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<td>April 19, 2018</td>
<td>The Role of the Nurse in Diabetes Care</td>
<td>Sentara Medical Group</td>
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<td>May 17, 2018</td>
<td>Succeeding in the Together 2 Goal® Bundle</td>
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<td>June 21, 2018</td>
<td>Blood Pressure Control for Patients with Diabetes</td>
<td>Robert Matthews (PriMed Physicians)</td>
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<td>July 19, 2018</td>
<td>Shared Medical Appointments for Diabetes Care</td>
<td>Marianne Sumego, M.D. (Cleveland Clinic)</td>
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<td>Aug. 16, 2018</td>
<td>Diabetes and Obesity</td>
<td>Timothy Garvey, M.D. (University of Alabama, Birmingham)</td>
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<td>Sept. 20, 2018</td>
<td>Removing Patient Barriers to Medication Adherence</td>
<td>Molly Ekstrand, RPh, BCACP, AE-C (Park Nicollet HealthPartners Care Group)</td>
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<td>Oct. 18, 2018</td>
<td>Diabetes and Mental Health</td>
<td>Joanne Rinker, M.S. (American Associate of Diabetes Educators) and Jasmine D. Gonzalvo, PharmD (Purdue University, Eskenazi Health)</td>
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<td>Nov. 15, 2018</td>
<td>How to Succeed in Your Diabetes Prevention Program (DPP)</td>
<td>Tony Hampton, M.D. (Advocate Medical Group)</td>
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<tr>
<td>Dec. 13, 2018</td>
<td>The Together 2 Goal® Innovator Track</td>
<td>Together 2 Goal® Innovator Track Participants</td>
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Join AMGA March 7-10 in Phoenix!

Shared Learning
Real-world case studies and insights, led by AMGA member groups

Inspiring Keynotes
Featuring burnout expert Abraham Verghese, disruption guru Jonah Berger, former Congresswoman Gabby Giffords, and astronaut Mark Kelly

Networking
15+ hours of free-flowing conversations and structured networking events

Learn more about our Annual Conference and register at: amga.org/ac18

Early bird registration deadline is Jan. 19!
Together2Goal
AMGA Foundation
National Diabetes Campaign

Monthly Campaign Webinar
January 18, 2018
INTRODUCTION

John W. Kennedy, M.D.
Chief Medical Officer, AMGA
President, AMGA Foundation
• **Together 2 Goal® Updates**
  – Webinar Reminders
  – Together 2 Goal® Campaign Impact
  – Together 2 Goal® January Resource of the Month: CORE Program

• **American Diabetes Association 2018 Standards of Care**
  – Andrea L. Cherrington, M.D., M.P.H.

• **Q&A**
  – Use Q&A or chat feature
WEBINAR REMINDERS

• Webinar will be recorded today and available the week of January 22\textsuperscript{nd}
  – www.Together2Goal.org
• Participants are encouraged to ask questions using the “Chat” and “Q&A” functions on the right side of your screen
Our Goal:
Improving care for 1 million people with Type 2 diabetes by 2019

"Today, I’m here for a much, much bigger fight—a fight against diabetes."

- Sugar Ray Leonard at Together 2 Goal® campaign launch, March 2016
TOGETHER 2 GOAL® CAMPAIGN IMPACT

- 150 groups in 35 states
- 61,000 FTE physicians
- 2.0 million patients with Type 2 diabetes
- Over 600,000 lives improved
Together, we took more than 240,000 actions that reached more than 2 million people!
TOGETHER 2 GOAL JANUARY RESOURCE OF THE MONTH: JOHNSON & JOHNSON CORE PROGRAM

“Checking our own blood glucose and wearing a pump was an awesome learning experience.”

"I liked not being PowerPoint-ed out!"

"I have a better idea of what patients go through.”

"All the presenters were fantastic!”

• Free all-day diabetes training for up to 40 staff at your organization
• Application is on the T2G website under the “Improve Patient Outcomes” tab and is due January 31, 2018
Andrea L. Cherrington, M.D., M.P.H.

Associate Professor at the Nutrition Obesity Research Center at University of Alabama Birmingham
Standards of Medical Care in Diabetes - 2018

Andrea Cherrington, MD MPH
Associate Professor of Medicine
University of Alabama, Birmingham
Behavioral Sub-committee Chair
Professional Practice Committee
Speaker disclosures

• Astra Zeneca (Advisory board)
• Novo Nordisk (Consultant)
• Boehringer-Ingelheim (Research support)
Standards of Care

• Funded out of the ADA’s general revenues and does not use industry support.

• Slides correspond with sections within the Standards of Medical Care in Diabetes - 2018.

• Reviewed and approved by the Association’s Board of Directors.
Process

• ADA’s Professional Practice Committee (PPC) conducts annual review & revision.
• Searched Medline for human studies related to each subsection and published since January 1, 2017.
• Recommendations revised per new evidence, for clarity, or to better match text to strength of evidence.

Professional.diabetes.org/SOC
General Process Changes

• Standards will be ADA’s sole source of Clinical Practice Recommendations

• The PPC will continue to update the Standards annually, but has the option to update more frequently online should the PPC determine that new evidence or regulatory changes merit immediate incorporation

• ADA will begin taking proposals from the community for statements, consensus reports, scientific reviews, and clinical/research conferences

Professional.diabetes.org/SOC
## Evidence Grading System

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
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</table>
| A     | Clear evidence from well-conducted, generalizable RCTs, that are adequately powered, including:  
         - Evidence from a well-conducted multicenter trial or meta-analysis that incorporated quality ratings in the analysis;  
         - Compelling nonexperimental evidence;  
         - Supportive evidence from well-conducted RCTs that are adequately powered |
| B     | Supportive evidence from a well-conducted cohort studies  
         - Supportive evidence from a well-conducted case-control study |
| C     | Supportive evidence from poorly controlled or uncontrolled studies  
         - Conflicting evidence with the weight of evidence supporting the recommendation |
| E     | Expert consensus or clinical experience |
Today’s Topics

• Lifestyle Management & DM Prevention
• Glycemic Targets
• Pharmacologic Approaches to Glycemic Control
• Cardiovascular Disease & Risk Management
1. Lifestyle Management
Diabetes Self-Management Education & Support

Four critical time points for DSMES delivery:

1. At diagnosis
2. Annually for assessment of education, nutrition, and emotional needs
3. When new complicating factors (health conditions, physical limitations, emotional factors, or basic living needs) arise that influence self-management; and
4. When transitions in care occur

Diabetes.org/FindAProgram
Diabetes Distress

• Diabetes distress
  – Very common and distinct from other psychological disorders
  – Negative psychological reactions related to emotional burdens of managing a demanding chronic disease

• Recommendation:
  – Routinely monitor people with diabetes for diabetes distress, particularly when treatment targets are not met and/or at the onset of diabetes complications. B
Referral for Psychosocial Care

Lifestyle Management: Standards of Medical Care in Diabetes - 2018. Diabetes Care 2018; 41 (Suppl. 1): S38-S50

Table 4.2—Situations that warrant referral of a person with diabetes to a mental health provider for evaluation and treatment

- If self-care remains impaired in a person with DD after tailored diabetes education
- If a person has a positive screen on a validated screening tool for depressive symptoms
- In the presence of symptoms or suspicions of disordered eating behavior, an eating disorder, or disrupted patterns of eating
- If intentional omission of insulin or oral medication to cause weight loss is identified
- If a person has a positive screen for anxiety or fear of hypoglycemia
- If a serious mental illness is suspected
- In youth and families with behavioral self-care difficulties, repeated hospitalizations for diabetic ketoacidosis, or significant distress
- If a person screens positive for cognitive impairment
- Declining or impaired ability to perform diabetes self-care behaviors
- Before undergoing bariatric or metabolic surgery and after surgery if assessment reveals an ongoing need for adjustment support

professional.diabetes.org/MHDirectory
2. Prevention or Delay of Type 2 Diabetes
• At least annual monitoring for the development of diabetes in those with prediabetes is suggested. E

• Patients with prediabetes should be referred to an intensive behavioral lifestyle intervention program modeled on the Diabetes Prevention Program to achieve and maintain 7% loss of initial body weight and increase moderate-intensity physical activity (such as brisk walking) to at least 150 min/week. A
3. Glycemic Targets
Approach to the Management of Hyperglycemia

**Patient/Disease Features**

- Risk of hypoglycemia/drug adverse effects
- Disease Duration
- Life expectancy
- Important comorbidities
- Established vascular complications
- Patient attitude & expected treatment efforts
- Resources & support system

**Glycemic Targets:**

- **Standards of Medical Care in Diabetes - 2018. Diabetes Care 2018; 41 (Suppl. 1): S55-S64**

**Resources & support system**

- **readily available**
- **limited**

**Patient attitude & expected treatment efforts**

- **highly motivated, adherent, excellent self-care capabilities**
- **less motivated, nonadherent, poor self-care capabilities**

**Disease Duration**

- **newly diagnosed**
- **long-standing**

**Life expectancy**

- **long**
- **short**

**Important comorbidities**

- **absent**
- **Few/mild**
- **severe**

**Established vascular complications**

- **absent**
- **Few/mild**
- **severe**

**Risk of hypoglycemia/drug adverse effects**

- **low**
- **high**

**A1C 7%**

- **more stringent**
- **A1C 7%**
- **less stringent**

**Usually not modifiable**

- **Potentially modifiable**

**American Diabetes Association**
4. Pharmacologic Approaches to Glycemic Treatment
Antihyperglycemic Therapy in Adults with T2DM

Pharmacologic Approaches to Glycemic Treatment:
Standards of Medical Care in Diabetes - 2018. Diabetes Care 2018; 41 (Suppl. 1): S73-S85
At diagnosis, initiate lifestyle management, set A1C target, and initiate pharmacologic therapy based on A1C:

- A1C is less than 9%, **consider Monotherapy**.
- A1C is greater than or equal to 9%, **consider Dual Therapy**.
- A1C is greater than or equal to 10%, blood glucose is greater than or equal to 300 mg/dL, or patient is markedly symptomatic, **consider Combination Injectable Therapy** (See Figure 8.2).

**Monotherapy**

Lifestyle Management + Metformin

Initiate metformin therapy if no contraindications* (See Table 8.1)

A1C at target after 3 months of monotherapy?

Yes: - Monitor A1C every 3–6 months

No: - Assess medication-taking behavior
- Consider Dual Therapy

**Dual Therapy**

Lifestyle Management + Metformin + Additional Agent
Antihyperglycemic Therapy in Adults with T2DM

Pharmacologic Approaches to Glycemic Treatment: Standards of Medical Care in Diabetes - 2018. Diabetes Care 2018; 41 (Suppl. 1): S73-S85
Table 8.1—Drug-specific and patient factors to consider when selecting antihyperglycemic treatment in adults with type 2 diabetes

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Efficacy*</th>
<th>Hypoglycemia</th>
<th>Weight Change</th>
<th>CV Effects</th>
<th>Cost</th>
<th>Oral Use Considerations</th>
<th>Renal Effects</th>
<th>Additional Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metformin</td>
<td>High</td>
<td>None</td>
<td>Neutral</td>
<td>Neutral</td>
<td>Low</td>
<td>Oral</td>
<td>Neutral</td>
<td>Carbohydrate side effects common (nausea, vomiting); Potential for B12 deficiency</td>
</tr>
<tr>
<td>SGLT2 Inhibitors</td>
<td>Intermediate</td>
<td>None</td>
<td>Less</td>
<td>Benefit: canagliflozin, empagliflozin</td>
<td>Benefit: canagliflozin, empagliflozin</td>
<td>Oral</td>
<td>Benefit: canagliflozin, empagliflozin</td>
<td>Canagliflozin not recommended with eGFR &lt; 60</td>
</tr>
<tr>
<td>GLP-1 RAs</td>
<td>High</td>
<td>None</td>
<td>Less</td>
<td>Neutral</td>
<td>High</td>
<td>SQ</td>
<td>Benefit: lixisludipe</td>
<td>Fasting blood glucose effect on hypoglycemia, hyperglycemia</td>
</tr>
<tr>
<td>DPP-4 Inhibitors</td>
<td>Intermediate</td>
<td>None</td>
<td>Neutral</td>
<td>Neutral</td>
<td>High</td>
<td>Oral</td>
<td>Neutral</td>
<td>Renal adjustment required can be used in mild impairment</td>
</tr>
<tr>
<td>Thiazolidinediones</td>
<td>High</td>
<td>None</td>
<td>Gain</td>
<td>Potential benefit: pioglitazone</td>
<td>Increased Risk</td>
<td>Oral</td>
<td>Neutral</td>
<td>No dose adjustment required</td>
</tr>
<tr>
<td>Sulfonylureas (Dihydropyrimidines)</td>
<td>High</td>
<td>Yes</td>
<td>Gain</td>
<td>Neutral</td>
<td>Low</td>
<td>Oral</td>
<td>Neutral</td>
<td>Glipizide not recommended</td>
</tr>
<tr>
<td>Insulin Analogs</td>
<td>Highest</td>
<td>Yes</td>
<td>Gain</td>
<td>Neutral</td>
<td>Low</td>
<td>SQ</td>
<td>Neutral</td>
<td>Lower insulin requirement with decrease in eGFR, worse peridural response</td>
</tr>
</tbody>
</table>

*See ref. 31 for description of efficacy. FDA approved for CVD benefit. CVD, cardiovascular disease; DKA, diabetic ketoacidosis; DKD, diabetic kidney disease; NASH, nonalcoholic steatohepatitis; RAAs, receptor antagonists; SQ, subcutaneous; TZD, type 2 diabetes.
Combination Injectable Therapy in T2DM

Pharmacologic Approaches to Glycemic Treatment:
Standards of Medical Care in Diabetes - 2018. Diabetes Care 2018; 41 (Suppl. 1): S73-S85
5. Cardiovascular Disease and Risk Management
Cardiovascular Disease

• ASCVD is the leading cause of morbidity & mortality for those with diabetes.
• Largest contributor to direct/indirect costs
• Common conditions coexisting with type 2 diabetes (e.g., hypertension, dyslipidemia) are clear risk factors for ASCVD.
• Diabetes itself confers independent risk
• Control individual cardiovascular risk factors to prevent/slow CVD in people with diabetes.
• Systematically assess all patients with diabetes for cardiovascular risk factors.
## Table 9.1—Randomized controlled trials of intensive versus standard hypertension treatment strategies

<table>
<thead>
<tr>
<th>Clinical trial</th>
<th>Population</th>
<th>Intensive</th>
<th>Standard</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCORD BP (16)</td>
<td>4,733 participants with T2D aged 40–79 years with prior evidence of CVD or multiple cardiovascular risk factors</td>
<td>Systolic blood pressure target: &lt;120 mmHg Achieved (mean) systolic/diastolic: 119.3/64.4 mmHg</td>
<td>Systolic blood pressure target: 130–140 mmHg Achieved (mean) systolic/diastolic: 133.5/70.5 mmHg</td>
<td>• No benefit in primary end point: composite of nonfatal MI, nonfatal stroke, and CVD death • Stroke risk reduced 41% with intensive control, not sustained through follow-up beyond the period of active treatment • Adverse events more common in intensive group, particularly elevated serum creatinine and electrolyte abnormalities</td>
</tr>
<tr>
<td>ADVANCE BP (17)</td>
<td>11,140 participants with T2D aged 55 years and older with prior evidence of CVD or multiple cardiovascular risk factors</td>
<td>Intervention: a single-pill, fixed-dose combination of perindopril and indapamide Achieved (mean) systolic/diastolic: 136/73 mmHg</td>
<td>Control: placebo Achieved (mean) systolic/diastolic: 141.6/75.2 mmHg</td>
<td>• Intervention reduced risk of primary composite end point of major cardiovascular and microvascular events (9%), death from any cause (14%), and death from CVD (18%) • 6-year observational follow-up found reduction in risk of death in intervention group attenuated but still significant (142)</td>
</tr>
<tr>
<td>HOT (143)</td>
<td>18,790 participants, including 1,501 with diabetes</td>
<td>Diastolic blood pressure target: ≤80 mmHg</td>
<td>Diastolic blood pressure target: ≤90 mmHg</td>
<td>• In the overall trial, there was no cardiovascular benefit with more intensive targets • In the subpopulation with diabetes, an intensive diastolic target was associated with a significantly reduced risk (51%) of CVD events</td>
</tr>
<tr>
<td>SPRINT (144)</td>
<td>9,361 participants without diabetes</td>
<td>Systolic blood pressure target: &lt;120 mmHg Achieved (mean): 121.4 mmHg</td>
<td>Systolic blood pressure target: &lt;140 mmHg Achieved (mean): 136.2 mmHg</td>
<td>• Intensive systolic blood pressure target lowered risk of the primary composite outcome 25% (MI, ACS, stroke, heart failure, and death due to CVD) • Intensive target reduced risk of death 27% • Intensive therapy increased risks of electrolyte abnormalities and AKI</td>
</tr>
</tbody>
</table>

CVD, cardiovascular disease; T2D, type 2 diabetes. Data from this table can also be found in the ADA position statement “Diabetes and Hypertension” (5).
Screening and Diagnosis:

- Blood pressure (BP) should be measured at every routine clinical visit. Patients found to have elevated BP (≥140/90) should have BP confirmed using multiple readings, including measurements on a separate day, to diagnose hypertension. B

- All hypertensive patients with diabetes should monitor their BP at home. B
Treatment Goals

- Most people with diabetes and hypertension should be treated to a systolic BP goal of $<140$ mmHg and a diastolic BP goal of $<90$ mmHg.  
  
- Lower systolic and diastolic BP targets, such as $130/80$ mmHg, may be appropriate for individuals at high risk of CVD, if they can be achieved without undue treatment burden.  
  
- In pregnant patients with diabetes and preexisting hypertension who are treated with antihypertensive therapy, BP targets of $120-160/80-105$ mmHg are suggested in the interest of optimizing long-term maternal health and minimizing impaired fetal growth.
Recommendations for the Treatment of Confirmed Hypertension in People With Diabetes

Initial BP between 140/90 mmHg and 160/100 mmHg

- Start one agent
- Lifestyle management
  - Albuminuria*
    - No
      - Start one drug: • ACEI • ARB • CCB*** • Diuretic**
    - Yes
      - Start: • ACEI or ARB

Initial BP ≥ 160/100 mmHg

- Start two agents
- Albuminuria*
  - No
    - Start drug from 2 of 3 options: • ACEI or ARB • CCB*** • Diuretic**
  - Yes
    - Start: • ACEI or ARB and • CCB*** or Diuretic***

Assess BP Control and Adverse Effects

- Treatment tolerated and target achieved
  - Continue therapy
- Not meeting target
  - Add agent from complementary drug class: • ACEI or ARB • CCB*** • Diuretic**
- Adverse effects
  - Consider change to alternative medication: • ACEI or ARB • CCB*** • Diuretic**
  - Not meeting target or adverse effects using a drug from each of three classes
    - Consider Addition of Mineralocorticoid Receptor Antagonist; Refer to Specialist With Expertise in BP Management

Assess BP Control and Adverse Effects

- Treatment tolerated and target achieved
  - Continue therapy
- Not meeting target on two agents
  - Not meeting target or adverse effects using a drug from each of three classes
    - Consider Addition of Mineralocorticoid Receptor Antagonist; Refer to Specialist With Expertise in BP Management
### Table 9.2—Recommendations for statin and combination treatment in adults with diabetes

<table>
<thead>
<tr>
<th>Age</th>
<th>ASCVD</th>
<th>Recommended statin intensity^ and combination treatment*</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;40 years</td>
<td>No</td>
<td>None†</td>
</tr>
<tr>
<td>Yes</td>
<td>High</td>
<td>• If LDL cholesterol ≥ 70 mg/dL despite maximally tolerated statin dose, consider adding additional LDL-lowering therapy (such as ezetimibe or PCSK9 inhibitor)#</td>
</tr>
<tr>
<td>≥40 years</td>
<td>No</td>
<td>Moderate‡</td>
</tr>
<tr>
<td>Yes</td>
<td>High</td>
<td>• If LDL cholesterol ≥ 70 mg/dL despite maximally tolerated statin dose, consider adding additional LDL-lowering therapy (such as ezetimibe or PCSK9 inhibitor)</td>
</tr>
</tbody>
</table>

*In addition to lifestyle therapy. †For patients who do not tolerate the intended intensity of statin, the maximally tolerated statin dose should be used. ‡Moderate-intensity statin may be considered based on risk-benefit profile and presence of ASCVD risk factors. ASCVD risk factors include LDL cholesterol ≥100 mg/dL (2.6 mmol/L), high blood pressure, smoking, chronic kidney disease, albuminuria, and family history of premature ASCVD. ‡High-intensity statin may be considered based on risk-benefit profile and presence of ASCVD risk factors. #Adults aged <40 years with prevalent ASCVD were not well represented in clinical trials of non-statin–based LDL reduction. Before initiating combination lipid-lowering therapy, consider the potential for further ASCVD risk reduction, drug-specific adverse effects, and patient preferences.
Antiplatelet Agents: Recommendations

- Use aspirin therapy (75-162 mg/day) as a secondary prevention strategy in those with diabetes and a history of ASCVD. A

- For patients with ASCVD and documented aspirin allergy, clopidogrel (75 mg/day) should be used. B

- Dual antiplatelet therapy (with low-dose aspirin and a P2Y12 inhibitor) is reasonable for a year after an acute coronary syndrome A and may have benefits beyond this period. B

Cardiovascular Disease and Risk Management: Standards of Medical Care in Diabetes - 2018. Diabetes Care 2018; 41 (Suppl. 1): S86-S104
Coronary Heart Disease: Recommendations

Treatment

• In patients with known ASCVD, consider ACE inhibitor or ARB therapy to reduce the risk of CV events. A

• In patients with prior myocardial infarction, β-blockers should be continued for at least 2 years after the event. B

• In patients with T2DM with stable congestive heart failure, metformin may be used if estimated glomerular filtration rate remains >30 mL/min but should be avoided in unstable or hospitalized patients with congestive heart failure. B
Coronary Heart Disease: Recommendations

Treatment

• In patients with T2DM and established ASCVD, antihyperglycemic therapy should begin with lifestyle management and metformin and subsequently incorporate an agent proven to reduce major adverse CV events and CV mortality (currently empagliflozin and liraglutide), after considering drug-specific and patient factors. 𝐀

• In patients with T2DM and established ASCVD, after lifestyle management and metformin, the antihyperglycemic agent canagliflozin may be considered to reduce major adverse CV events, based on drug-specific and patient factors. 𝐂
Helpful Resources
2018 Standards of Care - Resources

• Full version available
• Abridged version for PCPs
• Free app (February 2018)
• Pocket cards with key figures
• Free webcast for continuing education credit

Professional.Diabetes.org/SOC
Professional Education

• Live programs
• Online self-assessment programs
• Online webcasts

Professional.Diabetes.org/CE
Professional Membership

• Journals
• Meeting, book and journal discounts
• Career center
• Quarterly member newsletter

Professional.Diabetes.org/membership
Thank you
• **Date/Time:** Thursday, February 15, 2-3pm Eastern
• **Topic:**
  - Rx for Good Health: Geisinger’s Fresh Food Pharmacy
• **Presenter:** Andrea Feinberg, M.D. of Geisinger