Monthly Campaign Webinar
January 17, 2019
Today’s Webinar

• Together 2 Goal® Updates
  – Webinar Reminders
  – National Day of Action Wrap Report
  – AMGA Annual Conference
  – T2G Impact to Date
  – Extension Announcement
  – New Materials & Website

• Diabetes Prevention Program
  – Nisa Maruthur, M.D., M.H.S. of Johns Hopkins University

• Q&A
  – Use Q&A or chat feature
Webinar Reminders

• Webinar will be recorded today and available the week of January 21st  
  – www.Together2Goal.org

• Participants are encouraged to ask questions using the “Chat” and “Q&A” functions on the right side of your screen
National Day of Action Wrap Report

- More than **200 healthcare professionals** from nearly **30 groups** came together to take action to improve diabetes care!
- Thanks to everyone who participated. Next year’s National Day of Action will take place November 7, 2019. We hope you’ll join us!
2019 AMGA Annual Conference

March 27-30, 2019
National Harbor, MD

• New this year: AMGA will offer networking discussion groups by hot topic and by organizational type.

• Registration now open at amga.org/ac2019

• Register by Friday, February 8 for the lowest early bird rate
Together 2 Goal® Impact
Together 2 Goal® Impact
Improved care for more than 750,000 people with Type 2 diabetes
Together 2 Goal® Extends to 2021

- March 2016 Launch
- 2017
- 2018 750K Milestone
- April 1, 2019 Extension Begins
- 2020
- March 31, 2021 Completion

2-year extension
New Materials...

Together 2 Goal™—AMGA’s national diabetes campaign—extends to improve care for 1 million people with Type 2 diabetes.

**FRAMEWORK**
- 9 Case Processes of “Campaign Phase”
- 7 Nonprofit Partners & Supporting Organizations
- 5 Corporate Collaborators
- 3 Advisory Committees
- 1 Campaign Toolkit

**REACH AND IMPACT**
- 150 medical groups and health systems across 36 states
- Representing 61,000 FTE physicians
- Treating 2 million patients with Type 2 diabetes

**GOAL: 1 MILLION BY 2021**

**EXTENSION**
Over the next two years, Together 2 Goal™ will continue to offer:
- Tailored workshops
- Proven tools and resources that link the goals of AMGA and diabetes partners
- Blended comprehensive data reports to improve physician and community practices against peers
- Opportunities to engage with peers: connections, resources, or patient population

To join the campaign or view our latest resources, visit www.together2goal.org

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Welcome to the Together 2 Goal® campaign website! We are proud to collaborate with medical groups, health systems, partners, and corporate collaborators across the nation with the goal of improving care for 1 million people with Type 2 diabetes. We hope our website will provide you with the tools and resources needed to more effectively manage your patients with Type 2 diabetes. AMGA members interested in enrolling can learn more here.
Today’s Featured Presenter

Nisa Maruthur, M.D., M.H.S.

Associate Professor
Johns Hopkins University
Updates on ADA’s Standards of Medical Care – 2019

Nisa M. Maruthur, MD, MHS
Associate Professor of Medicine & Epidemiology
Johns Hopkins University
Division of General Internal Medicine
Member, ADA Professional Practice Committee
DISCLOSURES

No financial conflicts of interest.

Slides adapted from American Diabetes Association.
OBJECTIVES

Describe changes in ADA Standards of Medical Care related to *management* of diabetes.

New content related to prevention, diagnosis, or technology is *not* covered in this presentation.
Standards of Medical Care in Diabetes – 2019
The Standards.

Intended to provide clinicians, patients, researchers, payers, and other interested individuals with the components of diabetes care, general treatment goals, and tools to evaluate the quality of care.

- Search of scientific diabetes literature over past year
- Recommendations revised per new evidence
- Professional Practice Committee
- Reviewed by ADA’s Board of Directors
- Living Standards
- Funded out of ADA’s general revenues
- Does not use industry support
Improving Care and Promoting Health in Populations.

New data on the financial costs of diabetes to individuals and society: In 2017, the cost of diagnosed diabetes was **327 billion**, an increase of 26% since 2012.

Because telemedicine is a growing field that may increase access to care for patients with diabetes, discussion was added on its use to facilitate remote delivery of health-related services and clinical information.
Comprehensive Medical Evaluation and Assessment of Comorbidities.

New text was added to guide health care professionals’ use of language to communicate with people with diabetes and professional audiences in an informative, empowering, and educational style.

A diabetes care decision cycle figure from the ADA-EASD consensus report was added to emphasize the need for ongoing assessment & shared decision making to achieve health goals and avoid therapeutic inertia.

A new recommendation was added to explicitly call out the importance of the diabetes care team and to list the professionals that make up the team.
Comprehensive Medical Evaluation and Assessment of Comorbidities (continued).

A recommendation was added to include the 10-year atherosclerotic cardiovascular disease (ASCVD) risk as part of overall risk assessment.

The table listing the components of a comprehensive medical evaluation was revised, and the section on assessment and planning was used to create a new table (Table 4.2).

A new table was added listing factors that increase risk of treatment-associated hypoglycemia (Table 4.3).

The fatty liver disease section was revised to include updated text and a new recommendation regarding when to test for liver disease.
Decision Cycle for Patient-centered Glycemic Management in Type 2 Diabetes
<table>
<thead>
<tr>
<th>Table 4.2—Assessment and treatment plan*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess risk of diabetes complications</td>
</tr>
<tr>
<td>• ASCVD and heart failure history</td>
</tr>
<tr>
<td>• ASCVD risk factors (see Table 10.2) and 10-year ASCVD risk assessment</td>
</tr>
<tr>
<td>• Staging of chronic kidney disease (see Table 11.1)</td>
</tr>
<tr>
<td>• Hypoglycemia risk (Table 4.3)</td>
</tr>
<tr>
<td>Goal setting</td>
</tr>
<tr>
<td>• Set A1C/blood glucose target</td>
</tr>
<tr>
<td>• If hypertension present, establish blood pressure target</td>
</tr>
<tr>
<td>• Diabetes self-management goals (e.g., monitoring frequency)</td>
</tr>
<tr>
<td>Therapeutic treatment plan</td>
</tr>
<tr>
<td>• Lifestyle management</td>
</tr>
<tr>
<td>• Pharmacologic therapy (glucose lowering)</td>
</tr>
<tr>
<td>• Pharmacologic therapy (cardiovascular disease risk factors and renal)</td>
</tr>
<tr>
<td>• Use of glucose monitoring and insulin delivery devices</td>
</tr>
<tr>
<td>• Referral to diabetes education and medical specialists (as needed)</td>
</tr>
</tbody>
</table>

ASCVD, atherosclerotic cardiovascular disease. *Assessment and treatment planning is an essential component of initial and all follow-up visits.
Table 4.3—Assessment of hypoglycemia risk
Factors that increase risk of treatment-associated hypoglycemia

- Use of insulin or insulin secretagogues (i.e., sulfonylureas, meglitinides)
- Impaired kidney or hepatic function
- Longer duration of diabetes
- Frailty and older age
- Cognitive impairment
- Impaired counterregulatory response, hypoglycemia unawareness
- Physical or intellectual disability that may impair behavioral response to hypoglycemia
- Alcohol use
- Polypharmacy (especially ACE inhibitors, angiotensin receptor blockers, nonselective β-blockers)
The sodium consumption recommendation was modified to eliminate the further restriction that was potentially indicated for those with both diabetes and hypertension.

More discussion was added about the importance of macronutrient distribution based on an individualized assessment of current eating patterns, preferences, and metabolic goals. There is not a one-size-fits-all eating pattern for individuals with diabetes, and meal planning should be individualized.

A recommendation was modified to encourage people with diabetes to decrease consumption of both sugar sweetened and nonnutritive-sweetened beverages and use other alternatives, with an emphasis on water intake.

The sodium consumption recommendation was modified to eliminate the further restriction that was potentially indicated for those with both diabetes and hypertension.
Additional discussion was added to the physical activity section to include the benefit of a variety of leisure-time physical activities and flexibility and balance exercises.

The discussion about e-cigarettes was expanded to include more on public perception and how their use to aide smoking cessation was not more effective than “usual care.”
Glycemic Targets.

This section now begins with a discussion of A1C tests to highlight the centrality of A1C testing in glycemic management.

The self-monitoring of blood glucose and continuous glucose monitoring text and recommendations were moved to the new Diabetes Technology section.

To emphasize that the risks and benefits of glycemic targets can change as diabetes progresses and patients age, a recommendation was added to reevaluate glycemic targets over time.

The section was modified to align with the living Standards updates made in April 2018 regarding the consensus definition of hypoglycemia.
## Patient and Disease Factors Used to Determine A1C Targets

<table>
<thead>
<tr>
<th>Patient / Disease Features</th>
<th>More stringent</th>
<th>A1C 7%</th>
<th>Less stringent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risks potentially associated with hypoglycemia and other drug adverse effects</td>
<td>low</td>
<td>high</td>
<td></td>
</tr>
<tr>
<td>Disease duration</td>
<td>newly diagnosed</td>
<td>long-standing</td>
<td></td>
</tr>
<tr>
<td>Life expectancy</td>
<td>long</td>
<td>short</td>
<td></td>
</tr>
<tr>
<td>Important comorbidities</td>
<td>absent</td>
<td>few / mild</td>
<td>severe</td>
</tr>
<tr>
<td>Established vascular complications</td>
<td>absent</td>
<td>few / mild</td>
<td>severe</td>
</tr>
<tr>
<td>Patient preference</td>
<td>highly motivated, excellent self-care capabilities</td>
<td>preference for less burdensome therapy</td>
<td></td>
</tr>
<tr>
<td>Resources and support system</td>
<td>readily available</td>
<td>limited</td>
<td></td>
</tr>
</tbody>
</table>
A recommendation was modified to acknowledge the benefits of tracking weight, activity, etc., in the context of achieving and maintaining a healthy weight.

A brief section was added on medical devices for weight loss, which are not currently recommended due to limited data in people with diabetes.

The recommendations for metabolic surgery were modified to align with recent guidelines, citing the importance of considering comorbidities beyond diabetes when contemplating the appropriateness of metabolic surgery for a given patient.
The section on the pharmacologic treatment of type 2 diabetes was significantly changed to align, as per the living Standards update in October 2018, with the ADA-EASD consensus report on this topic, summarized in the new Figs. 9.1 and 9.2. This includes consideration of key patient factors: a) important comorbidities such as ASCVD, chronic kidney disease, and heart failure, b) hypoglycemia risk, c) effects on body weight, d) side effects, e) costs, and f) patient preferences.

To align with the ADA-EASD consensus report, the approach to injectable medication therapy was revised (Fig. 9.2). A recommendation that, for most patients who need the greater efficacy of an injectable medication, a glucagon-like peptide 1 receptor agonist should be the first choice, ahead of insulin.
GLUCOSE-LOWERING MEDICATION IN TYPE 2 DIABETES: OVERALL APPROACH

**FIRST-LINE THERAPY IS METFORMIN AND COMPREHENSIVE LIFESTYLE (INCLUDING WEIGHT MANAGEMENT AND PHYSICAL ACTIVITY) IF HbA1c ABOVE TARGET PROCEED AS BELOW**

**ESTABLISHED ASCVD OR CKD**

- **ASCVD PREDOMINATES**
  - **GLP-1 RA with proven CVD benefit**
  - **SGLT2i with evidence of reducing HF and CVD progression in CVOTs if eGFR adequate**
- **HF OR CKD PREDOMINATES**
  - **SGLT2i with evidence of reducing HF and CVD progression in CVOTs if eGFR adequate**
- **PREFERABLY**
  - **SGLT2i with evidence of reducing HF and CVD progression in CVOTs if eGFR adequate**
- **OR**
  - **If SGLT2i not tolerated or contraindicated or if eGFR less than adequate add GLP-1 RA with proven CVD benefit**

- **If HbA1c above target**
  - **If further intensification is required or patient is now unable to tolerate GLP-1 RA or SGLT2i, choose agents demonstrating CV safety:**
    - Consider adding the other class (GLP-1 RA or SGLT2i) with proven CVD benefit
    - DPP-4i if not on GLP-1 RA
    - Basal insulin
    - TZD
    - SU

- **COMPELLING NEED TO MINIMISE HYPOGLYCAEMIA**
  - **DPP-4i**
  - **GLP-1 RA**
  - **SGLT2i**
  - **TZD**

- **If HbA1c above target**
  - **If HbA1c above target**
  - **If HbA1c above target**
  - **If HbA1c above target**

- **If triple therapy required or SGLT2i and/or GLP-1 RA not tolerated or contraindicated use regimen with lowest risk of weight gain**
  - **PREFERABLY**
  - **DPP-4i (if not on GLP-1 RA)**
  - **Based on weight neutrality**

- **WITHOUT ESTABLISHED ASCVD OR CKD**

- **COMPPELLING NEED TO MINIMISE WEIGHT GAIN OR PROMOTE WEIGHT LOSS**
  - **ESTABLISH**
  - **SU**
  - **TZD**

- **If HbA1c above target**
  - **If HbA1c above target**
  - **If HbA1c above target**

- **COST IS A MAJOR ISSUE**

1. Proven CVD benefit means it has label indication of reducing CV events. For GLP-1 RA strongest evidence of liraglutide = semaglutide = exenatide. for SGLT2i evidence mostly stems from empagliflozin = canagliflozin
2. Be aware that SGLT2i may be expensive or beyond cost sharing. For GLP-1 RA evidence mostly stems from exenatide = liraglutide = dulaglutide.
3. Both empagliflozin and canagliflozin have proven reduction in risk of CV events in primary prevention in CVD.
4. Explore use of DPP-4i in patients with established CV disease.
5. Use of DPP-4i may decrease CV risk but this has been studied for VIOLENT trials.
6. Choose a later generation SU with lower risk of hypoglycaemia.
7. Exenatide = dulaglutide
8. Consider canagliflozin = liraglutide = exenatide = dulaglutide.
9. For specific contraindications (i.e. no established CV risk), the risk of hypoglycaemia and lower priority in avoiding weight gain vs co-morbidities (e.g. CKD).
10. Consider country- and regimen-specific cost of drugs. In some countries TZD is relatively more expensive and DPP-4 relatively cheaper.
ASCVD PREDOMINATES

GLP-1 RA with proven CVD benefit¹

SGLT2i with proven CVD benefit¹, if eGFR adequate²

EITHER/OR

If HbA₁c above target

If further intensification is required or patient is now unable to tolerate GLP-1 RA and/or SGLT2i, choose agents demonstrating CV safety:
- Consider adding the other class (GLP-1 RA or SGLT2i) with proven CVD benefit
- DPP-4i if not on GLP-1 RA
- Basal insulin
- TZD
- SU

HF OR CKD PREDOMINATES

PREFERABLY

SGLT2i with evidence of reducing HF and/or CKD progression in CVOTs if eGFR adequate³

OR

If SGLT2i not tolerated or contraindicated or if eGFR less than adequate³ add GLP-1 RA with proven CVD benefit¹

If HbA₁c above target

- Avoid TZD in the setting of HF
- Choose agents demonstrating CV safety:
  - Consider adding the other class with proven CVD benefit¹
  - DPP-4i (not saxagliptin) in the setting of HF (if not on GLP-1 RA)
  - Basal insulin
  - SU
COMPELLING NEED TO MINIMISE HYPOGLYCAEMIA

DPP-4i
If HbA1c above target
SGLT2i or TZD

GLP-1 RA
If HbA1c above target
SGLT2i or TZD

SGLT2i2
If HbA1c above target
GLP-1 RA or DPP-4i or TZD

TZD
If HbA1c above target
SGLT2i2 or DPP-4i or GLP-1 RA

If HbA1c above target
Continue with addition of other agents as outlined above

If HbA1c above target
Consider the addition of SU or basal insulin:
- Choose later generation SU with lower risk of risk of hypoglycaemia
- Consider basal insulin with lower risk of hypoglycaemia
COMPELLING NEED TO MINIMISE WEIGHT GAIN
OR PROMOTE WEIGHT LOSS

Either/or

GLP-1 RA with good efficacy for weight loss

SGLT2

If HbA1c above target

GLP-1 RA with good efficacy for weight loss

SGLT2

If HbA1c above target

If triple therapy required or SGLT2i and/or GLP-1 RA not tolerated or contraindicated use regimen with lowest risk of weight gain

PREFERABLY

DPP-4i (if not on GLP-1 RA) based on weight neutrality

If DPP-4i not tolerated or contraindicated or patient already on GLP-1 RA, cautious addition of:

- SU
- TZD
- Basal insulin
COST IS A MAJOR ISSUE⁸-¹⁰

SU⁶ → TZD¹⁰ → If HbA₁c above target

TZD¹⁰ → SU⁶ → If HbA₁c above target

- Insulin therapy basal insulin with lowest acquisition cost
- OR
  - Consider DPP-⁴i OR SGLT₂i with lowest acquisition cost¹⁰
Pharmacologic Approaches to Glycemic Treatment (continued).

A new section was added on insulin injection technique, emphasizing the importance of technique for appropriate insulin dosing and the avoidance of complications (lipodystrophy, etc.).

The section on noninsulin pharmacologic treatments for type 1 diabetes was abbreviated, as these are not generally recommended.
Cardiovascular Disease and Risk Management.

For the first time, this section is endorsed by the American College of Cardiology. Additional text was added to acknowledge heart failure as an important type of CVD in people with diabetes for consideration when determining optimal diabetes care.

Blood pressure recommendations were modified:
- For individuals with diabetes and hypertension at higher cardiovascular risk (existing ASCVD or 10-year ASCVD >15%), a blood pressure target of <130/80 mmHg may be appropriate, if it can be safely attained.
- For individuals with diabetes and hypertension at lower risk for CVD (10-year ASCVD risk <15%), treat to a blood pressure target of <140/90 mmHg.

A discussion of the appropriate use of the ASCVD risk calculator was included, and recommendations were modified to include assessment of 10-year ASCVD risk as part of overall risk assessment and in determining optimal treatment approaches.
The recommendation and text regarding the use of aspirin in primary prevention was updated with new data:

- Aspirin therapy (75-162 mg/day) may be considered as a primary prevention strategy in those who are at increased CV risk, after a discussion with the patient on the benefits versus increased risk of bleeding.

For alignment with the ADA-EASD consensus report, two recommendations were added for the use of medications that have proven cardiovascular benefit in people with ASCVD, with and without heart failure.
Microvascular Complications and Foot Care.

The recommendation on the use of telemedicine in retinal screening was modified:

- Telemedicine programs that use validated retinal photography with remote reading by an ophthalmologist or optometrist and timely referral for a comprehensive eye examination when indicated can be an appropriate screening strategy for diabetic retinopathy.

Gabapentin was added to the list of agents to be considered for the treatment of neuropathic pain in people with diabetes based on data on efficacy and the potential for cost savings.
Microvascular Complications and Foot Care (continued).

The gastroparesis section includes a discussion of a few additional treatment modalities.

The recommendation for patients with diabetes to have their feet inspected at every visit was modified to only include those at high risk for ulceration. Annual examinations remain recommended for everyone.

To align with the ADA-EASD consensus report, a recommendation was added for people with type 2 diabetes and chronic kidney disease to consider agents with proven benefit with regard to renal outcomes.
HF OR CKD PREDOMINATES

PREFERABLY
SGLT2i with evidence of reducing HF and/or CKD progression in CVOTs if eGFR adequate

OR
If SGLT2i not tolerated or contraindicated or if eGFR less than adequate
add GLP-1 RA with proven CVD benefit

If HbA1c above target

• Avoid TZD in the setting of HF
Choose agents demonstrating CV safety:
• Consider adding the other class with proven CVD benefit
• DPP-4i (not saxagliptin) in the setting of HF (if not on GLP-1 RA)
• Basal insulin
• SU
A new section and recommendation on lifestyle management was added to address the unique nutritional and physical activity needs and considerations for older adults.

Within the pharmacologic therapy discussion, deintensification of insulin regimes was introduced to help simplify insulin regimen to match individual’s self-management abilities. A new figure was added (Fig. 12.1) that provides a path for simplification. A new table was also added (Table 12.2) to help guide providers considering medication regimen simplification and deintensification/deprescribing in older adults with diabetes.
Simplification of Complex Insulin Therapy

Patient on basal (long- or intermediate-acting) and/or mealtime (short- or rapid-acting) insulin:

**Basal insulin**
- Change timing from bedtime to morning
- Titrate dose of basal insulin based on fasting fingerstick glucose test results over a week
  - Fasting Goal: 90–150 mg/dL (4.9–8.3 mmol/L)
  - May change goal based on overall health and goals of care
- If 60% of the fasting fingerstick glucose values are over the goal:
  - ↑ dose by 2 units
- If >2 fasting fingerstick values/week are <80 mg/dL (4.4 mmol/L):
  - ↓ dose by 2 units

**Mealtime insulin**
- If mealtime insulin >10 units/dose:
  - ↓ dose by 50% and add noninsulin agent
- Titrate mealtime insulin doses down as noninsulin agent doses are increased with aim to discontinue mealtime insulin

Patient on premixed insulin:

**Use 70% of total dose as basal only in the morning**
- If mealtime insulin ≤10 units/dose:
  - Discontinue mealtime insulin and add noninsulin agent(s)
- Add noninsulin agents:
  - If eGFR is ≥45 mg/dL, start metformin 500 mg daily and increase dose every 2 weeks, as tolerated
  - If eGFR is <45 mg/dL, patient is already taking metformin, or metformin isn't tolerated, proceed to second-line agent

Additional Tips
- Do not use short-acting insulin at bedtime
- While adjusting mealtime insulin, may use simplified sliding scale, for example:
  - Premeal glucose >250 mg/dL (13.9 mmol/L), give 2 units of short- or rapid-acting insulin
  - Premeal glucose >360 mg/dL (19.4 mmol/L), give 4 units of short- or rapid-acting insulin
  - Stop sliding scale when not needed daily

Using patient and drug characteristics to guide decision making, as depicted in Fig. 9.1 and Table 9.1, select additional agent(s) as needed:
- Every 2 weeks, adjust insulin dose and/or add glucose-lowering agents based on fingerstick glucose testing performed before lunch and before dinner
- Goal: 90–150 mg/dL (4.9–8.3 mmol/L) before meals; may change goal based on overall health and goals of care
- If 50% of premeal fingerstick values over 2 weeks are above goal, increase the dose or add another agent
- If >2 premeal fingerstick values/week are <90 mg/dL (4.9 mmol/L), decrease the dose of medication
Management of Diabetes in Pregnancy.

Women with preexisting diabetes are now recommended to have their care managed in a multidisciplinary clinic to improve diabetes and pregnancy outcomes.

Greater emphasis has been placed on the use of insulin as the preferred medication for treating hyperglycemia in gestational diabetes mellitus as it does not cross the placenta to a measurable extent and how metformin and glyburide should not be used as first-line agents as both cross the placenta to the fetus.
Diabetes Care in the Hospital

Because of their ability to improve hospital readmission rates and cost of care, a new recommendation was added calling for providers to consider consulting with a specialized diabetes or glucose management team where possible when caring for hospitalized patients with diabetes.
Standards of Care Resources

- Full version available
- Abridged version for PCPs
- Free app, with interactive tools
- Pocket cards with key figures
- Free webcast for continuing education credit

Professional.Diabetes.org/SOC
Thank you!
February Webinar

• **Date/Time:** February 21, 2019 from 2-3pm Eastern

• **Topic:** Clinical Inertia and Diabetes Care

• **Presenter:** Daniel McCall, M.D. (Hattiesburg Clinic)
## TOGETHER 2 GOAL® 2019 WEBINAR SCHEDULE

WEBINARS WILL BE HELD FROM 2-3PM EASTERN

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<td>Nisa Maruthur, M.D., M.H.S. (Johns Hopkins University)</td>
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<td>Feb. 21, 2019</td>
<td><strong>Clinical Inertia and Diabetes Care</strong></td>
<td>Daniel McCall, M.D. (Hattiesburg Clinic)</td>
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<td>March 21, 2019</td>
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<td>Jodi Lavin-Tompkins, M.S.N., R.N., CDE, BC-ADM (American Association of Diabetes Educators) and Valerie Spier, M.P.H., R.D., CDE (Sutter Health)</td>
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<td>T.B.D.</td>
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<td>T2G Diabetes Bundle Collaborative Participants</td>
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Questions